Date	**12/08/2025**
Time	**10:00 - 13:00**
Location	**MS Teams; Ystwyth Board Room Avocor (Hywel Dda UHB - Generic Account)**

Virtual Audit & Risk Assurance Committee Meeting

HDD_Audit and Risk Committee

NHS Wales

Agenda - 12 August 2025

1 1 Introductions

10:00, 0 min

1.1 Apologies

10:00, 0 min
Rhodri Evans (Hywel Dda UHB - Independent Member)

1.2 Declaration of Interests

10:00, 0 min

2 Governance

10:00, 0 min

2.1 Minutes of the Meeting held on 24 June 2025

10:00, 0 min
Rhodri Evans (Hywel Dda UHB - Independent Member)

2.2 Table of Actions

10:00, 5 min
Rhodri Evans (Hywel Dda UHB - Independent Member)

2.3 Matters Arising not on Agenda

10:05, 0 min
Rhodri Evans (Hywel Dda UHB - Independent Member)

2.4 Escalation Status Update Report

10:05, 15 min
Philip Kloer (Hywel Dda UHB - Chief Executive), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Shaun Ayres (Hywel Dda UHB - Director of Delivery), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience), Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding)

2.5 All Wales NHS Audit Committee Chairs' Meeting Update

10:20, 0 min
Rhodri Evans (Hywel Dda UHB - Independent Member)

2.6 Committee Self-Assessment

10:20, 5 min
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

2.7 NHS Wales Shared Services Partnership's Construction Frameworks for Swansea Bay and Hywel Dda University Health Boards

10:25, 15 min
Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Eldeg Rosser (Head of Capital Planning), Julian Wheeler Jones (Hywel Dda UHB - Discretionary Capital Projects Manager)

3 Audit Wales

10:40, 0 min

3.1 Audit Wales Update Report

10:40, 5 min
Anne Beegan, Urvisha Perez, david.williams@audit.wales

3.2 Structured Assessment - Progress Update on Recommendations

10:45, 15 min
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Huw Thomas (Hywel Dda UHB - Director of Finance), Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience), Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health)

3.3 Review of Urgent and Emergency Care (Discharge Planning and Impact of Patient Flow)

11:00, 0 min
Anne Beegan, Urvisha Perez, Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

3.4 Review of Investment in Digital Systems

11:00, 0 min
Anne Beegan, Urvisha Perez, Huw Thomas (Hywel Dda UHB - Director of Finance)

3.5 Review of the Management of Outpatients

11:00, 0 min
Anne Beegan, Urvisha Perez, Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

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4 **BREAK**

11:00, 10 min

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5 **NWSSP – Audit and Assurance Services - Internal Audit**

11:10, 0 min

5.1 **Internal Audit Plan Progress Report**

11:10, 5 min
James Johns (NWSSP - Internal Audit)

5.2 **Standards of Cleanliness Internal Audit - Action Plan Progress**

11:15, 20 min
James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science), Elin Brock (Hywel Dda UHB - Head of Research, Innovation & Improvement), Simon Chiffi (Hywel Dda UHB - Head of Operations)

5.3 **Corporate Risk: Ophthalmology (Reasonable Assurance)**

11:35, 10 min
James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care), Victoria Coppack (Hywel Dda UHB - Service Delivery Ophthalmology Ophthalmology & Neurology)

5.4 **Sickness Management (Limited Assurance)**

11:45, 20 min
James Johns (NWSSP - Internal Audit), Lisa Gostling (Hywel Dda UHB - Director of Workforce & OD/Deputy CEO), Heather Hinkin (Hywel Dda UHB - Assistant Director People Management)

5.5 **Nursing Management (Limited Assurance)**

12:05, 20 min
James Johns (NWSSP - Internal Audit), Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience), Janice Cole-Williams (Hywel Dda UHB - Assistant Director of Nursing), Helen Humphreys (Hywel Dda UHB - Head of Nursing for Professional Standards and Regulation)

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6 **Financial Focus**

12:25, 0 min

6.1 Financial Assurance Report

12:25, 10 min
Huw Thomas (Hywel Dda UHB - Director of Finance)

6.2 Counter Fraud Update

12:35, 5 min
Benjamin Rees (Hywel Dda UHB - Local Counter Fraud Specialist)

6.3 Counter Fraud, Bribery and Corruption Policy Review

12:40, 0 min
Benjamin Rees (Hywel Dda UHB - Local Counter Fraud Specialist)

7 Assurance and Risk

12:40, 0 min

7.1 Risk Assurance Report

12:40, 5 min
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

7.2 Risk Management Framework and Strategy

12:45, 5 min
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

8 Post Payment Verification

12:50, 0 min

8.1 Post Payment Verification (PPV) Annual Report

12:50, 5 min
Huw Thomas (Hywel Dda UHB - Director of Finance), Amanda Legge (NWSSP - PCS), Sue Tillman (NWSSP - PCS)

8.2 Primary Care PPV Report

12:55, 5 min
Jill Paterson (Hywel Dda Health Board - Director of Primary Care, Community and Long Term Care), Rhian Bond (Hywel Dda UHB - Assistant Director of Primary Care)

9 For Information

13:00, 0 min

9.1 **Audit Wales - Letter regarding Future Report Writing Style**

13:00, 0 min

9.2 **ARAC Workplan 2025/26**

13:00, 0 min

10 **Any Other Business**

13:00, 0 min

11 **Review of Meeting**

13:00, 0 min

11.1 **Matters and Risks for Escalation to the Board**

13:00, 0 min

12 **Date and Time of Next Meeting**

13:00, 0 min

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12/08/2025 10:00 - 13:00

1

10:00, 0 Mins

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1 - 1 Introductions

1.1

10:00, 0 Mins

1.1 - Apologies

Rhodri Evans (Hywel Dda UHB - Independent Member)

For information

1.2 **10:00, 0 Mins**

1.2 - Declaration of Interests

All

For information

2

10:00, 0 Mins

2 - Governance

2.1

10:00, 0 Mins

2.1 - Minutes of the Meeting held on 24 June 2025

Rhodri Evans (Hywel Dda UHB - Independent Member)

For approval

Attachments

2.1 Unapproved ARAC Minutes 24 June 2025.pdf

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

Date of Meeting: **09:30, Tuesday 24 June 2025**
Venue: **Microsoft Teams Meeting/ Ystwyth Boardroom**

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

In Attendance:
Mr Anthony Veale, Audit Wales (VC) (part)
Ms Anne Beegan, Audit Wales
Mr Tomos Jones, 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)
Mr David Butler, NWSSP Specialist Estates Services (VC)
Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary
Ms Claire Bird, Assurance and Risk Officer, deputising for Miss Charlotte Wilmshurst, Assistant Director of Assurance and Risk
Mr Huw Thomas, Director of Finance
Mr Ben Rees, Head of Counter Fraud (part)
Professor Phil Kloer, Chief Executive (part)
Mr Shaun Ayres, Director of Delivery (VC) (part)
Mr Andrew Carruthers, Chief Operating Officer (part)
Ms Anna Chiffi, Assistant Director of Nursing (VC) (part)
Mr Tom Alexander, Principal Programme Manager (VC) (part)
Ms Eldeg Rosser, Head of Capital Planning (VC) (part)
Mr James Severs, Executive Director of Allied Health Professions and Health Science (part)
Mr Simon Chiffi, Head of Operations (VC) (part)
Ms Elin Brock, Head of Research, Innovation & Improvement (VC) (part)
Dr Neil Wooding, HDdUHB Chair (part)
Ms Rhian Davies, Assistant Director of Finance, Financial Planning and Statutory Reporting (VC) (part)
Mr Tim John, Head of Accounting and Statutory Reporting (VC) (part)
Ms Anna Lewis, Independent Member (observing)
Ms Clare Moorcroft, Committee Services Officer (minutes)

Minutes Ref.	Item	Action
AC(25)93	**Introductions and Apologies for Absence**	

Cllr. Rhodri Evans, Audit and Risk Assurance Committee (ARAC) Chair, welcomed everyone to the meeting. Apologies for absence were received from:

- Ms Urvisha Perez, Audit Wales
- Ms Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience

- Mr Lee Davies, Executive Director of Strategy and Planning
- Mr Gareth Cottrell, Deputy Chief Operating Officer
- Mr Peter Skitt, Clinical Care Group Service Director - Community and Integrated Medicine

AC(25)94 **Declaration of Interests**

No declarations of interest were made.

AC(25)95 **Minutes of the Meetings held on 15 April and 8 May 2025**

Decision: RESOLVED – the Minutes from the meetings held on 15 April and 8 May 2025 were approved as an accurate record.

AC(25)96 **Table of Actions**

An update was provided on the Table of Actions from the meeting held on 15 April and 8 May 2025 and confirmation received that outstanding actions had been progressed. In terms of matters arising:

AC(25)47 – Mrs Joanne Wilson advised that the action to consider how Clinical Audit might contribute to a wider piece of work around inefficiencies in Patient/Clinical Pathways will be taken forward by Ms Sharon Daniel. An update would be requested for the next meeting. **SD**

All other actions were complete and would be removed from the Table of Actions.

With regard to action **AC(25)63**, Mr Winston Weir requested assurance around value for money, and confirmation that the amount of VAT recovered exceeded the fee paid. Mr Huw Thomas confirmed that the amount reclaimed was significant, with the fee representing 25% of the total.

AC(25)97 **Matters Arising not on Agenda**

There were no other matters arising.

AC(25)98 **Escalation Status Update Report**

Professor Phil Kloer and Mr Shaun Ayres joined the Committee meeting.

Mr Shaun Ayres presented the Escalation Status Update Report, highlighting that all domains are rated as 'Assure', with the exception of Criterion 43 (Programme and Performance Management Framework with Effective Board Oversight Assessment), which is rated as 'Advise'. This refers to support for the various programmes running within the Health Board. Mr Ayres indicated that this remains an area of concern for him. The only other area for ARAC to be aware of is the letter around the amendment to the framework around Healthcare Inspectorate Wales (HIW) and HEIW inspections and reports in terms of actioning the recommendations. Finally, ARAC requested that it be sighted on any material issues, even if not aligned to this Committee, to ensure maximum oversight. To this end, a number

of issues had been summarised as succinctly as possible, including ambulance handovers, Pathway Of Care Delays, Ophthalmology R1 and the deterioration in 104 week waits performance.

With regard to these matters, Professor Phil Kloer explained that HIW had contacted the Health Board due to the volume of concerns raised in this calendar year, compared with other organisations. It is recognised that there have been issues around scheduling meetings with HIW and changes in personnel there, and actions have been put in place to address this. HIW were not so much concerned with the individual responses to concerns; rather the numbers involved. HIW also had some concerns regarding whistleblowing, which it was felt might be related to changes relating to the Organisational Change Process (OCP) and Clinical Services Plan. This will be monitored carefully, and work in relation to 'Speaking Up Safely' and by the Equality, Diversity and Inclusion (EDI) Taskforce should assist in this regard. There has been a follow-up with Welsh Government and HIW, who were both assured by the actions proposed by the Health Board.

Professor Kloer reminded Members that there is a significant Unscheduled Care programme in place, with ambitions far in excess of the improvements seen so far. However, the targets outlined within the Ministerial Advisory Group (MAG) report are extremely challenging, and there is much work required to prepare for winter 2025/26. In terms of Planned Care, the Health Board is predicting 171 breaches by the end of Quarter 1, within Orthopaedics, ENT and Ophthalmology. There are various factors involved; however, it is believed that it will be possible to recover the position in Quarter 2 and the Health Board has been in close discussion with Welsh Government over this matter. With regard to the HIW issue, Members heard that Ms Anna Lewis, Chair of the Quality, Safety and Experience Committee (QSEC), attending ARAC today, has requested that more detail be provided to QSEC. How the Health Board works with HIW and Health Education and Improvement Wales (HEIW) will also form part of the requirements within the Targeted Intervention Framework, under Governance and Leadership.

Mr Ayres wished to add one further key material point, which was the Welsh Government letter around the Health Board's Target Control Total of £31.5m no longer being supportable or acceptable as they regard this as a deterioration in the 2024/25 outturn. On this topic, Mr Maynard Davies expressed concern regarding capital provision, highlighting that any reduction would have major implications for capital projects; which would, in turn, cause issues with compliance in areas such as fire safety. Mr Thomas advised that discussions are ongoing with Welsh Government, who are seeking responses framed in a specific manner. This focuses on choices that the Health Board could make; actions that the Health Board could take; and options that the Health Board would need to pursue. Clearly, any choices would have consequences,

because these have already been included in the current Annual Plan. If it is then decided to exclude them, there will be delays to certain elements of the Plan. There is, however, a limit to the number of investments that the Health Board could now choose not to take forward, because some commitments have already been made.

In terms of possible actions, enhancing savings plans is one which could be considered. There have been some positives, including nurse agency expenditure and medicines management, which have both improved over and above expectations. However, there is a need in the first instance for an assured trajectory to get to £31.5m. This is an area requiring de-risking, which has been and will continue to be a focus for the Executive Team. Whilst there are positive signs, there are still a number of risks requiring management. There will be options which need to be discussed with Welsh Government, as part of an ongoing dialogue.

Professor Kloer indicated that the letter referred to has been shared with Board Members. It should be highlighted that there is a timing issue involved. Ideally, Professor Kloer would have preferred that the Health Board's response be discussed at the Finance and Performance Committee (FPC) and Board; however, Welsh Government have set a deadline of 30 June 2025. It may be possible to have a limited discussion at FPC and Board on 26 June; however, if not, any response will need to reflect this. Whilst the Health Board's Target Control Total is a deficit of £31.5m, and it may be possible to reduce the forecast deficit slightly, there is currently no 'routemap' to the £24m which has been suggested by Welsh Government. Members were also reminded that the Statutory Duty is break-even and Welsh Government's expectation is for a zero deficit within three years. So there are a number of expectations which the Health Board is trying to manage. Agreeing, Mr Thomas emphasised that Welsh Government is facing significant financial pressures 'across the board', and the Health Board needs to demonstrate its support.

Cllr. Evans enquired whether Welsh Government are planning on including additional elements relating to working with the regulators in the de-escalation criteria. Professor Kloer confirmed that this has been added to the Escalation Framework under Governance and Leadership. The intention is to monitor the appropriateness and timeliness of responding to HIW and HEIW.

In terms of Criteria 43, Mrs Eleanor Marks requested clarification around whether ARAC is concerned with assurance regarding the systems to ensure reporting and engagement. She enquired how this would work in practice, and whether it would fall mainly to leaders of operational teams to ensure the inputting of information and that new systems are implemented. It was highlighted that this involves a significant change in culture. Mrs Wilson advised that ARAC's role is to oversee and seek assurance. It is for FPC to examine the detail and for operational teams to deliver. This was confirmed by Mr Ayres, who added that performance in this

regard is aligned to the new Clinical Care Group (CCG) structure. It is vital to ensure maximum 'grip and control' at this level, and overarching clarity at an organisational level. Going forward, there needs to be a focus on risks and mitigations, possibilities, performance management and planning. Whilst welcoming this context, Mrs Marks emphasised that ARAC needs awareness and information around accountability, in order to take assurance regarding delivery. Agreeing, Cllr. Evans highlighted the need for mapping to committees.

Mr Ayres confirmed that the risks would all be mapped to the relevant committee; for example, the Integrated Care and Medicine Group would report into FPC around ambulance handovers. Monitoring and management would be via the performance framework. The challenge is around establishing responsibility and timescales for delivery, given the number and complexity of programmes. Mr Thomas confirmed that the majority of performance reporting would go to FPC; however, all performance metrics are attributed to committees for assurance purposes. For delivery purposes, accountability is outlined within the Health Board's processes. Members heard that there is a revised approach to reporting for FPC, the first iteration of which will be presented on 26 June 2025. Mr Thomas felt that this offers a clear articulation of the Health Board's escalation status, per CCG and function, and a clear articulation of the issues the Health Board is experiencing, which should provide an appropriate framework for accountability. The first round of the new internal escalation process is also underway, and should be complete by the end of the month. This too provides real clarity around accountability operationally. In an effort to address Mrs Marks' query, Professor Kloer requested that Mr Thomas and Mr Ayres work together to add to future reports details of responsibility and accountability; in terms of assurance committee, CCG/operational group, Executive Lead and officer. **HT/SA**

Decision: The Committee **NOTED** the Escalation Status Update.

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

Professor Phil Kloer and Mr Shaun Ayres left the Committee meeting.

AC(25)99 Committee Self-Assessment

DEFERRED to 12 August 2025 meeting

AC(25)100 Annual Review of Committee Terms of Reference

Mrs Wilson introduced this item, which meets the requirement for an annual review of the ARAC Terms of Reference. The report outlines the proposed amendments for the Committee's consideration.

Mr Davies noted that paragraph 2.4.3, whilst mentioning 'other Committees of the Board', does not mention the recently

established Regional Joint Committee (RJC). Mrs Wilson agreed to include reference to the RJC. **JW**

Decision: Subject to addition of reference to the RJC, the Committee **APPROVED** the ARAC Terms of Reference (version 19) for onward ratification by the Board on 31 July 2025.

AC(25)101 Standing Financial Instructions

Presenting the Standing Financial Instructions report, Mrs Wilson explained that these have been updated to reflect changes resulting from a recent Welsh Health Circular (WHC). The proposed amendments are detailed within the report.

Decision: The Committee **RECOMMENDED** the revised version of HDdUHB's Standing Financial Instructions to the Board on 31 July 2025 for approval.

AC(25)102 Audit Wales Update Report

In terms of financial audit work, Mr David Williams noted that the ISA 260 and final accounts appear later on today's agenda. The Charitable Funds accounts audit work will take place later in the year; the exact timing will be confirmed in due course. With regard to performance audit, Ms Anne Beegan presented a summary of planned and current work, advising that there are several Audit Wales reports on the agenda. Members heard that the Structured Assessment work has now commenced. The planned work in relation to Digital has been delayed and consideration will be given to how best to take this forward. Page 11 of the report highlights other relevant publications, including the Cost Savings Arrangements checklist, which also appears on today's agenda. Members were advised that Audit Wales is hosting a Good Practice Exchange event 'No time to lose: Prioritising prevention' which will run in two locations on 15 and 17 July 2025.

Mrs Wilson highlighted that concerns around capacity and fragility in the Health Board's Radiology service may have an impact on the planned review into this specialty; however, Audit Wales are working with the service to discuss possibilities.

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

AC(25)103 Review of Urgent and Emergency Care

Mr Winston Weir left the Committee meeting; Mr Andrew Carruthers, Ms Anna Chiffi and Mr Tom Alexander joined the Committee meeting.

Ms Beegan presented the Review of Urgent and Emergency Care (UEC) report, drawing Members' attention to the key findings and noting that there are several recommendations made. These included around using data to inform plans for improvements, and data quality; funding arrangements and evaluating impact; improved signposting for patients and aligning to the Welsh

Ambulance Services NHS Trust (WAST) directory of service; increasing consideration and collation of feedback both patient and staff; dental contract performance; ensuring compliance with Same Day Emergency Care (SDEC) referral guidance and improving SDEC access to patient information. Members heard that all of the recommendations had been accepted by the Health Board.

Mr Andrew Carruthers welcomed the report and thanked the Audit Wales team for their work. He noted that this review had been ongoing for some time and had been started under the previous operational structure. The recommendations identified, however, were all familiar. He was hopeful that the Six Goals programme, accelerated improvement programme, changes to the operational structure and the proposed strategic plan for UEC presented at the most recent Board Seminar will all contribute to addressing the report's findings. Members heard that there had been a useful session yesterday, facilitated by the Health Board's Digital Partner on the topic of data, which is being approached regionally.

Professor Phil Kloer joined the Committee meeting.

Mr Davies agreed that at least three of the report's recommendations had been covered during discussions at last week's Board Seminar. Focusing on Recommendation 9 around access to GP records for SDEC, he highlighted that the GP Out Of Hours service has had this for some time. The technical mechanism to allow this should, therefore, be in place and Mr Davies requested clarification regarding the impediment. Moving onto Recommendation 12, and given HIW's interest in this area, he enquired whether there will be an option for face-to-face staff feedback, as only web-based engagement is mentioned. In response to the first query, Mr Carruthers explained that different parts of the healthcare system utilise different systems for the data. This was highlighted and discussed at the session yesterday and it was not felt that the issue was insurmountable; however, a decision on the most appropriate system to use is required. There may be short-term solutions which can also be applied. The proposed developments in terms of eObservations and Patient Flow will also be vital in facilitating this improvement.

In terms of staff engagement and feedback, Mr Carruthers observed that the Health Board's Communications Plan tends to prioritise its response to urgent pressures and notices around these. There needs to be an improved Communications Plan for staff. Mrs Marks agreed with this view. She expressed concern over the findings around dental services and access to dental treatment in HDdUHB and enquired regarding actions to address this. Mr Carruthers recognised that this is an area of significant challenge, not necessarily through want of trying. The issue has been primarily around an inability to secure contracts and recruit practices to deliver services. A more detailed piece of work and alternative approach is probably required. Mrs Wilson highlighted that the Health Board Chair has requested that a report on the

topic of sustainable dental services be presented to the July 2025 Public Board meeting.

Ms Anna Lewis noted that the report references issues and concerns around staff engagement and a 'blame culture'. Whilst Board Members may be hearing a great deal about actions being taken around, for example, the Health Board's Strategy, she queried how 'close' the broader workforce is to this – particularly given that it will be for the workforce to deliver. Ms Lewis requested assurance on this matter. In response, Mr Carruthers felt optimistic that the new operational structure, which aligns community and acute services together under one leadership team, both at a system level and at a CCG level, starts to address this issue. Bringing teams together and managing them as a single service starts to break down some of the barriers. There does need to be a 'read across' into Primary Care to ensure that different separations do not develop. Mr Carruthers suggested that some of the success seen in Pembrokeshire has been attributable to bringing together teams and breaking down silo-working and barriers. He has asked Dr Karen Brown to make this approach more widespread in her new role.

Mrs Marks was somewhat concerned by the optimism, requesting assurance that the management and structures are in place to achieve this, and requesting an indication of timescales. Mr Carruthers acknowledged that the structure is still in a transitional phase and that the detail is being worked through. There will be an OCP element involved, and this is a clinically-led model. In terms of timescale, he has stated the end of the month, in order to take it forward during the summer. It was agreed that Mr Carruthers would provide an update on progress to the next meeting, via the Table of Actions. Ms Anna Chiffi emphasised that care was being taken to ensure the next stage of the OCP facilitates the ambition for integrated working. As indicated, the aim is for a clinically-led approach, and this must include a focus on building trust and incorporate patient feedback. **AC**

Referencing the key findings around planning arrangements and the lack of clarity on 'how new models will be funded in the medium to longer term', Cllr. Evans requested further information. Mr Carruthers indicated that a key piece of work is required to establish clarity around the capacity needed to meet demand across the system. Until this has been undertaken, it will be challenging to determine funding requirements and source. As an example, the Health Board has 5 Emergency Medicine consultants in total across its Emergency Departments; Glangwili Hospital alone should have 16-20 to meet national staffing standards. All of the relevant information needs to be coalesced, in order to 'right size' the system. Mr Thomas highlighted that acute services represent the largest part of the Health Board's system and expenditure. The issue is reallocating resources optimally. Funding will need to be found from elsewhere, via benefits from reducing waste, harm and variation.

Returning to the issue of communications, Cllr. Evans enquired whether there is liaison with the Communications team. In response, Mr Carruthers advised that this does take place when there is a need to communicate system pressures, etc; however, consideration should probably be given to a wider communication strategy for both public and staff. Mrs Wilson confirmed that the Communications and Engagement Director is involved with the work taking place. Suggesting that some of the Health Board's responses might have been stronger, and include acronyms and jargon, Cllr. Evans enquired whether Audit Wales are content with the management response. Ms Beegan confirmed that they are, in general, and felt that this was a timely review, given the work being undertaken in this area.

Finally, Cllr. Evans requested assurance that the completion dates for actions are realistic and achievable, to which Mr Carruthers responded that many of these link with existing work programmes and ambitions in regard to UEC. Members were assured that all recommendations and associated actions are tracked.

Decision: The Committee **NOTED** the Review of Urgent and Emergency Care report.

The Committee agreed to **ADVISE** the Board in relation to the Review of Urgent and Emergency Care report.

Mr Tom Alexander left the Committee meeting.

AC(25)104 Planned Care Review

Ms Beegan introduced the Planned Care Review report, explaining that this focuses on Health Board arrangements for Planned Care recovery. It considered the progress the Heath Board is making in tackling its planned care challenges and reducing its waiting list backlog, with a specific focus on action that the Health Board has taken to tackle the planned care backlog; waiting list performance; and understanding and overcoming the barriers to improvement. The report makes six recommendations, some of which are similar to the UEC review, such as clarity around funding. Others include the need to develop long-term plans outside the Clinical Services Plan; the need for an operational Planned Care risk register and completion of recommendations from Getting It Right First Time (GIRFT) reports. The management response is appended.

Mr Carruthers thanked the Audit Wales team for their report. Ms Lewis welcomed in particular Recommendation 6, around developing a consistent methodology for assessing the risk of harm to patients caused by long waits and looked forward to seeing the report to QSEC. Noting that there was an issue of timing, Mr Davies highlighted that the Health Board had met the target in relation to 104 week waits, although performance had since deteriorated. This aligns with the recommendation around the need for long-term plans. Mr Davies noted that page 20 of the report references regional working, but this is not contained within

AC

the recommendations or management response. With regard to Recommendation 6, he enquired whether there are plans to undertake more work on risk stratification of waiting lists, to prioritise efforts where they will have the greatest impact. Responding to the first query, Mr Carruthers felt that this was a fair comment, suggesting that regional working is probably implicit in a number of specialties. He agreed that it could have been made clearer in the management response. In terms of risk stratification, this becomes easier with lower waiting lists. There is, however, an issue around escalation, with variation in clinical behaviour in categorising cases as urgent. Further work to address this is required.

Mr Winston Weir rejoined the Committee meeting.

Both Mr Davies and Mrs Marks welcomed the statistics and figures within the report, which (whilst concerning in some cases) add value. Referencing cancellations of elective surgery, Mrs Marks noted that a report around productivity is planned for FPC, which she hoped would be enlightening. She was concerned, however, by recent visits to wards which had been empty in the week following Bank Holidays, due to surgeries not being scheduled. Mrs Marks enquired whether additional funding provided by Welsh Government to reduce waiting lists is matched or allocated to vital 'support' functions such as Radiology, Pathology and testing. Mr Carruthers acknowledged that this probably does not occur as much as it should. These functions have been somewhat isolated from Referral to Treatment (RTT) discussions, although their input should be enhanced following the establishment of CCGs.

In reference to whether Audit Wales were content with the management response, Ms Beegan indicated that their only concern was around the use of 'Quarters' as completion dates for actions. It was agreed that specific calendar dates would be provided. **AC**

Mrs Wilson highlighted that there is a discussion around Planned Care as part of the In-Committee agenda. Also, that the numbers quoted in the report differ from those within the Audit Tracker, which may be due to timing, but needs to be checked. **CB**

<u>Decision</u>: The Committee **NOTED** the Planned Care Review report.

The Committee agreed to **ADVISE** the Board in relation to the Planned Care Review report.

Mr Andrew Carruthers and Ms Anna Chiffi left the Committee meeting.

AC(25)105 Review of Capital Investment Prioritisation

Ms Eldeg Rosser joined the Committee meeting.

Mr Tomos Jones presented the Review of Capital Investment Prioritisation report, advising that this was a local audit for HDdUHB only. The review considered the Health Board's arrangements for prioritising its capital investment and how this aligns with delivery of its strategic objectives. Specifically, it considered capital assets including land and property estate, and high-cost clinical and digital equipment. The review did not assess any individual capital investment decisions. In general, the findings of this report were largely positive and only one recommendation was made. Key findings were that the Health Board has good arrangements in place for prioritising its capital investment; the level of oversight was good; the infrastructure investment plan that the Health Board has produced to outline its capital plans was well developed and aligned to the strategic objectives; the plan was costed in short-, medium- and long-term. However, the capital resources to try and meet the substantial backlog costs that are facing the organisation are quite limited. Currently, the Capital team is sufficiently resourced, however, if more projects were to become live, that staffing resource could become challenged. Governance arrangements around capital decisions were sufficient and allowed sufficient scrutiny. The one recommendation relates to how some of the CCGs recorded their medical equipment on asset registers and the need to ensure that all follow the correct procedure. Audit Wales is satisfied with the management response provided.

Ms Eldeg Rosser thanked Audit Wales for their review and report, welcoming the opportunity for external scrutiny. The findings and recommendation were fully accepted. The team had welcomed recognition of the fact that access to capital resource is limited, and Ms Rosser advised Members that there are ongoing discussions with Welsh Government around the constraints this creates.

Cllr. Evans congratulated the team on a positive report and thanked them for their efforts. He requested and received assurance that completion dates are achievable. Referencing the Health Board’s aging estate, Mrs Marks enquired around the practicalities and implications this has for capital investment prioritisation. Reminding Members of the success of the existing Integrated Care Centres (ICCs), she expressed concern that links to the Strategy are not strong enough to ensure that the Health Board is optimising future possibilities (such as Cross Hands) as opposed to taking a more minimal or pragmatic approach. Mr Thomas suggested that the scarce capital resource is making it necessary to prioritise those risks which can be managed within the resources available, rather than prioritisation in the truest sense. This makes optimising future projects extremely difficult, and means that the Health Board cannot necessarily respond strategically to the challenges it faces as an organisation.

Ms Rosser agreed, advising that the Health Board has an annual Discretionary Capital Programme allocation of £10m. Prioritisation of spending is not easy, and precedence is generally given to

those projects which are most pressing. A certain proportion of the allocation is held back to fund unforeseen and urgent costs, such as medical equipment breakdowns or estate issues. However, Ms Rosser acknowledged comments around the ICCs. Mrs Marks accepted that the most urgent and high-risk areas need to be prioritised, whilst suggesting that there is still a need for a discussion around the Strategy and capital allocation, perhaps by the Executive Team. Mr Davies highlighted that – due to the lack of capital availability – there are a number of minor repairs and improvements not being undertaken, such as improvements to toilets on wards. This is resulting in substandard facilities, which impact on patient experience and infection prevention and control (IPC). It was accepted, however, that the Capital team make the best use of the limited resource available. **LD**

Mr Thomas counselled that the situation is unlikely to improve following the Government's Comprehensive Spending Review, suggesting that there will probably be another three years of constrained growth at least. It is likely that consideration will need to be given to what is funded centrally, and what is funded via Charitable Funds where appropriate. Ms Beegan reminded Members that Audit Wales is planning a Structured Assessment Deep Dive review of the arrangements to manage estates. This is scheduled to begin in September 2025. She would ensure that this draws upon the comments made today. Members were also advised that Mr Lee Davies is considering how those issues and concerns which are 'flagged' during Board Member Patient Safety Walkabouts can be fed into discussions around capital prioritisation.

Welcoming this, Ms Lewis emphasised that there is a danger of 'getting lost in the headlines' of a £300m estates backlog, when within this, there are bathrooms and kitchens and ward areas and clinical areas which are substandard and which contribute to the Health Board's issues with IPC. As such, the prioritisation should be regarded as secondary to the risk identification.

Decision: The Committee **NOTED** the Review of Capital Investment Prioritisation report.

The Committee agreed to **ASSURE** the Board in relation to the Review of Capital Investment Prioritisation report.

Ms Eldeg Rosser left the Committee meeting.

AC(25)106 Cost Savings Arrangements Checklist

Ms Beegan presented the Audit Wales Cost Savings Arrangements Checklist, with Members noting that this has been circulated to all Board Members for their information.

Cllr. Evans wished to thank the Audit Wales team for their work across the year.

Decision: The Committee **NOTED** the Cost Savings Arrangements Checklist.

AC(25)107 Internal Audit Plan Progress Report

Mr James Johns introduced the Internal Audit Plan Progress Report, which was of the usual format. The report includes, in Section 2, details of the audits finalised since the previous meeting. These reports represent the conclusion of the 2024/25 Internal Audit Plan programme of work and contribute to the Head of Internal Audit Opinion and Annual Report, which appears on today's agenda. The Internal Audit Plan programme of work for 2025/26 has already commenced.

Decision: The Committee **TOOK ASSURANCE** with regard to the delivery of the Internal Audit plan and the outcomes of the finalised audit reports.

AC(25)108 Discharge Management Follow-up (Advisory Report)

Mr Andrew Carruthers and Ms Anna Chiffi rejoined the Committee meeting.

Ms Sophie Corbett introduced the Discharge Management Follow-up Internal Audit report, which assessed progress in addressing two high and two medium priority matters arising identified in the previous full scope audit undertaken earlier the year, and is purely a follow-up. No assurance rating had been assigned for this review, which had established that three of the matters arising have been addressed and one high priority matter arising remains outstanding. This relates to the documentation of discharge planning, with no evidence that staff had been educated on the information and compliance requirements and sample testing confirming that completion of the discharge element in the Welsh Nursing Care Record (WNCR) remains an issue.

Mr Davies expressed disappointment that there is no evidence of progress on the high priority matter arising. In response, Mr Carruthers suggested that there has been progress, with a higher completion rate, whilst acknowledging that the target within the original recommendation has not been met. Withybush Hospital (WGH) has made more progress in this regard than other sites. Ms Chiffi agreed that progress has been made, highlighting the programme of online training for staff and raised awareness. This requirement will, however, be escalated across sites with a particular focus on Bronglais (BGH), Glangwili (GGH) and Prince Philip (PPH) Hospitals. Compliance will be reviewed over the coming months and it is hoped that completion rates will increase.

Mrs Marks enquired whether parties such as Porth Preseli, Delta Wellbeing and Eastgate in discharge conversations, highlighting that, as well as preventing admission to hospital, they also provide community support for people coming out of hospital. Secondly, Mrs Marks had recently established that there is a disparity in

closing times between Discharge Lounges and hospital Pharmacies, meaning that if a patient's medications have not been organised by 5pm, they cannot be discharged. Whilst noting that medications were only a part of the discharge process, Mr Carruthers committed to investigate this matter. In response to the first query, Members were assured that these parties are involved in the discharge process, with Ms Chiffi recognising the importance of partnerships such as these as the accelerated workstreams around access and flow move forward. With regard to the pharmacy issue, Ms Chiffi suggested that there may be alternatives which can be considered. She however shared Mr Carruthers' view that medication should be sorted at an earlier stage, to ensure that it is not preventing discharge. It was agreed that Mr Carruthers and Mrs Marks would discuss this matter outside the meeting. **AC** **AC**

Mr Weir welcomed the positive aspects of the report, whilst noting that there are some negatives also. In terms of implementation of management actions, he noted that this primarily sits with the Interim Assistant Director of Nursing rather than the wider CCG. Mr Weir queried regarding hurdles to implementation of outstanding actions; whether these were overly ambitious or whether there is a lack of engagement, etc. In response, Mr Carruthers suggested that certain of the challenges are similar to those in Planned Care, with variations in clinical approach. There is also an aspect of 'hearts and minds' and culture change. This issue is, however, at the centre of the Optimum Flow work. He felt that the main priority is addressing variation and ensuring consistency. Ms Chiffi emphasised that a great deal of work is taking place, whilst agreeing that a more systematic (rather than siloed) approach is required. The challenge has been that the process is spread across four acute hospitals and three community/county systems. She hoped that the new CCG triumvirate structure will offer improved stability.

There is also work ongoing in discharge planning in terms of 'Red to Green' and the 50 day challenge, which considers the key constraints to discharge and what can be done to actively and proactively manage some of those constraints. Once the Health Board applies a more system-based approach, aligned to other UEC work around flow, access and environments, Ms Chiffi was confident that there will be more progress. Mr Weir requested assurance that all patients are given a date for discharge on admission to hospital. Ms Chiffi confirmed that every patient has a defined clinical pathway on admission, which includes a planned date for discharge. They are also provided with a Discharge Information Leaflet. This requirement is included in the training for staff mentioned earlier. In view of the likely staged or phased nature of implementation, Mr Weir suggested that it would be helpful to define dates or milestones for achieving the outstanding actions. Mrs Wilson explained that it is not possible to revise completion dates, as these have already been set and have passed, meaning that these recommendations will continue to be 'flagged' as outstanding on the Audit Tracker. Instead it was

agreed that an update would be provided to the next meeting via the Table of Actions. **AC**

Decision: The Committee **NOTED** the Discharge Management Follow-up (Advisory) Internal Audit Report.

The Committee agreed to **ASSURE** the Board in relation to the Discharge Management Follow-up (Advisory) Internal Audit report.

Ms Anna Chiffi left the Committee meeting.

AC(25)109 Standards of Cleanliness (Limited Assurance)

Mr James Severs, Ms Elin Brock and Mr Simon Chiffi joined the Committee meeting.

Ms Corbett introduced the Standards of Cleanliness Internal Audit report, which details the findings of a follow-up to the previous review undertaken in 2023/24. The previous audit had concluded Limited Assurance and identified a number of areas requiring urgent management attention. The follow-up had established that, whilst some progress had been made in addressing these issues, a number of the actions remained ongoing with the associated risks not fully addressed. Whilst governance groups are now in place, the reporting of cleaning audit scores to the county infection prevention and control groups was inconsistent; scheduled meetings were not always taking place, and on occasion facilities representation was poor; operational performance delivery meetings had not been taking place on a monthly basis. Whilst a central database of staff training has been established and training has commenced, it will take time to complete the roll-out. The previous audit reported positive outcomes from a pilot study of new working arrangements for domestics, and wider roll-out of this is ongoing; however is at a relatively early stage. There is limited use of cleaning schedules at wards within WGH and GGH. Documentation is often incomplete; the frequency of cleaning audits was not always compliant with the cleaning standards and policy; and target scores were not always being achieved. Overall, Limited Assurance had been concluded, with two high and four medium priority actions agreed.

Cllr. Evans expressed disappointment at the lack of progress identified by the audit report, which makes for uncomfortable reading. Ms Lewis shared his sentiments, whilst suggesting that the Limited Assurance rating of the first audit was disappointing; with this outcome beyond disappointing. She would hope and indeed expect that Executive Director colleagues are treating this with the gravity it deserves. Ms Lewis enquired whether the organisation possesses the management capacity and capability required to deliver the improvements required.

Mr Carruthers explained that responsibility for Estates and Facilities is currently in a transitional period between himself and Mr James Severs. He echoed the disappointment regarding a lack of progress in this matter, emphasising that the Health Board is

not in the position it would wish. He felt that the focus has perhaps been on actions rather than outcomes, which has been to the detriment of delivery. Mr James Severs indicated that, at present, the Health Board does not have a Director of Estates and Facilities in post; therefore, it does not have the capacity to deliver on this work. The priority is to get this individual in place, as such, the Job Description for this post is undergoing job evaluation this week. In the meantime, Mr Severs is providing line manager support to the relevant staff. He suggested that the organisation is short of four key senior (Band 8a) personnel in this area. Whilst filling this gap would involve a cost pressure of £300k, it will not be possible to address the audit's findings without this resource. Mr Severs has raised this matter with the Executive Team, and options are being considered. He agreed with Mr Carruthers that the actions are somewhat transactional and, as such, have failed to deliver both the target and the desired outcome. Mr Severs is working with the Director of Nursing, Quality and Patient Experience, and nursing colleagues to develop a SMART management response. In addition, Ms Elin Brock has been seconded to the CCG to lead a Task and Finish Group (sub-group) of the Environmental Hygiene Group, focused on actioning the management plan.

Mr Simon Chiffi recognised the Committee's disappointment with the audit outcome, and indicated that this is shared by the Facilities team, who are committed to addressing the findings. Despite challenges within that team during the past year, there has been some progress. Ms Elin Brock agreed, highlighting that there is now a consistent and accountable governance structure in place, via the CCG and service groups. In addition, as mentioned by Mr Severs, a monitoring Task and Finish Group has been established in conjunction with nursing colleagues to implement the management actions identified in the Internal Audit report. Since February 2025, a considerable amount of work has been taking place around stabilising the Health Board's cleaning service, following recognition that the structure and the operating model were not fit for purpose. There has been close working with teams on all hospital sites to map, review, validate and restructure the operating model and rotas for the cleaning service. This has been completed for GGH and PPH and the same work will be undertaken for WGH and BGH, with a completion date of September 2025. She hoped that this provides some assurance regarding the team's commitment to progress in this area.

Mr Thomas welcomed the context provided by colleagues. Regarding the issue of resource, he highlighted that additional funding had been provided two years ago; however, this had been used by the department to support other cost pressures. In terms of the further funding indicated as required, this is not currently part of discussions around cost pressures. There has been no decision to date, and this request would need to form part of the standard prioritisation process.

Cllr. Evans enquired whether the proposed completion dates in July 2025 are realistic. In response, Mr Severs indicated that he had no reason to doubt these are achievable. He is meeting regularly with the team and no concerns have been flagged to date. The CCG is meeting on 25 June 2025 and the Task and Finish Group on 26 June 2025, which should provide further clarity. Noting that it will take some time to put additional personnel in place, even if funding is agreed, Cllr. Evans felt that an interim position should be reported. Mr Severs offered to provide an update to the next meeting, following the meetings he has mentioned. In response to a query around the likely timescale for appointing a new Director of Estates and Facilities, Mr Severs indicated that he was working on the basis of three months. In terms of monitoring, Ms Lewis advised that this topic has been added to the QSEC agenda for August 2025, at which time there should be a good sense of progress. She enquired, however, whether full implementation of the management actions is contingent on the additional staff and funding of £300k. Mr Severs confirmed that it is predicated on this additional resource. He explained that the actions indicated in the management response were developed before the challenges and leadership capacity issues were fully appreciated. Progress is, therefore, at risk. As stated by Mr Thomas, the additional resource is not yet part of financial priority discussions. **JS**

Mr Ben Rees joined the meeting.

Whilst welcoming the additional context provided during discussions, Mrs Marks expressed concern that this issue has been ongoing for two years. During which time, there have been dirty hospitals, poor patient experience and risk of infection. This issue needs to be addressed urgently. Mrs Marks highlighted that concerns have been raised in various fora, and that it is an issue which should be possible to resolve with robust leadership and management. Professor Kloer, who had seen the first audit report, shared the concerns of other Members and echoed the need for progress in this area. He emphasised, however, that, even if it is possible to identify the additional resource required, there will be a significant delay in recruiting to posts. He suggested that an interim solution and/or reconsideration of the proposed timescales for management actions is required. Discussion of this issue is also required at Executive Team. Mr Thomas highlighted that Estates and Facilities are due to attend an Executive Improving Together session (EITs) this afternoon. He suggested that the topic of cleaning standards be prioritised during this session. **HT**

Mr Carruthers reiterated his disappointment at the audit outcome. He suggested that there are a number of separate factors and issues being managed; however, Mr Severs' assessment regarding the current leadership capacity and capability is correct. He felt that it was important, however, to recognise that the Cleaning Standards defined as targets within this audit are now out of date. Even if they can be achieved at some point, the organisation may still be in a position where it does not meet more

recent standards, for example any set by Welsh Government. Whilst accepting this, Ms Lewis emphasised that the standards detailed within the report are not especially onerous, and the Health Board is still not meeting them. Agreeing that there is a need for a clear timescale for progress and an interim solution, it was suggested that this should be identified prior to the next meetings of QSEC and ARAC in August 2025. **JS**

Mr Chiffi wished to highlight that the team of individuals tasked with managing this issue is extremely small, and consideration needs to be given to their pastoral care and wellbeing. Mrs Wilson emphasised that the discussion is not intended to place personal or collective blame or criticism, but to identify a process for management of the issue to provide the required assurance.

Decision: The Committee **NOTED** the Standards of Cleanliness (Limited Assurance) Internal Audit report and **REQUESTED** an interim update to the next meeting.

The Committee agreed to **ADVISE** the Board in relation to the Standards of Cleanliness (Limited Assurance) Internal Audit report.

Professor Phil Kloer, Ms Elin Brock and Mr Simon Chiffi left the Committee meeting.

AC(25)110 **Reinforced Autoclaved Aerated Concrete (RAAC) – Withybush General Hospital (Reasonable Assurance)**

Mr David Butler introduced the Reinforced Autoclaved Aerated Concrete (RAAC) – Withybush General Hospital Internal Audit report, noting that this is the second audit undertaken of the WGH RAAC project. The previous review had focused on the initial mobilisation of the early works for immediate interventions in spring 2024 and had concluded Substantial Assurance. The second review focused on the arrangements in place to manage the project and the programme of work to mitigate the ongoing risks associated with RAAC during 2024/25. The audit outcome was a positive assessment, providing an overall Reasonable Assurance rating. The project had been delivered on time and under budget, including £0.5m already returned to Welsh Government. Whilst noting certain project control issues, it was clear that these hadn't impacted on overall delivery. Matters requiring management attention included the need for additional reporting narrative to confirm the accuracy of in-house costs, in accordance with funding requirements; and to apply parent company guarantees at contracts, an issue also raised at the wider systems audit reported in November 2024.

Noting reference to national research regarding the management of RAAC, Mr Davies enquired as to any indication that such research is taking place and the findings of this. Mr Butler advised that NWSSP are not sighted on any such research currently; however, are conscious that this will be an area of ongoing focus. Mr Carruthers had also not been notified by Welsh Government of

any developments in this field, although changes in approach were possible.

Decision: The Committee **NOTED** the Reinforced Autoclaved Aerated Concrete (RAAC) – Withybush General Hospital (Reasonable Assurance) Internal Audit report.

The Committee agreed to **ASSURE** the Board in relation to the Reinforced Autoclaved Aerated Concrete (RAAC) – Withybush General Hospital (Reasonable Assurance) Internal Audit report.

AC(25)111 Continuing Health Care – Database Maintenance and Finance Processes (Substantial Assurance)

Ms Corbett introduced the Continuing Health Care – Database Maintenance and Finance Processes Internal Audit report. This was a limited scope review, focusing on the arrangements in place for maintaining and updating the All Wales National Complex Care Database and the subsequent accounting and forecasting processes, both of which we found to be robust. The audit had concluded Substantial Assurance overall, with one medium priority matter requiring management attention, relating to the receipt of invoices from local authorities.

Mr Thomas welcomed the audit findings and thanked the team for their review. He emphasised that this area necessitates a strong interface between the Finance and Primary Care teams. In response to the matter requiring management attention, he had asked the Finance team to review the process for escalating late invoices.

Decision: The Committee **NOTED** the Continuing Health Care – Database Maintenance and Finance Processes (Substantial Assurance) Internal Audit report.

The Committee agreed to **ASSURE** the Board in relation to the Continuing Health Care – Database Maintenance and Finance Processes (Substantial Assurance) Internal Audit report.

Mr Andrew Carruthers and Mr James Severs left the Committee meeting.

AC(25)112 Contract Management (Advisory Report)

Ms Corbett introduced the Contract Management Internal Audit report, indicating that this review was prompted by a similar review undertaken at Betsi Cadwaladr UHB at the request of Welsh Government in 2023/24, which identified several areas of concern. The review has been replicated at eight other organisations this year which has enabled Internal Audit to compare and contrast, with common issues identified across all eight organisations. These relate to the lack of contract management, guidance and procedures; the absence of central comprehensive contract registers; the need to ensure sufficient capacity and expertise to meet contract management requirements; contract management responsibilities not formally assigned and accepted; inconsistent

contract management approach, performance reporting and documentation; and a lack of clarity regarding internal reporting, accountability and escalation arrangements. The actions identified will need to be taken forward in partnership with other NHS Wales organisations, including NWSSP Procurement Services, via an appropriate forum such as the Directors of Finance forum, with a view to developing a co-ordinated, agreed action plan to address common themes.

Cllr. Evans queried the absence of timescales and delegation of actions; with Mr Thomas explaining that a national response and action plan will be required in the first instance. This will be via the Directors of Finance forum, followed by consideration of the local implications and actions. He would provide an update to the next meeting. Noting that Objective 2 states that the issue of contract registers has been highlighted in previous Internal Audit reviews of Procurement Services, Mr Davies enquired whether this was recorded on the Audit Tracker and (if so) why it has not been addressed. With regard to Objective 3, which indicates a lack of specific contract management training, he queried suggested that this should be highlighted within Performance Appraisal Development Reviews (PADRs). **HT**

Responding to the query around contract registers, Mr Thomas advised that the Health Board does have one in place, which covers off Service Level Agreements (SLAs), Long Term Agreements (LTAs) and healthcare contracting. However, what is currently missing is the additional element, around the rest of the supply chain management. Mr Thomas felt that, whilst the procurement processes in place are robust, the management of contracts currently provides less assurance. This report provides a helpful prompt to ensure that efforts are focused appropriately. A local response will be developed once the national position and approach is understood, and this will include the suggestion that contract management training be considered within PADRs.

Decision: The Committee **NOTED** the Contract Management (Advisory) Internal Audit Report.

The Committee agreed to **ASSURE** the Board in relation to the Contract Management (Advisory) Internal Audit report.

AC(25)113 Follow Up Review (Reasonable Assurance)

Ms Corbett introduced the Follow Up Review Internal Audit report, which assessed the status of implemented recommendations on the Audit Tracker and the arrangements in place within the Health Board to monitor implementation progress, which were found to be robust. The team had focused on five Limited Assurance reviews and also high priority actions from Reasonable Assurance reports. This had produced a total of 16 actions which were marked as implemented and past the due date at the time of the review. 50% of these have been implemented and 38% are partially implemented, representing good progress. The remaining 12% were deemed as not implemented. Full details of

recommendation status is included within the report. The audit had concluded Reasonable Assurance overall.

Mrs Wilson confirmed that all recommendations are included within the Audit Tracker. Outstanding actions are raised with Directors and their teams, and during the EIT sessions; however, the audit, along with discussions today, has demonstrated that there are instances whereby the Health Board is not achieving the deadlines it has set itself. Cllr. Evans enquired whether the EITs discussions are having any impact with regard to outstanding actions. Mr Thomas suggested that corporate governance arrangements appear to be robust, operational governance less so, which is reflected largely in the audit assurance ratings. There has been a change in tone at EITs, to introduce more challenge, and this needs to be an area of focus for the organisation. Members were advised that the Corporate Governance team is undertaking a programme of training with CCGs. However, Planned Care, Mental Health and Learning Disabilities (MHLD) and Estates and Facilities are particular areas of concern.

Decision: The Committee **NOTED** the Follow-up Review (Reasonable Assurance) Internal Audit report.

The Committee agreed to **ASSURE** the Board in relation to the Follow-up Review (Reasonable Assurance) Internal Audit report.

AC(25)114 Head of Internal Audit Opinion and Annual Report 2024/25

Mr Johns presented the Head of Internal Audit Opinion and Annual Report 2024/25, which is a key document presented on an annual basis. It includes both the overall year-end opinion, and the supporting information around how this had been formed. The report's key element was the overall opinion following the conclusion of all audits from the Internal Audit workplan, which had been finely balanced. An additional briefing paper had been provided this year, which outlines the development and rationale of the opinion. As detailed in Section 1.2, an overall opinion of Reasonable Assurance had been concluded, which was an improvement on last year. Whilst there had been a number of Limited Assurance audits this year, there have also been a number which had returned positive assurance ratings and improved positions. Section 1.4 presents a summary of audit outcomes, and Section 2 includes a greater level of detail and the basis for the overall opinion. Also contained within the report are details of wider audit activity including work with other NHS Wales organisations and information around compliance with the Public Sector Audit Standards. Mr Johns concluded by emphasising that, whilst the Health Board needs to ensure that progress is maintained, he was comfortable with the award of a Reasonable Assurance opinion.

Cllr. Evans recognised that the final decision had been finely balanced, and thanked Mr Johns and the Internal Audit team for their work during the year. The variation in audit outcomes was clear, and there needs to be a concerted focus on the operational

functions. Mrs Wilson added her thanks to Mr Johns and Ms Corbett, who she meets with on a weekly basis. Internal Audits are an extremely important part of the governance architecture. As has been highlighted, all seven of the Limited Assurance audits are within the operational space.

Decision: The Committee **CONSIDERED** and **TOOK ASSURANCE** from the Head of Internal Audit Opinion and Annual Report 2024/25.

AC(25)115 Primary Care Strategy including Managed Practices

DEFERRED to 2025/26 Plan

AC(25)116 Financial Assurance Report

Mr Thomas presented the Financial Assurance Report, drawing Members' attention in particular to 2.2.3, which highlighted that there have been no Single Tender Actions (STAs) in excess of £25k throughout the whole of 2024/25; the first year that this has been the case. Members heard that there is national work taking place in relation to Invoices on Hold (IOH) and actions that the Health Board can adopt locally to improve the position. The number of salary overpayments is still too high and again, the Health Board needs to consider approaches being discussed nationally. The report presents, in Appendix 3, losses and special payments for ARAC's approval. It also includes details of breaches of Standing Financial Instructions (SFIs). A systematic approach is being applied to the management of these; whilst the number has reduced, they are still occurring.

Building on this final point, Cllr. Evans requested assurance that actions to address SFI breaches are proving effective. Mr Thomas, whilst confident that the approach of education followed by escalation was working, emphasised that it is not a 'quick fix'. Mr Davies congratulated the team on reducing the use of STAs, and suggested that consideration be given to whether these be reported 'by exception' going forward. Referencing the section in relation to IOH, Mr Davies highlighted that the values within the narrative and graph do not match. Mr Thomas committed to raise this with his team. Responding to a query around Direct Award Contracts, Mr Thomas assured Members that these are awarded via the procurement framework and are considered by the Financial Control Sub-Group. The Value for Money 'test' is at the point of being added to the framework. It is recognised that this is a pragmatic approach to procurement. Cllr. Evans enquired whether any actions are being taken to reduce losses and special payments. In response, Mr Thomas explained that most are associated with drug write-offs, where mitigations are limited. There is, however, a process in place to avoid drug wastage where possible and, overall, this is not a material issue of concern.

HT

HT

Decision: The Committee:

- **APPROVED** the losses as detailed

- **DISCUSSED** the breaches of Standing Financial Instructions (SFIs) as detailed
- **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 (STAs)
- **DISCUSSED** staff overpayments and **TOOK ASSURANCE** that actions to control them are sufficiently embedded
- **SCRUTINISED** the award of contracts listed

AC(25)117 Counter Fraud Update

Mr Anthony Veale, Ms Rhian Davies and Mr Tim John joined the Committee meeting.

Mr Ben Rees introduced the Counter Fraud Update report, highlighting information on page 3 in relation to identification of a risk linked to introduction of a new rostering system in MHLD. Members heard that the service had been quick to respond to this issue and put mitigating actions in place. The National Fraud Initiative is progressing, with the sharing and matching of data. There are 10 Payroll to Payroll enquiries which remain open, 3 of which have been progressed as investigations and 7 enquiries remain outstanding with third parties. An update is planned in August or September 2025 on any actions required.

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

AC(25)118 Audit Tracker

Professor Kloer joined the Committee meeting.

Ms Claire Bird presented the Audit Tracker report, which has been amended to reflect the new CCG structure. The analysis of overdue recommendations has also been strengthened. As mentioned earlier, page 11 highlights three areas which show a continued concerning trend. Mrs Wilson added that there are 200 recommendations overdue by more than six months.

Responding to a query around the areas which are of most concern to the team, Mrs Wilson indicated the three previously mentioned; Planned Care, MHLD and Estates and Facilities. It is hoped that the new CCG structure will assist in addressing these concerns. Whilst the team provides as much support as possible, the recommendations, actions and risks involved are owned by the services. Mr Thomas felt that the Carmarthenshire System, as part of Community and Integrated Medicine could be added to this list. Cllr. Evans suggested that consideration be given to a discussion with the services of concern at a future meeting. **RE/JW**

Decision: The Committee **TOOK ASSURANCE** that the Health Board is continuing to address findings from audits, inspections and regulators, and is strengthening the internal escalation arrangements for the domain of governance.

AC(25)119 **Audit Wales ISA 260 and Letter of Representation**

Dr Neil Wooding joined the Committee meeting.

Mr Anthony Veale introduced the report, noting that it is his third year of auditing HDdUHB's accounts, and suggesting that this year has been the best, with a very successful audit process. This had culminated in a positive closure meeting with Mr Thomas last week, and Mr Veale wished to thank the Finance team for all their support. Providing that ARAC is content to recommend the accounts for approval by the Board, this will take place on 26 June 2025, and the Auditor General for Wales would sign them off on 27 June 2025. The accounts would then be submitted well in advance of the 30 June 2025 deadline.

Mr David Williams presented the audit accounts report, which summarises the main findings from the audit of the 2024/25 annual report and accounts at the time of preparing the report. Members heard that there were a couple of tasks outstanding, noted as bullet points in the introduction to the report; both of these tasks have since been completed. Audit Wales intend to issue an unqualified, true and fair opinion, but a qualified regularity opinion on the accounts. The audit report at Appendix 3 explains that the regularity opinion for 2024/25 is qualified, in line with previous years. The regularity opinion is qualified because the Health Board did not meet its revenue resource allocation over a three-year period ending 31 March 2025. It is also intended to issue a substantive report, also at Appendix 3, which explains why our audit opinion in respect of the regularity is qualified. This report also refers to the fact that the Health Board did not meet its financial duty to have an approved three-year Integrated Medium Term Plan. The regularity opinion is not qualified for this. There are no other significant matters to report; there are no uncorrected, non-trivial misstatements in the accounts to draw to the Committee's attention. There are no significant recommendations arising from the audit work.

The report also confirms Audit Wales' independence and objectivity as auditors. Appendix 1 of the of the report provides a summary of the audit risks that previously reported to the Committee as part of the detailed audit plan and confirms that each of those risks have been addressed. No new or additional audit risks were identified during the final phase of the audit. Appendix 2 provides a summary of a small number of corrections made to the accounts. During the audit, these were narrative corrections only to disclosure notes. They had no financial impact on the accounts at all. So as proposed, the audit report is that set out at Appendix 3. The report includes, at Appendix 4, a Letter of Representation for signature, the contents of which are in line with the standard request for representations as part of the audit process. Minor recommendations arising from the audit work will be set out in a separate accounts memorandum report, which will

be communicated with officers in due course. There is nothing significant in that report.

As Mr Veale has suggested, it has been a relatively clean audit process this year. Audit Wales received the accounts in early May 2025 and were able to hold a clearance meeting with the Finance team in early June 2025. Mr Williams also extended thanks to the officers and staff of the Health Board for their cooperation throughout the audit process, which has helped Audit Wales to deliver the audit effectively.

Cllr. Evans and Mr Thomas both expressed gratitude to the Audit Wales team, with Mr Thomas also thanking Internal Audit, the Corporate Governance team, Finance team, Performance team, other Health Board colleagues and Independent Members for their contributions. The weekly 'touchpoint' meetings with Audit Wales had proved extremely useful, although nothing of note or concern had been raised. Mr Thomas was content with the report and had nothing further to add.

Decision: The Committee **NOTED** the Audit Wales ISA 260 and Letter of Representation.

AC(25)120 Final Accounts for 2024/25

Mr Thomas presented the Final Accounts for 2024/25, drawing Members' attention to the presentation provided. He confirmed that, post audit, there will be no changes to our Key Performance Indicators on Page 3. In terms of the revenue resource limit, the Health Board's deficit remains at £24.139m; the measure is the deficit over three years, which stands at £148.998m. The Health Board achieved the target in relation to working within the capital resource limit, the underspend being £86k or £188k cumulatively over the three-year period. The target to submit a three-year Plan was not met. The administrative duty to pay invoices within 30 days of receipt of goods or service was achieved within year. There were some very minor narrative changes to the accounts themselves. Mr Thomas concluded by thanking Ms Rhian Davies and Mr Tim John in particular for their work on the accounts.

Mrs Wilson reminded Members that the accounts had been discussed in detail at the meeting on 8 May 2025. Cllr. Evans thanked all of those involved for their efforts and noted an earlier comment around an additional report. Mr Williams confirmed that Audit Wales will be preparing a separate accounts addendum report, whilst emphasising that this will contain only minor issues for consideration, nothing which had warranted inclusion in the ISA 260 report. Mr Thomas committed to share this with Members when received. **HT**

Decision: The Committee **APPROVED** the Audited Annual Accounts for 2024/25, for onward ratification by the Board.

AC(25)121 HDdUHB Annual Report 2024/25

Mrs Wilson introduced the HDdUHB Annual Report 2024/25, highlighting that all comments and feedback resulting in amendments to the draft version are recorded and reported in the SBAR, to ensure transparency. Mrs Wilson reiterated her earlier comment around the discussion due to take place during the In-Committee session around Planned Care. whilst this does not impact the Annual Report, it is important that Members are aware. She wished to thank in particular Miss Charlotte Wilmshurst, Ms Tracy Price, Ms Fiona Hancock, Ms Davies and Mr John for their contributions to the Annual Report.

Mr Davies highlighted that, on page 176 of the report, there is a figure missing in relation to Mr Huw Thomas' attendance at the Staff Partnership Forum (SPF). Mrs Wilson thanked Mr Davies and the other Committee Chairs for their diligence in checking the content of the Annual Report. **JW**

Decision: The Committee **AGREED** to provide assurance to the Board that a robust governance process was enacted during the year, and subject to the above amendment, to recommend approval of the HDdUHB Annual Report 2024/25 to the Board, prior to its submission to the Welsh Government, via Audit Wales, by 30 June 2025, and its subsequent presentation at the Annual General Meeting on 25 September 2025.

AC(25)122 **Post Payment Verification (PPV) Annual Report**

DEFERRED to 12 August 2025 meeting

AC(25)123 **Primary Care PPV Report**

DEFERRED to 12 August 2025 meeting

AC(25)124 **ARAC Workplan 2025/26**

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

AC(25)125 **Any Other Business**

There was no other business reported.

AC(25)126 **Matters and Risks for Escalation to the Board**

As noted.

AC(25)127 **Date and Time of Next Meeting**

9.30am, 12 August 2025

2.2

10:00, 5 Mins

2.2 - Table of Actions

Rhodri Evans (Hywel Dda UHB - Independent Member)

For assurance

Attachments

2.2 Table of Actions ARAC 24 Jun 2025.pdf

Audit & Risk Assurance Committee
TABLE OF ACTIONS
Arising from Meeting held on 24 June 2025

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
AC(25)47	**15/04/2025**	**Clinical Audit Update**	To consider how Clinical Audit might contribute to a wider piece of work around inefficiencies in Patient/ Clinical Pathways and to discuss this with the Chair of QSEC	**SD**	~~**June**~~ **August 2025**	24 June 2025 **In Progress** Meeting scheduled for 16 June 2025. 12 August 2025 Verbal update to be provided.
AC(25)96	**24/06/2025**	**Table of Actions**	**AC(25)47** – to provide a further update to the June 2025 meeting	**SD**	**August 2025**	See AC(25)47, above.
AC(25)98	**24/06/2025**	**Escalation Status Update Report**	For Mr Huw Thomas and Mr Shaun Ayres to work together to add to future reports responsibility and accountability in terms of assurance committee, CCG/operational group, Executive Lead and officer	**HT/SA**	**August 2025**	**Complete** The report presented to this meeting incorporates the updates.
AC(25)100	**24/06/2025**	**Annual Review of Committee Terms of Reference**	To include in paragraph 2.4.3 reference to the Regional Joint Committee	**JW**	**July 2025**	**Complete** Approved by the Board on 31 July 2025.
AC(25)103	**24/06/2025**	**Review of Urgent and Emergency Care**	To provide an update on progress to the next meeting, via the Table of Actions	**AC**	~~**August**~~ **October 2025**	**In Progress** Intention to share finalised plan for Phase 2 OCP with Executive Team by 20 August 2025, with any required OCP consultation commencing before 29 August 2025, to allow progress to be made.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
AC(25)104	**24/06/2025**	**Planned Care Review**	To present to QSEC the methodology for assessing the risk of harm to patients caused by long waits	**AC**	**August 2025**	**Complete** Added to the QSEC work programme.
			To provide specific calendar dates for completion dates, instead of 'Quarters'	**AC**	**August 2025**	**Complete** Specific dates now added to the management response.
			To cross-check the numbers quoted in the report and those within the Audit Tracker, as they differ	**CB**	**August 2025**	**Complete** The discrepancies between the submitted management responses to Audit Wales and the Audit and Inspection tracker were due to the misinterpretation of the definition "overdue" by Clinical Care Group (CCG) leads when compiling data. As per definitions provided to ARAC via the Audit Tracker paper, recommendations considered overdue are those which are "in progress, but have exceeded **its agreed original timeframe for implementation (**i.e. overdue) (AMAT Status: Overdue / Partially Complete (Overdue))". As such, the figures which ought to have been included in management responses at the time of data extraction are as follows: Urology GIRFT: 3 overdue, 6 on track, 17 complete and 3 external

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
						General Surgery GIRFT: 22 recommendations on the original report, 21 of which are complete, and 1 overdue Ophthalmology: 20 overdue, 39 complete. Position statements on the performance of each CCG are included within the relevant meeting papers, and performance is monitored monthly via the Governance domain as part of the Health Board's internal escalation framework. The Business Partner will clarify the statuses with the CCG, and this will be covered in the Corporate Governance training that will be delivered to the CCGs over the summer.
AC(25)105	**24/06/2025**	**Review of Capital Investment Prioritisation**	To schedule a discussion around the Health Board Strategy and how this aligns with the capital allocation at an Executive Team meeting	**LD**	**August 2025**	**Complete** Discussed regularly at ET meetings.
AC(25)108	**24/06/2025**	**Discharge Management Follow-up (Advisory Report)**	To investigate the disparity in closing times between Discharge Lounges and hospital Pharmacies, which	**AC**	**August 2025**	**Complete** Information below in relation to discharge lounges across the four sites:

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
			could delay patients being discharged from hospital			BGH – currently does not have a discharge lounge but this is part of the planning, post fire work. WGH – Mon-Fri 9am-6pm - a HCSW arrives at 9am and can take in patients with site team support. RN arrives at 10am, and finishes at 6pm. GGH – Mon-Friday 8-6pm. PPH – Mon-Fri 10-6pm. Due to a lower discharge profile at weekend, patients due for discharge on a Saturday or Sunday tend to sit away from bedspace until transport arrives.
			For Mr Andrew Carruthers and Mrs Eleanor Marks to discuss the disparity in closing times between Discharge Lounges and hospital Pharmacies outside the meeting	**AC**	**~~August~~ October 2025**	**In Progress** A meeting to discuss this issue specifically has not yet taken place. However, these matters are areas of focus for the Ambulance Handover Improvement Plan over the next 60 days.
			To provide an update to the next meeting, via the Table of Actions, on progress towards achieving the outstanding actions	**AC**	**~~August~~ October 2025**	**In Progress** This action is being reviewed in the context of the Accelerated Urgent Emergency Care Actions and the new 60-day focus on handover improvement, and alignment of clinical executive support to assist with oversight and implementation. A further verbal update will be provided at the next ARAC.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
AC(25)109	**24/06/2025**	**Standards of Cleanliness (Limited Assurance)**	To provide an update on progress to the next meeting	**JS**	**August 2025**	Forward planned for 12 August 2025 meeting.
			To prioritise the topic of cleaning standards at the Executive Improving Together session (EITs) with Estates and Facilities this afternoon	**HT**	**June 2025**	**Complete** The issue was raised within the Estates and Facilities EITs meeting. Further work is being progressed within the CCG.
			To identify a clear timescale for progress and an interim solution prior to the August 2025 meetings of QSEC and ARAC	**JS**	**July 2025**	**Complete** Discussed with ARAC Chair on 31 July 2025.
AC(25)112	**24/06/2025**	**Contract Management (Advisory Report)**	To provide an update on progress to the next meeting	**HT**	**~~August~~ December 2025**	**In Progress** Raised nationally, but not as yet discussed by the Directors of Finance peer group. A request has been submitted to include this on the workplan. Suggest that this action is deferred for a response by December 2025, to allow a fuller response.
AC(25)116	**24/06/2025**	**Financial Assurance Report**	To consider reporting STAs 'by exception' in the future	**HT**	**August 2025**	**Complete** Report is being re-designed, and this will be reviewed as part of this process.
			To raise with the Finance team the issue of the values within the IOH narrative and graph not matching	**HT**	**August 2025**	**Complete** Response made directly to IM who raised the question.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
AC(25)118	**24/06/2025**	**Audit Tracker**	To consider scheduling a discussion with the services of concern at a future meeting	**RE/JW**	**~~August~~ October 2025**	**In Progress** This will be considered as part of the next Audit, inspection and regulatory Assurance Report, scheduled for the October 2025 meeting.
AC(25)120	**24/06/2025**	**Final Accounts for 2024/25**	To share the Audit Wales accounts addendum report with Members when received	**HT**	**~~August~~ October 2025**	**In Progress** Not yet received from Audit Wales.
AC(25)121	**24/06/2025**	**HDdUHB Annual Report 2024/25**	To add the figure in relation to Mr Huw Thomas' attendance at the Staff Partnership Forum (SPF) on page 176 of the report	**JW**	**June 2025**	**Complete** The Annual Report was subsequently approved by Board on 26 June 2025 and submitted to Audit Wales by 30 June 2025.

2.3

10:05, 0 Mins

2.3 - Matters Arising not on Agenda

Rhodri Evans (Hywel Dda UHB - Independent Member)

For discussion

2.4

10:05, 15 Mins

2.4 - Escalation Status Update Report

Philip Kloer (Hywel Dda UHB - Chief Executive), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Shaun Ayres (Hywel Dda UHB - Director of Delivery), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience), Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding)

For assurance

Attachments

2.4 Escalation Status Update ARAC August 2025.pdf

2.4 Hywel Dda - Escalation Framework - final version.pdf

2.4 Inspection Actions.pdf

2.4 Inspection Action Plan.pdf

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

ARAC Escalation De-escalation - Governance and Leadership Criteria – Evidence and Assessment (August 2025)

ARAC Escalation De-escalation - Governance and Leadership Criteria – Evidence and Assessment

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

1. **Revised Standard Operating Processes (SOPs) in Place & Tested by Internal Audit**

Status – ASSURE
Committee: ARAC
Lead Executive: Joanne Wilson

Explanation

Following the organisational restructure, all core Board and Committee SOPs were revised, standardised, and rolled out across governance functions. This implementation has been subjected to an independent Internal Audit (May 2025), which provided “Reasonable Assurance” with only two medium-priority recommendations. This demonstrates robust process design and operationalisation at every level. In addition, the Board’s 2025 Maturity Matrix exercise rates “Oversight & Administration Principles” at Level 4 (“Firm Progress”), indicating that staff understand the revised procedures and are routinely applying them.

Why Assure?

- **Tested by Audit -** External scrutiny found SOPs were operational, not just theoretical.
- **Low Residual Risk -** Only minor administrative updates (e.g., flowchart/induction slide deck) remain, with completion dates and owners logged in the ARAC action tracker.
- **Practical Impact -** Evidence that the processes are understood, embedded, and not just “on paper.”
- **Conclusion -** With strong assurance from audit, and the Board actively monitoring outstanding minor actions, there is robust control in this area, warranting an Assure rating.

ARAC Escalation De-escalation - Governance and Leadership Criteria – Evidence and Assessment

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

2. Consistent Oversight & Scrutiny of Current Service Provision by Board/Committees (Including Duty of Quality)

Status – ASSURE
Committee: ARAC
Lead Executive: Joanne Wilson

Explanation

Oversight and scrutiny by the Board and Committees is now embedded. Throughout 2024/25, all planned public Board meetings and seminars were delivered as scheduled. Committee papers are issued at least a week in advance, with the Corporate Governance Code self-assessment (Mar 2025) verifying compliance with best practice for transparency and public accountability.
Since April 2024, the Board's reporting template now includes explicit prompts to address the Duty of Quality (pilot across six Board papers in April–May 2025).

Why Assure?

- **Regular Cycle -** There is no evidence of missed scrutiny, and challenge is routinely documented in public minutes.
- **Duty of Quality -** This is now being hard-wired into all major decision templates—not just noted in passing.
- **Validation -** Board Maturity Matrix rates "Transparency and Public Reporting" as "In development but effective"—with full implementation due by October.
- **Conclusion -** The system is mature, and scrutiny of quality issues is consistent and evidence-based. No significant gaps remain, supporting an **Assure** judgement.

ARAC Escalation De-escalation - Governance and Leadership Criteria – Evidence and Assessment

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

3. Programme & Performance Management Structure with Effective Board Oversight

Status – ADVISE
Committee: ARAC
Lead Executive: Lee Davies

Explanation

The introduction of a new Power BI-based Integrated Performance Assurance Report (IPAR) marks a significant upgrade, now tracking 42 key KPIs, with 28 also benchmarked nationally. Internal Audit (April 2025) returned "Substantial Assurance," noting that the management framework and data culture are robust. However, the Board's Maturity Matrix rates the "Delivery of Outcomes" at only Level 2, reflecting that benchmarking and outcome-focus are not yet fully embedded for all measures. Moreover, these are complemented with the clear escalation summaries by CCG/Directorate.

Why Advise?

- **Framework Present, Maturity Emerging -** The reporting tool is sound, but work needed on being outcome-focused and resource mapping are still developing.
- **Ongoing Roll-out -** Full extension to all Tier 1 KPIs and a more comprehensive outcomes dashboard are scheduled for December 2025.
- **Ownership Clarity Needed -** There remains some ambiguity about who is accountable for the delivery of individual outcomes, and how resource is allocated in support of complex, cross-cutting priorities.
- **Conclusion -** Progress is strong, but further development is required to fully embed a Board-level, outcome-driven assurance culture. **Advise** reflects the need to monitor ongoing delivery and resource clarity.

ARAC Escalation De-escalation - Governance and Leadership Criteria – Evidence and Assessment

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

4. Board Sighted on Key Risks and Able to Offer Constructive Scrutiny

Status – ASSURE
Committee: ARAC
Lead Executive: Joanne Wilson

Explanation

The Board receives the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) at least quarterly. These documents provide clear identification, scoring, and narrative explanation of the Health Board's principal risks. The Risk Appetite Statement was refreshed in January 2025, ensuring that decision-making aligns with the agreed level of risk tolerance. Internal Audit ("Emergency and Business Continuity Planning," 2025) gave Reasonable Assurance, confirming that all clinical and corporate services now have documented continuity plans.

Scenario testing and live action planning have become the norm, with real-time dashboards in development for November 2025.

Why Assure?

- **Regular Challenge -** Principal risks (via the BAF) and corporate risks (via CEO report) are reported to the Board to provide assurance that these have been considered, challenged and discussed at Board level Committees. Any areas of concern are reported through the Committee Update Reports to the Board.
- **Independent Validation -** Both internal and external audit confirm effectiveness and results.
- **Results Achieved -** Risk Maturity is assessed annually and reported to ARAC. Board Maturity Matrix also rates Risk Management as Level 4 ("Results Achieved").
- **Conclusion -** No apparent critical gaps in Board oversight of risk however organisational capacity to manage effectively risk is constrained (as at June 2025, 83% of risks were scored high or extreme). This area is well-controlled and highly visible, supporting an **Assure** status.

5. Clear Governance & Assurance Systems with Effective Escalation

Status – ASSURE
Committee: ARAC
Lead Executive: Lee Davies

Detailed Committee Explanation

The Health Board completed a major review of its governance and assurance systems in January 2025, prompted by both local learning and the formal requirements of the NHS Wales Oversight and Escalation Framework 2025 - Hywel Dda. This review resulted in refreshed and Board-approved Terms of Reference (ToRs) for all major committees - including ARAC, Quality & Safety, and Finance & Performance with clear escalation protocols and annual business cycles embedded across all governance layers.

A key outcome of this work was the implementation, from January 2025, of a standardised “Triple-A” escalation model Alert, Advise, Assure within all committee and sub-committee reports. This model, directly aligned to the requirements of the Welsh Government escalation framework, ensures that any risks or issues identified at operational or executive level are systematically escalated to the appropriate committee, and ultimately to the Board, for discussion and resolution when required.

All items escalated as “Alert” or “Advise” are now formally logged, tracked and reviewed as part of every ARAC and Board agenda cycle, with audit trails documenting actions taken, lessons learned, and closure of items. This ensures that significant issues are never “lost” in the system. The escalation protocol is further strengthened by scheduled six-monthly reviews (next due December 2025) to assess its effectiveness and identify opportunities for refinement. The new ToRs and escalation pathways are publicly available, supporting openness.

ARAC Escalation De-escalation - Governance and Leadership Criteria – Evidence and Assessment

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Transparency and external assurance have remained positive. Audit Wales' Structured Assessment (2024) and the most recent Internal Audit review (May 2025) both found the governance and escalation arrangements to be "appropriate and effective," citing the clarity of escalation routes and the reduction of private ("in-committee") business from 14% to 9% of agenda items as indicators of improved accountability and openness.

Additionally, the escalation and assurance framework is explicitly referenced in the Escalation Framework (April/June 2025) agreed by both the Health Board and Welsh Government, meaning that the local systems are mapped directly to national expectations. This mapping was confirmed in the Board's June 2025 submission to Welsh Government and validated in subsequent Tripartite discussions.
In operational terms, this means that any significant governance or risk issue whether identified internally (e.g., through the risk register, internal audit, or committee challenge) or externally (via HIW, Audit Wales, or Welsh Government) is escalated through a standard, Board-approved process, with clear timescales for action and closure. "Alert" issues are prioritised for immediate executive or Board response, "Advise" items are monitored and scheduled for formal update, and "Assure" reflects sustained, evidence-backed confidence.

Summary

- This approach ensures that the Health Board's governance and assurance systems are not only robust and responsive to internal risks but are also fully compliant with the NHS Wales Escalation Framework and external regulatory requirements. The combination of standardised protocols, transparent tracking, regular external validation, and scheduled review means ARAC can be confident in providing a strong ASSURE rating for this criterion.

ARAC Escalation De-escalation - Governance and Leadership Criteria – Evidence and Assessment

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

6. Self-assessment Against Governance & Leadership Maturity Matrix

Status – ASSURE
Committee: ARAC
Lead Executive: Joanne Wilson

Explanation
The Board undertook a detailed self-assessment against the Central Government Good Practice Code and an updated Governance/Leadership Maturity Matrix at a Board seminar in April 2025. The process was externally validated by Welsh Government, then formally received and endorsed by ARAC in May 2025. Welsh Government has acknowledged this and is “content with the processes in place”.

Why Assure?

- **Full Cycle Completed -** Assessment, external validation, ARAC review.
- **Board Endorsement -** Explicit Board/Committee acceptance.
- **WG Content -** Formal recognition from regulator.
- **Conclusion -** Robust, documented, and endorsed—supports **Assure**.

ARAC Escalation De-escalation - Governance and Leadership Criteria – Evidence and Assessment

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

7. Board Acts on and Addresses Concerns Raised by Regulators (HIW, Audit Wales, etc.)

Status – ALERT
Committee: ARAC
Lead Executive: Sharon Daniel

Overview

This criterion requires the Board not only to respond promptly to regulatory concerns, but also to demonstrate *systematic closure and learning* from recommendations raised by external bodies such as Health Inspectorate Wales (HIW), Audit Wales, and the Royal Colleges. A credible "Assure" position depends on being able to evidence both immediate action on critical risks and timely, sustainable delivery of all improvement actions.

Current Position (as of July/August 2025)

- **Some Improvement - but not yet assurance -** The Health Board has made progress in recent months in closing overdue HIW actions. The number of outstanding or overdue recommendations has dropped from 51 (Feb 2024) to 17 (July 2025), which reflects better operational grip and focus.
- **Ongoing Monitoring -** Updates on HIW recommendations continue to be reported through the regular Quality Assurance Report to QSEC, with an overview of compliance reported 3 times to ARAC. Issues are also picked up via our internal escalation framework.
- **Process improvements -** Dedicated service leads have been assigned to HIW action plans, and the Board receives summary updates through 3As reports from Committees.

ARAC Escalation De-escalation - Governance and Leadership Criteria – Evidence and Assessment

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Welsh Government amendment – new HIW Governance & Leadership criterion (July 2025)
In July 2025 Welsh Government updated the NHS Wales Oversight & Escalation Framework, adding a specific Governance & Leadership requirement: “Boards must evidence robust escalation, tracking, closure and organisational learning from HIW recommendations.”

This new national criterion sits alongside the existing ARAC measures and requires clear assurance that recommendations are:
- Clarified at draft stage if unclear or undeliverable.
- Resourced (people, time, budget) before acceptance.
- Delivered to risk-based deadlines, with evidence of embedding and thematic learning.

Key Issues/Concerns

- **Persisting delays on high-risk items -** Of the 17 outstanding actions, several relate to services with a history of regulatory and safety concern, such as maternity, critical care, ward safety, and elements of medical workforce. The risks here are not just administrative - unresolved HIW recommendations often indicate deeper underlying workforce, culture, or patient safety issues.
- **Regulatory perception -** HIW and Welsh Government have flagged (in correspondence and in meetings) that although progress has been made, the pace of closure is still “too slow,” particularly for high-risk recommendations. This is a reputational risk to the organisation and can undermine public and stakeholder confidence.
- **Learning and assurance -** Delays in adopting recommendations increase the risk that “lessons identified” are not truly “lessons learned,” which may result in repeated incidents or missed opportunities to improve care. External reviews highlight that some actions have remained open for over a year due to system, cultural, or resource barriers, not just technical delay.
- **Action closure vs. evidence -** There is ongoing tension between closing recommendations quickly and being able to demonstrate that underlying changes are embedded and sustainable. In some cases, HIW has asked for additional evidence or follow-up before accepting actions as complete, which can further slow the process. In these examples, a longer period of the action being open is reasonable as the key here is to ensure lessons are learnt and embedded.

ARAC Escalation De-escalation - Governance and Leadership Criteria – Evidence and Assessment

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Why this Remains an ALERT

- **Volume of open recommendations -** Even at 17 outstanding, the number is high, and the Board remains under closer regulatory scrutiny as a result i.e. this was specifically added to the escalation
- **Nature of open actions -** Some overdue items relate directly to patient safety, workforce, or statutory compliance, increasing the seriousness of the risk if left unresolved.
- **HIW and WG concern -** Ongoing correspondence and oversight meetings indicate that regulators are not yet satisfied with the pace or depth of response.
- **Board and ARAC oversight -** ARAC, QSEC and the Board need to receive assurance that there is robust oversight and challenge of closure of recommendations and sustainable change, that can be evidenced.

What Needs to Happen Next

- Prioritise the closure of the highest-risk recommendations, with Board-level ownership and clear timescales.
- Provide QSEC with assurance around clear targeted recovery plans for areas that are not progressing.
- Work with HIW and WG to clarify evidence requirements for action closure.
- Ensure that lessons learned from HIW recommendations are systematically embedded, and that thematic analysis is used to prevent recurrence.

Summary

- While the Board continues to have clear processes for managing and reporting HIW and regulatory actions, the number and nature of overdue recommendations remain a cause for external concern. Until all high-risk HIW recommendations are closed (with clear evidence of sustained improvement), and the Health Board can demonstrate a move from reactive to proactive assurance, this criterion must remain at ALERT.

ARAC Escalation De-escalation - Governance and Leadership Criteria – Evidence and Assessment

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Recommendation

The recent amendment by Welsh Government to our Escalation Framework explicitly places greater emphasis on the governance and leadership arrangements regarding HIW recommendations. ARAC has previously acknowledged that our governance processes around regulatory actions are robust. This assurance is supported by external validation from Audit Wales and Internal Audit. However, it is recommended that to drive further assurance that:

ARAC formally notes the need to strengthen professional and operational responses to ensure consistent adherence to established HIW processes, particularly concerning resource allocation, capacity, and realistic timeframe setting. Progress and effectiveness should be tracked through our internal escalation framework and reported back to ARAC via future reports.

Health, Social Care and Early Years Group
Welsh Government

Hywel Dda University Health Board

Escalation Framework

April 2025

Llywodraeth Cymru
Welsh Government

Contents

1. Introduction

Following an assessment against the NHS Wales oversight and escalation framework in February 2025, Hywel Dda Bay University Health Board escalation levels are as follows:

- Level 4 for finance, strategy and planning, performance and outcomes related to urgent and emergency care, cancer and quality of care related to HCAIs and fragile services
- Level 3 for performance and outcomes related to planned care, CAMHS and leadership and governance

Level 4 (targeted intervention) is the second highest level of escalation within the NHS oversight and escalation framework. It is applied when organisations have serious problems and where there are concerns that they cannot make the necessary improvements without external support. The Welsh Government will take and co-ordinate action and direct intervention to support the health board to strengthen its capability and capacity to drive improvement. It consists of a set of interventions designed to remedy the problems within a reasonable timeframe. The interventions will normally be undertaken by the NHS Wales Executive directed by Welsh Government. If appropriate, external support will be agreed with the organisation.

Level 3 (enhanced monitoring) occurs when Welsh Government has identified serious concerns related to the NHS organisation. Monitoring will be more frequent than that carried out under routine arrangements and may also take a wider variety of forms, including regular interactions and meetings in addition to written progress updates and submission of evidence, including updated action plans and qualitative and quantitative data. The NHS organisation will need to demonstrate that it is taking a proactive response to the escalation and will need to put in place effective processes to address the issue(s) and drive improvement itself. Welsh Government will co-ordinate activity to closely monitor, challenge and review progress.

2. Escalation history

In *September 2022*, the health board was escalated to targeted intervention from enhanced monitoring for finance and planning. Quality and performance remained in enhanced monitoring following concerns around urgent and emergency care, planned care including cancer, neurodevelopment and child and adolescent mental health services.

In *January 2024*, the health board was escalated to level 4 (targeted Intervention). The escalation of the whole organisation into level 4 reflected escalating concerns across all the domains within the oversight and escalation framework.

In March 2025, the health board was de-escalated to level 3 for performance and outcomes relating to planned care and CAMHS and for leadership and governance.

3. NHS Wales oversight and escalation framework

The NHS Wales oversight and escalation framework sets out the process by which the Welsh Government maintains oversight of NHS bodies and gains assurance across the system. It describes the escalation, de-escalation and intervention process, the five levels of escalation and the domains against which each health board will be assessed.

Interventions will be:

- Collaborative – we will seek to minimise duplication by working collaboratively with other national committees, groups and programmes.
- Collective – we will maximise shared knowledge by sharing common approaches, tools, guidance.
- Impact focussed - we will examine and seek assurance and evidence how organisations are obtaining assurance over delivery and impact of actions.
- Be undertaken with openness; transparency; and mutual trust and respect between the health board, Welsh Government, and the NHS Executive.

Whilst in escalation:

- Normal performance management arrangements will continue through the Integrated Quality, Planning and Delivery Board (IQPD) and Joint Executive Team (JET) meetings.
- Quarterly escalation meetings will be chaired by the Director General of the Health, Social Care and Early Years Group / Chief Executive NHS Wales – these will cover both the level 4 and 3 progress, but with a greater scrutiny on level 4 actions and impact.
- Finance, strategy and planning level 4 touchpoint meetings will be agreed with the Finance, Planning and Delivery team within NHS Executive - these will examine progress made against the action log, review evidence and agree outputs for inclusion at the Welsh Government led escalation meetings.
- The monthly IQPD meetings led by Welsh Government will be utilised to ensure effective ongoing oversight against the concerns related to performance and outcomes domain.

4. Roles and responsibilities

Welsh Government

1. Support a formal structure for reviewing and reporting progress.
2. Signpost relevant best practice guidance and frameworks.
3. Act as a critical friend and sounding board on existing practices and new developments.
4. Review and provide feedback on action plans.
5. Undertake and share relevant analysis and deep dives of national data.
6. Enable shared approaches to key national issues across Welsh organisations and promote shared learning.
7. Direct the NHS Executive to provide targeted support to areas of concern to help the health board to improve their progress against programme objectives.
8. Work with the health board on critical enablers relating to regional planning, clinical services redesign, infrastructure (digital and buildings).

Hywel Dda University Health Board

1. Appoint an SRO(s) for all areas of escalation.
2. Ensure Board ownership and oversight with a clear governance structure, ensure that the Board is appraised of the escalation plan and evidence regular progress updates to the Board on progress against de-escalation criteria.
3. To produce an enhanced monitoring/targeted interventions plan in response to the areas of concern and commit sufficient resources to ensure that the plan deliverables are achieved.
4. Provide progress reports and evidence against the escalation plan to Welsh Government.
5. Give assurance that there are formal review mechanisms in place within the health board to monitor and deliver the required improvements.

5. Finance, strategy and planning

5.1 Finance – level 4

The finance intervention and focus whilst in level 4 covers the following areas and the health board will be required to:

- Demonstrate financial governance and financial control environment mechanisms are robust and sufficient assurance is received on their effectiveness by undertaking a review of the financial management arrangements in place against an appropriate best practice framework(s) and developing and implementing an action plan to address any gaps in approach.
- Clearly articulate the drivers of the current deficit to inform a triangulated approach to identify and deliver actions that will improve efficiency, sustainably reduce costs, and maximise the sustainable use of resources.
- Demonstrate clear policies and processes supporting the identification, delivery and monitoring of all savings schemes and opportunities. This should include having a clear and robust opportunities framework (and pipeline) that contains realistic opportunities to support and manage the short-term challenges being faced, as well as driving the larger-scale transformational changes that will support long-term sustainability.
- Demonstrate and evidence an integrated planning approach and strategy to deliver as a minimum the target control total set for the health board, with a clear roadmap and key milestones for delivery of a breakeven plan over the medium term. This should include clear and realistic planning assumptions, which triangulates with the organisation's longer-term strategic objectives around service delivery, workforce, infrastructure, etc.
- Stress-test and challenge the health board's plan submission for 2025/26 and identifying opportunities for improvement.
- Evidence delivery of an improving financial trajectory in line with the organisation's Board approved plans, including significant progress towards delivery of the target control total; improved grip and control of the existing financial and operational pressures; and further progress around identification and delivery of opportunities.

<u>Financial governance and control environment</u>

- The financial governance framework at the health board is robust in both design and implementation, including a self-assessment against best practice frameworks.
- The financial committee structure is clearly articulated and addresses key risks.
- Financial reports and supplementary presentations include the analysis and narrative explanation required to enable management and board to discharge their duties.
- Financial controls at the health board are robust in both design and implementation, including a self-assessment against model frameworks, review implementation of the Standing Financial Instructions, internal audit reviews or other control reviews.

- The finance function has the necessary capacity and capability to support the needs of the wider organisation.
- Budget holders and managers are held to account for delivering their financial plans.
- That as a result of the above, it has developed and is delivering an action plan to improve the financial governance and financial control environment.

Understanding the existing deficit and key drivers

- There is a clear understanding of the cost drivers and investment decisions responsible for the growth in deficit across the organisation, including an explicit breakdown by key service area and cost driver.
- It has reviewed prior year investments to assess whether the planned benefits have been delivered.
- Has a robust process for challenging underlying deficits reported at local divisional levels.
- The drivers and investment decisions responsible for the growth in workforce are well understood; are reviewed for ongoing value; and are monitored through the Integrated Performance Report.
- The integrated performance reports clearly identify and monitor metrics against key activity cost drivers.
- Triangulated approaches to identify and deliver actions to improve efficiency and maximise the use of resources.

Development and realisation of opportunities

- Has a clear process and approach across the organisation to support the identification, delivery and monitoring of all savings schemes.
- Development of a comprehensive opportunities framework with a constant pipeline of opportunities, and establish clear roles and responsibilities for developing opportunities into saving schemes and subsequent delivery of these saving schemes.
- Is translating national opportunities identified through the Value and Sustainability Board into local savings.
- Has clear policies and processes in place to enable budget holders and managers to realise and deliver identified savings schemes.
- Value based health care principles have been embedded across the organisation.

Clear financial plan and strategy

- An integrated and triangulated plan, with clear and realistic planning assumptions to deliver a (recurrent) breakeven position over the medium-term, with a clear roadmap and key milestones for delivery.
- A clear engagement plan to communicate the necessity for financial improvement across the organisation.

Delivery of Plan

- It is delivering clear improvement in the planned financial trajectory for 2025/26 (significant progress towards delivery of the target control total), including further progress around identification and delivery of recurring opportunities.

De-escalation criteria

1. The health board must demonstrate that there are robust financial governance and robust financial control environment in place with risks minimised.
2. Substantial progress to be made in delivering the targeted intervention action plan including actions to improve the organisation's understanding of the existing deficit and key drivers and development and realisation of opportunities.
3. Annual plan developed with board approval demonstrating a substantial financial improvement trajectory to deliver as a minimum the target control total.

5.2 Strategy and planning – level 4

The strategy and planning intervention and focus whilst in level 4 escalation covers the following areas and the health board will be required to action and demonstrate areas as highlighted below:

Submission and delivery of an approvable plan

- Improved integrated planning evident across the organisation to develop an approvable IMTP, providing a route map towards the health board's longer-term ambition.
- Deliver a credible annual plan as a stepping stone towards a full and financially balanced IMTP.
- Make good progress in delivering the ministerial targets, delivery expectations and enabling actions (as set out in the NHS Wales Planning framework 2025-28), accountability criteria and the level 4 requirements.

Clinical strategy

- Clearly agreed refreshed clinical strategy and development of a clinical plan to lead future planning and investment decisions.
- Demonstrate how the clinical strategy and plan are driving decision making across the organisation.

Regional planning

- Ensure the delivery of key objectives are made through the Joint Committee with Swansea Bay University Health Board, demonstrating improved regional collaboration where required to ensure continued safety, quality and ongoing viability and sustainability of regional services, including orthopaedics and ophthalmology.

De-escalation criteria

1. Submission of an acceptable annual plan in line with the current planning framework.
2. Evidence of integrated planning across the organisation which supports the development of a coherent and deliverable annual plan.
3. Evidence of a clear roadmap and implementation of the health board's Clinical Services Plan.
4. Welsh Government's confidence in delivery based on an assessment against an agreed planning maturity matrix.
5. Progress made with regional planning in relation to orthopaedics, ophthalmology, stroke services, urology, and upper GI services in 2025/26.

6. Clinical services – level 4

The fragile services intervention and focus whilst in level 4 will alter over time in response to workforce and estate challenges. At this point the focus will be on the nine clinical areas identified in the clinical services plan as follows:

- Critical care
- Dermatology
- Elective orthopaedics
- Ophthalmology
- Urology
- Emergency general surgery
- Stroke
- Endoscopy
- Radiology

For each service, the health board will be expected to produce a summary document setting out the issues of concern, and action plans with agreed outcomes and access targets.

<u>De-escalation criteria</u>

1. Evidence that the health board has the appropriate mechanism to understand the drivers behind a fragile service through the triangulation of key data points, including staffing levels, staff and patient feedback, concerns, incidents, stakeholder feedback (HIW, Audit Wales, HMC, Royal Colleges, Llais etc), mortality reviews, duty of quality / candour, infection protection control, performance, clinical and medical leadership.
2. Fragile services are supported by strong clinical leadership, have an effective integrated improvement plan, project management structure and effective transformation support.
3. Progress is being made towards key performance metrics
4. Evidence that all recommendations from the Royal Colleges, 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.
5. Evidence that the Board is sighted on fragile services and has a robust response to these issues that is being addressed by the health board.
6. 65% R1 ophthalmology patient pathways to be waiting within or no longer than 25% of their target date for an outpatient appointment and maintained for 3 months.

7. Performance and outcomes

7.1 Urgent and emergency care – level 4

The performance and outcomes intervention and focus for urgent and emergency care (UEC) covers the following areas and the health board will be required to action and demonstrate:

Sustainable services

- Ensure that recovery and improvement plans are in place and that agreed priorities are being implemented, in accordance with evidence-based practice and national requirements.
- Improve unscheduled care performance to ensure that patients access safe, timely and clinically effective unscheduled care services, reducing waiting times, delays and improving quality.
- Deliver activity in line with agreed trajectories and implement any necessary changes where performance falls below trajectory.

Work with national programmes and respond to external reviews

- Work with and implement the recommendations from national programmes including but not limited to Strategic Programme of Primary Care, Six Goals for Emergency Care and the National Diagnostic and Endoscopy Programmes.
- Support the implementation and realisation of GIRFT and the national programme reviews opportunities.
- Develop a prompt response to any HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.

Communications and engagement

- Ensure that patients are clear where they can and should access support, signposting away from emergency services.

De-escalation criteria

- A continuous reduction of ambulance handovers over an hour of at least 11% in three consecutive months and maintained for 3 months (Based on agreed baseline).
- Continuous improvement towards no more than 7% of patients waiting over 12 hours at each individual site and across the health board.
- Continuous improvement in the median time from arrival at an emergency department to assessment by a clinical decision maker to achieve a maximum of 60 minutes.
- A continuous reduction in delayed pathways of care (with a focus on those caused by assessment issues) of 5% for three consecutive months and then maintained (based on agreed baseline).
- Assessment of health board response and handling of concerns, complaints, incidents and patient experience feedback related to UEC. Assessment of declared BCIs, including reasons why, actions taken, and lessons learnt.

7.2 Cancer – level 4

The performance and outcomes intervention and focus for cancer covers the following areas and the health board will be required to action and demonstrate:

Sustainable services

- A robust improvement plan in accordance with evidence-based practice and national requirements.
- Ensure compliance with all aspects of the NOPs
- Maintain cancer performance in line with the agreed standards and ensure that the backlog of patients waiting over 62 and 104 days is kept to a minimum agreed level.

Work with national programmes and respond to external reviews

- Work with and implement the recommendations from the Cancer Recovery Programme
- Effective responses to HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.

Communications and engagement

- Effective and meaningful engagement with patients related to the potential urgency of their condition, waiting times policies and the provision of appropriate support that keep patients well whilst waiting
- Ensure effective communication and engagement with general practice in relation to referral management

De-escalation criteria

- 60% performance maintained for 3 months against the SCP target.

7.3 Quality of care related to HCAIs - level 4

The performance and outcomes intervention and focus for quality of care related to HCAIs covers the following areas and the health board will be required to action and demonstrate:

Sustainable services

- Stabilisation of the increased trajectory of cases of HCAI and evidence of continuous improvement accompanied by a strong QI approach and plan that has oversight and monitoring by board Quality Safety Committee and Board.

Governance and Leadership

- The health board to have a clear improvement plan based on a root cause analysis to address the issue of hospital onset HCAIs
- Clear and effective response mechanisms in place to respond to outbreaks reporting directly to Board

De-escalation criteria

- C-Diff: reduce the number of hospital onset infections by 25% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 8 cases to no more than 6 per month)
- Staph aureus: reduce the number of hospital onset infections by 33% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 3 cases to no more than 2 per month)
- E-coli: reduce the number of hospital onset infections by 25% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 7 cases to no more than 5 per month)

7.4 Planned care – level 3

The performance and outcomes intervention and focus for planned care covers the following areas and the health board will be required to action and demonstrate:

Sustainable planned care services

- A robust improvement plan in accordance with evidence-based practice and national requirements.
- Improved access to planned care with reduced waiting times in line with the de-escalation criteria.
- Delivery of the enabling actions in the 2025/28 planning guidance.
- Implementation of an outpatient's transformation plan in line with the requirements of the planned care programme.
- Impact of regional working arrangements.

Work with national programmes and respond to external reviews

- Work with and implement the recommendations from national programmes including but not limited to Planned Care Improvement and the National Diagnostic and Endoscopy Programmes.
- Support the implementation and realisation of the three Ps policy, GIRFT, theatre optimisation, the CIN optimisation programmes and related national improvement recommendations.
- Effective responses to HIW unannounced inspections, Audit Wales and Royal College recommendations, developing and completing action plans that demonstrate sustainable evidence.

Communications and engagement

- Effective and meaningful engagement with patients related to service changes, waiting times policies and the provision of appropriate support that keep patients well whilst waiting.
- Ensure that patients are clear where they can and should access support.
- Ensure that the benefits of new pathways such as straight to test, primary care management, self-management and see on symptoms pathways are communicated effectively.

De-escalation criteria

- 100% of open outpatient pathways to be waiting less than 52 weeks and maintained for 3 months.
- Continuous improvement towards 75% of all open outpatient pathways waiting less than 26 weeks.
- 100% of open pathways to be waiting less than 104 weeks and maintained for 3 months.
- Continuous improvement towards 80% of all open pathways waiting less than 36 weeks.
- 12% reduction in the number of patients delayed by 100% for their follow up appointment in three consecutive months and maintained for 3 months (Based on the November 2024 baseline.)
- 85% of patients waiting for a diagnostic test to be waiting less than 8 weeks and maintained for 3 months.

    - 85% of patients waiting for a diagnostic endoscopy to be waiting less than 8 weeks and maintained for 3 months.
    - 85% of patients waiting for a NOUS and non-cardiac MRI to be waiting less than 8 weeks and maintained for 3 months.
- 90% of patients waiting for therapies to be waiting less than 14 weeks and maintained for 3 months.
- Assessment of health board response and handling of concerns, complaints, incidents and patient experience feedback related to planned care.

7.5 Children and adolescence mental health services – level 3

The performance and outcomes intervention and focus for CAMHS covers the following areas and the health board will be required to action and demonstrate:

Sustainable services

- A robust improvement plan in accordance with evidence-based practice and national requirements.
- Maintain CAMHS performance in line with the standards set out in the Mental Health Act and Mental Health (Wales) Measure, for adult and children's services.

Work with national programmes and respond to external reviews

- Work with and implement the recommendations from the Inpatient Safety Programme
- Effective responses to HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.

Communications and engagement

- Effective and meaningful engagement with patients related to service changes, waiting times policies and the provision of appropriate support that keep patients well whilst waiting and that they are able to access the appropriate levels of support

De-escalation criteria

- 80% of LPMHSS mental health assessments undertaken within 28 days from the date of receipt of referral.
- 70% of therapeutic interventions started within 28 days following an assessment by LPMHSS.
- 85% of health board residents in receipt of secondary mental health services who have a valid care and treatment plan.
- Demonstrate a prompt response to any HIW inspections, concerns, incidents, never-events, coroners requests and regulation 28s.
- Improved patient and family feedback.

8. Governance and leadership – level 3

The governance and leadership intervention and focus covers the following areas and the health board will be required to action and demonstrate:

Governance

- That all parts of the organisation are clear on accountability and expectations at all levels to ensure successful delivery.
- Effective decision making that supports financial management, performance improvement, safe, timely and quality care.
- Revised standard operating processes are in place following the organisational restructure.
- Effective programme management, 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; effective, open and transparent reporting, with effective strategic Board oversight.
- Ensuring the health board is a data-driven organisation that ensures data is understood and utilised in decision making at all levels.
- Effective oversight and scrutiny of current service provision consistently being provided by the Board and the appropriate Committees.
- Succession and development plans in place to ensure operational efficiency at all times.

Leadership

- Demonstrate through delivery, leadership that enables the organisation to implement national strategic programme objectives.
- Lead the improvement in sustainable service delivery with increased focus on the short and medium term.
- Ongoing development of leadership and management skills at all levels / professions to strengthen management maturity.
- The organisation is focussed on all aspects of strategic workforce planning and maximising the skills of its current staff.
- Continuation of embedding / demonstrating lived values and behaviours throughout the organisation.
- Clinical leadership is visible and effective.
- There is evidence of positive shifts in culture in key areas such as multidisciplinary working.
- Senior leaders set the desired culture and tone for the organisation which promotes equality, inclusivity, openness and transparency.
- A culture of listening, learning, and improving is embedded throughout the organisation based on early and rapid triangulation and resolution of issues from a variety of sources, including patient outcomes, user and staff feedback.

Board Self-Assessment

- Review strategic risks and ensure that risk management is aligned with the health board’s risk appetite.

- Ensure an appropriate governance framework is in place, particularly with regards to providing appropriate scrutiny of performance, leadership style and practice.
- Regular self-assessment against an agreed maturity matrix.
- Responding to the outcome of self-assessments and external assessments and observations by setting objectives that will improve effectiveness.

De-escalation criteria

1. Revised standard operating processes in place following the organisational restructure assessed as effective by internal audit.
2. Effective oversight and scrutiny of current service provision consistently being provided by the Board and the appropriate Committee(s) as demonstrated by Committee and Board papers, including evidence of Board considering the Duty of Quality to inform their decision making.
3. Effective programme and performance management structure is in place, with effective Board oversight and a clear performance and delivery framework that drives improvement.
4. 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.
5. Clear governance and assurance systems in place with issues escalated appropriately through clear structures and processes.
6. A full and substantive Executive Director Team, with a clear organisational structure in place with robust succession and development plans in place to ensure adequate capacity and capability in all areas of the organisation to deliver high quality, sustainable care.
7. Effective leadership programmes are in place to support the ongoing development of leadership and management skills at all levels / professions to strengthen management maturity.
8. Positive staff engagement in NHS Wales surveys.
9. Self-assessment against the governance and leadership maturity matrix with evidence the agreed level.
10. The Board acts on, and addresses appropriately, concerns raised through NHS regulators such as HIW.

9. Document control

Date	Comments
April 2025	New framework following changes in in escalation status in March 2025.
15 May 2025	Amended following comments from health board
12 June 2025	Amended governance de-escalation criteria
30 June 2025	Agreed by Hywel Dda UHB

Inspection Code	Inspection Title	Recommendation Priority	Recommendation	Reference Number	Action	Site	Service	Person Responsible	Lead Person	Date Raised	Original Due Date	Current Due Date	Due Date Change Count	Date Last Updated	Last Updated By	Action Rating	Progress Status	Progress Status Reason	Previous Progress Status	Approval Board	Date of Next Committee Meeting	Risks	Barriers	Comments/Updates	Evidence
Targeted intervention/2025/558	Enhanced Monitoring Criteria and Actions - Audit and Risk Assurance Committee	Must do	Revised standard operating processes in place following the organisational restructure assessed as effective by internal audit.	Targeted intervention/2025/558/MD1/1	Revised standard operating processes in place following the organisational restructure assessed as effective by internal audit. Please provide a summary of the progress so far and the next steps.	TRUSTWIDE	TRUSTWIDE	Ms Joanne Wilson	Miss Charlotte Wilmhurst	14/07/2025	22/07/2025	22/07/2025		29/07/2025	Mrs Katrina Davies	Amber	Fully complete (Approved)		Fully complete (Awaiting approval)					The review of the Executive Team Governance was concluded by Internal Audit and reported to ARAC in May 2025. The IA review of the new operational governance arrangements has been included in the IA plan for 2025/26 - to take place in Q2/Q3. This plan was agreed by ARAC in April 2025	20250725161625_62hduhbinternalauditplanandcharter202526.pdf, 20250725161640_62sbarannualinternalauditplanandcharter2526aracapril2025.pdf
Targeted intervention/2025/558	Enhanced Monitoring Criteria and Actions - Audit and Risk Assurance Committee	Must do	Effective oversight and scrutiny of current service provision consistently being provided by the Board and the appropriate Committee(s) as demonstrated by Committee and Board papers, including evidence of Board considering the Duty of Quality to inform their decision making.	Targeted intervention/2025/558/MD2/1	Effective oversight and scrutiny of current service provision consistently being provided by the Board and the appropriate Committee(s) as demonstrated by Committee and Board papers, including evidence of Board considering the Duty of Quality to inform their decision making. Please provide a summary of the progress so far and the next steps.	TRUSTWIDE	TRUSTWIDE	Ms Joanne Wilson	Miss Charlotte Wilmhurst	14/07/2025	22/07/2025	22/07/2025		29/07/2025	Miss Charlotte Wilmhurst	Amber	Fully complete (Approved)		Fully complete (Awaiting approval)					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. A number of reports to Board requesting decisions on service changes demonstrate the impact on quality has been considered. Finance paper to Board in July 2025 demonstrates the impact to quality. Fragile Services Framework paper to Board in July 2025. 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 Audit and Risk Assurance Committee, People, Organisational Development and Culture Committee, Quality, Safety and Experience Committee, Finance and Performance Committee and the Strategy and Planning Committee.	20250725162433_37pphmiuplusappendices14.pdf, 20250725162453_37appendix5miuppheqia.pdf, 20250725162539_37appendix5miupphqia.pdf, 20250725162602_37annex1miuattendancesfromswanseabayarea.pdf, 20250725162612_37annex2swanseapatientaudit.pdf, 20250725162738_371clinicalservicesplanupdatenovember2024.pdf, 20250725162757_371closingreportnovemberboard2024.pdf, 20250725162814_371equalityimpactassessmentscreeningsnovemberboard2024.pdf, 20250725162831_371healthimpactassessmentscreeningsnovember2024.pdf, 20250725162848_371qualityimpactassessmentsnovemberboard2024.pdf, 20250725162941_38bghpaediatricsseptember2024.pdf, 20250725162955_38bghpaedseqia.pdf, 20250725163013_38bghpaedsqia.pdf, 20250725163048_15fragileservicesframeworkjuly2025.pdf, 20250725163105_15fragileservicesupd
Targeted intervention/2025/558	Enhanced Monitoring Criteria and Actions - Audit and Risk Assurance Committee	Must do	Effective programme and performance management structure is in place, with effective Board oversight and a clear performance and delivery framework that drives improvement.	Targeted intervention/2025/558/MD3/1	Effective programme and performance management structure is in place, with effective Board oversight and a clear performance and delivery framework that drives improvement. Please provide a summary of the progress so far and the next steps.	TRUSTWIDE	TRUSTWIDE	Mr Lee Davies	Mr Lee Davies	14/07/2025	22/07/2025	22/07/2025		18/07/2025	Mrs Katrina Davies	Amber	Overdue								
Targeted intervention/2025/558	Enhanced Monitoring Criteria and Actions - Audit and Risk Assurance Committee	Must do	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.	Targeted intervention/2025/558/MD4/1	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. Please provide a summary of the progress so far and the next steps.	TRUSTWIDE	TRUSTWIDE	Ms Joanne Wilson	Miss Charlotte Wilmhurst	14/07/2025	22/07/2025	22/07/2025		29/07/2025	Mrs Katrina Davies	Green	Fully complete (Approved)		Fully complete (Awaiting approval)					The Board receives the Board Assurance Framework (BAF) and Corporate Risk Register on a quarterly basis, ensuring regular oversight of principal and corporate risks. The Board is consistently sighted on key risks and areas of concern through well-defined reporting lines through our formal governance structure. This allows the Board to engage in constructive scrutiny of performance and risk, providing effective oversight, especially in the management of fragile and high-risk services and to fulfil its role, not only in terms of monitoring, but also in challenging and supporting the development of mitigation strategies. AW Structured Assessment 2024 provided assurance that the Board continues to have a mature approach to overseeing strategic and corporate risks and risk management arrangements. The Risk Appetite Statement was refreshed in January 2025 and has been operationalised throughout the year, this informs decisions on 'accepting' risks'. The Health Board undertakes a review of	20250725163752_39riskappetitestatementjanuary2025.pdf, 20250725163811_39appendix1revisedriskappetitestatement.pdf, 20250725163841_7ceosreportmarch2025.pdf, 20250725163937_14boardassuranceframeworkmarch2025.pdf, 20250725163949_14principalriskregistermarch2025.pdf, 20250725164033_ceoreportjul25updated.pdf, 20250725164047_6appendix2corporateriskregisterjuly2025.pdf, 20250729124007_hduhbstructuredassessment2024reportfinal.pdf, 20250729124116_4sbarboardeffectivenessjun2025.pdf, 20250729124157_4appendix1hduhbboardmaturitymatrix202425.pdf
Targeted intervention/2025/558	Enhanced Monitoring Criteria and Actions - Audit and Risk Assurance Committee	Must do	Clear governance and assurance systems in place with issues escalated appropriately through clear structures and processes.	Targeted intervention/2025/558/MD5/1	Clear governance and assurance systems in place with issues escalated appropriately through clear structures and processes. Please provide a summary of the progress so far and the next steps.	TRUSTWIDE	TRUSTWIDE	Mr Lee Davies	Mr Lee Davies	14/07/2025	22/07/2025	22/07/2025		18/07/2025	Mrs Katrina Davies	Amber	Overdue								
Targeted intervention/2025/558	Enhanced Monitoring Criteria and Actions - Audit and Risk Assurance Committee	Must do	Self-assessment against the governance and leadership maturity matrix with evidence the agreed level.	Targeted intervention/2025/558/MD6/1	Self-assessment against the governance and leadership maturity matrix with evidence the agreed level. Please provide a summary of the progress so far and the next steps.	TRUSTWIDE	TRUSTWIDE	Mr Lee Davies	Mr Lee Davies	14/07/2025	22/07/2025	22/07/2025		18/07/2025	Mrs Katrina Davies	Amber	Overdue								
Targeted intervention/2025/558	Enhanced Monitoring Criteria and Actions - Audit and Risk Assurance Committee	Must do	The Board acts on, and addresses appropriately, concerns raised through NHS regulators such as HIW.	Targeted intervention/2025/558/MD7/1	The Board acts on, and addresses appropriately, concerns raised through NHS regulators such as HIW. Please provide a summary of the progress so far and the next steps.	TRUSTWIDE	TRUSTWIDE	Ms Sharon Daniel	Ms Sharon Daniel	11/07/2025	22/07/2025	22/07/2025		18/07/2025	Mrs Katrina Davies	Amber	Overdue								

Enhanced Monitoring Criteria and Actions - Audit and Risk Assurance Committee - Action plan

Inspection origin: Targeted intervention

Date of inspection: 12/08/2025

Inspection lead: Shaun Ayres

Inspection team: Katrina Davies, Shaun Ayres

Date action plan generated: 30th July 2025

Recommendations & actions

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Targeted intervention/2025/558/MD1	MD	Revised standard operating processes in place following the organisational restructure assessed as effective by internal audit.	Must do	Ms Joanne Wilson	TRUSTWIDE	TRUSTWIDE		NO		1/1	All Fully Complete

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Targeted intervention/2025/558/MD1/1	Revised standard operating processes in place following the organisational restructure assessed as effective by internal audit. Please provide a summary of the progress so far and the next steps.	TRUSTWIDE	TRUSTWIDE	Ms Joanne Wilson	14/07/2025	22/07/2025	Fully complete (Approved)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
The review of the Executive Team Governance was concluded by Internal Audit and reported to ARAC in May 2025. The IA review of the new operational governance arrangements has been included in the IA plan for 2025/26 - to take place in Q2/Q3. This plan was agreed by ARAC in April 2025.	None	None	2	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Targeted intervention/ 2025/558/MD2	MD	Effective oversight and scrutiny of current service provision consistently being provided by the Board and the appropriate Committee(s) as demonstrated by Committee and Board papers, including evidence of Board considering the Duty of Quality to inform their decision making.	Must do	Ms Joanne Wilson	TRUSTWIDE	TRUSTWIDE		NO		1/1	All Fully Complete

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Targeted intervention/ 2025/558/MD2/1	Effective oversight and scrutiny of current service provision consistently being provided by the Board and the appropriate Committee(s) as demonstrated by Committee and Board papers, including evidence of Board considering the Duty of Quality to inform their decision making. Please provide a summary of the progress so far and the next steps.	TRUSTWIDE	TRUSTWIDE	Ms Joanne Wilson	14/07/2025	22/07/2025	Fully complete (Approved)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
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. A number of reports to Board requesting decisions on service changes demonstrate the impact on quality has been considered. Finance paper to Board in July 2025 demonstrates the impact to quality. Fragile Services Framework paper to Board in July 2025. 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 Audit and Risk Assurance Committee, People, Organisational Development and Culture Committee, Quality, Safety and Experience Committee, Finance and Performance Committee and the Strategy and Planning Committee. 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 have been addressed (see Feb25 TI update to ARAC). Standardised reporting on TI taking place across the Health Board's committees. The new Clinical Care Group (CCG) model was implemented in April 2025 to strengthen governance through Integrated Governance Groups (IGGs) that meets fortnightly to examine planning, performance, Finance, people, quality, health and safety matters. This was a planned transition from the previous directorate-based approach. While this transition represents a significant organisational change that will require time to fully embed, it is designed to provide greater cohesion across related clinical services and strengthen local ownership of care pathways while maintaining robust Health Board-wide oversight. In Internal Audit review is planned for Q4 of 2025/26, with further AW review on quality governance arrangements to take place in 2026. Structured Assessment 2025 will also provide a high level feedback on implementation so far. AW Structured Assessment 2024 concluded 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.	None	None	19	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Targeted intervention/2025/558/MD3	MD	Effective programme and performance management structure is in place, with effective Board oversight and a clear performance and delivery framework that drives improvement.	Must do	Mr Lee Davies	TRUSTWIDE	TRUSTWIDE		NO		1/1	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Targeted intervention/2025/558/MD3/1	Effective programme and performance management structure is in place, with effective Board oversight and a clear performance and delivery framework that drives improvement. Please provide a summary of the progress so far and the next steps.	TRUSTWIDE	TRUSTWIDE	Mr Lee Davies	14/07/2025	22/07/2025	Overdue

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
None	None	None	0	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Targeted intervention/ 2025/558/MD4	MD	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.	Must do	Ms Joanne Wilson	TRUSTWIDE	TRUSTWIDE		NO		1/1	All Fully Complete

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Targeted intervention/ 2025/558/MD4/1	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. Please provide a summary of the progress so far and the next steps.	TRUSTWIDE	TRUSTWIDE	Ms Joanne Wilson	14/07/2025	22/07/2025	Fully complete (Approved)

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
The Board receives the Board Assurance Framework (BAF) and Corporate Risk Register on a quarterly basis, ensuring regular oversight of principal and corporate risks. The Board is consistently sighted on key risks and areas of concern through well-defined reporting lines through our formal governance structure. This allows the Board to engage in constructive scrutiny of performance and risk, providing effective oversight, especially in the management of fragile and high-risk services and to fulfil its role, not only in terms of monitoring, but also in challenging and supporting the development of mitigation strategies. AW Structured Assessment 2024 provided assurance that the Board continues to have a mature approach to overseeing strategic and corporate risks and risk management arrangements. The Risk Appetite Statement was refreshed in January 2025 and has been operationalised throughout the year, this informs decisions on 'accepting' risks'. The Health Board undertakes a review of its risk maturity annually against The Orange Book Risk Management Standard, which then informs the objectives set out its Risk Management Strategy, and agreed by the Board. The Board approved its Risk Management Strategy in March 2024. This is supported by an up-to-date risk management framework and procedure - both the Risk Management Strategy and Framework have been reviewed and will be presented to the Board for approval in September 2025. The Board's approach to risk management was also rated at Level 4 ("Results Achieved") in the Board Maturity Matrix in April 2025, reflecting the positive impact of scenario testing and action planning. The implementation of the Clinical Care Group model from April 2025 has strengthened risk management by integrating risk identification and management at service level. Each CCG's fortnightly Integrated Governance Group meetings are designed to ensure emerging risks are identified and addressed promptly, with clear escalation routes to the Integrated Quality, Finance & Performance Delivery Group where needed. This is intended to address the previously identified gap between risk identification and active mitigation, creating more responsive risk management closer to service delivery. Operational oversight has also improved through internal escalation processes, however 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 is being 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, as set out in the Health Board's Annual Plan. 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. No critical gaps are identified; residual risk remains low.	None	None	10	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Targeted intervention/2025/558/MD5	MD	Clear governance and assurance systems in place with issues escalated appropriately through clear structures and processes.	Must do	Mr Lee Davies	TRUSTWIDE	TRUSTWIDE		NO		1/1	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Targeted intervention/2025/558/MD5/1	Clear governance and assurance systems in place with issues escalated appropriately through clear structures and processes. Please provide a summary of the progress so far and the next steps	TRUSTWIDE	TRUSTWIDE	Mr Lee Davies	14/07/2025	22/07/2025	Overdue

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
None	None	None	0	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Targeted intervention/ 2025/558/MD6	MD	Self-assessment against the governance and leadership maturity matrix with evidence the agreed level.	Must do	Ms Joanne Wilson	TRUSTWIDE	TRUSTWIDE		NO		1/1	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Targeted intervention/ 2025/558/MD6/1	Self-assessment against the governance and leadership maturity matrix with evidence the agreed level. Please provide a summary of the progress so far and the next steps	TRUSTWIDE	TRUSTWIDE	Mr Lee Davies	14/07/2025	22/07/2025	Overdue

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
None	None	None	0	

Ref		Recommendation	Priority	Lead	Site	Service	Regulation	Clinical priority	Theme	Actions	Status
Targeted intervention/ 2025/558/MD7	MD	The Board acts on, and addresses appropriately, concerns raised through NHS regulators such as HIW.	Must do	Ms Sharon Daniel	TRUSTWIDE	TRUSTWIDE		NO		1/1	In progress

Ref	Action	Site	Service	Responsibility	Date raised	Due date	Progress status
Targeted intervention/2025/558/MD7/1	The Board acts on, and addresses appropriately, concerns raised through NHS regulators such as HIW. Please provide a summary of the progress so far and the next steps	TRUSTWIDE	TRUSTWIDE	Ms Sharon Daniel	11/07/2025	22/07/2025	Overdue

Comments/Updates	Risks	Barriers	Number of uploaded evidence	Reject reason (if applicable)
None	None	None	0	

2.5

10:20, 0 Mins

2.5 - All Wales NHS Audit Committee Chairs' Meeting Update

Rhodri Evans (Hywel Dda UHB - Independent Member)

DEFERRED to 14 October 2025 meeting

For information

2.6

10:20, 5 Mins

2.6 - Committee Self-Assessment

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

For assurance

Attachments

2.6 ARAC Self Assessment 6 month Update.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:**	12 August 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit and Risk Assurance Committee (ARAC) Self-Assessment Outcome Report 2024/25 – Progress Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rhodri Evans, ARAC Chair Joanne Wilson, Director of Corporate Governance/ Board Secretary
SWYDDOG ADRODD: **REPORTING OFFICER:**	Charlotte Wilmshurst, Assistant Director of Assurance and Risk

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide an update to the actions agreed by the Audit and Risk Assurance Committee (ARAC) in response to the outcomes from the ARAC Self-Assessment 2024/25 process.

Cefndir / Background

In December 2024, ARAC received a report which presented the outcomes of the ARAC Self-Assessment 2024/25 process. For ARAC, this involved:

- Short digital form which requested feedback on the following areas:
  - Governance and administration
  - Committee's inputs
  - Conduct of Committee meetings
  - Interface with other Committees, including the Board
  - Committee's impact
  - Individual role on Committee

The feedback from this form was considered alongside other information, such as:

- Matters alerted to the Board
- IM Reflective sessions
- Auditor/Regulator feedback

Asesiad / Assessment

The following actions were agreed in response to the outcomes of the ARAC Self-Assessment 2024/25:

Action	By whom	By when	Progress/Evidence
To improve TI reporting to ensure focus is on areas aligned to ARAC and receiving assurance on TI governance reporting and arrangements	Director of Strategy and Planning	Completed	Format of TI Report to ARAC changed to increase focus
To focus on matters of alert and advise when reporting to the Board	ARAC Chair	Completed	Board minutes
To provide report writing and presenting guidance to operational teams as part of the implementation of the Operational Governance Structure	Director of Corporate Governance /Board Secretary	Completed	Training with Clinical Care Groups is currently underway, Three out of the five CCGs (MHLD, Estates and Facilities, Community and Integrated Medicine) have already received training, with the remaining two scheduled to follow.
To consider including suggested areas of focus for 2025/26 on Committee Workplan	Director of Corporate Governance /Board Secretary/ Committee Services Officer	Completed	Discussed at ARAC agenda setting meetings
To undertake discussions with auditors on the focus of audit plans that supports the delivery of TI Domains and risks associated with financial loss, patient safety and operational effectiveness	Director of Corporate Governance /Board Secretary	Completed	The IA plan for 2025/26 was agreed by ARAC in April 2025. The risk based internal audit planning approach, and how it links with the Health Board's systems of assurance, are set out in section 2.2 and 2.3. Alongside this, Internal Audit meet with Executive Directors and Independent Members to discuss current areas of risk and related assurance needs. The IA plan includes areas relating to TI, and risks associated with financial loss, patient safety and operational effectiveness all form part of the IA Plan.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to take an assurance from the progress made against the actions being undertaken to improve its effectiveness.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	10.6 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation, including that of any sub-committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	ARAC Terms of Reference ARAC Self-Assessment Outcome Report Auditor and Regulator feedback through Structured Assessment and Internal Audit reports
Rhestr Termau: Glossary of Terms:	Included within report

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	ARAC Chair Director of Corporate Governance/Board Secretary

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

2.7

10:25, 15 Mins

2.7 - NHS Wales Shared Services Partnership's Construction Frameworks for Swansea Bay and Hywel Dda University Health Boards

Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Eldeg Rosser (Head of Capital Planning), Julian Wheeler Jones (Hywel Dda UHB - Discretionary Capital Projects Manager)

For assurance

Attachments

2.7 Construction Framework Review August 2025 FINAL.pdf

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	12 August 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	NHS Wales Shared Services Partnership's Construction Frameworks for Swansea Bay and Hywel Dda University Health Boards (CAP-OJEU-91888)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Lee Davies, Executive Director of Strategy and Planning
SWYDDOG ADRODD: **REPORTING OFFICER:**	Eldeg Rosser, Head of Capital Planning Julian Wheeler Jones, Discretionary Capital Projects Manager

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 is presented to the Audit and Risk Assurance Committee (ARAC) to provide assurance on the action to review process following a recent Chair's Action Meeting to confirm the use of the Health Board Common Seal in the execution of the Bronglais Lift Shaft Repair contract document.

The Chair of ARAC requested in the meeting that a review of the Construction Framework be prepared and presented to ARAC, to provide assurance that the use of the framework and awarding of contracts is undertaken in line with Procurement Regulations and provides value for money.

Cefndir / Background

The Construction Framework was set up in 2022, as a joint framework between Swansea Bay University Health Board (UHB) and Hywel Dda UHB as a 3-year contract with a 12-month extension period.

The framework was managed and set-up by NHS Wales Shared Services Partnership (NWSSP) - Procurement and, in line with Welsh Government procurement rules, signed off by the Cabinet Secretary for Health and Social Care.

The Construction Framework was set up to embed the principles of partnering and collaborative working to modernise the NHS approach to construction projects, as well as to deliver benefits in terms of quality, time and cost. This approach also provides a flexible procurement solution when procuring construction works project, particularly at year end.

The framework can deliver construction projects up to £2m net construction work value threshold.

Work packages are divided into 4 separate framework lots according to value:

Lot 1 Minor - up to £200,000
Framework 1 – East Swansea Bay UHB
Framework 2 – Hywel Dda UHB

Lot 2 Intermediate £200,001 - £2,000,000
Framework 3 – East Swansea Bay UHB
Framework 4 – Hywel Dda UHB

Works over £2,000,000 and up to £4,000,000 are subjected to individual tender exercises and works over £4,000,001 are procured via the Designed for Life Frameworks operated by NWSSP.

Following a rigorous procurement process facilitated by NWSSP – Procurement, the following contractors were included on the Frameworks for Hywel Dda University Health Board:

Framework 2
- TRJ
- Edmunds Webster
- Lewis Construction

Framework 4
- TRJ
- John Weaver
- Lewis Construction

The framework has run successfully since early 2022 and was set up for a 3-year period with a 1-year extension. We are currently in the extension period and work has commenced on the procurement of a new framework, with the anticipation that this be available from June 2026.

Contracts are awarded on a rotational basis, with a call-off option of direct award being available subject to the supplier next on the rotation. All contracts issued are monitored utilising key contract performance indicators. NWSSP – Procurement also run annual Dunn and Bradstreet Reports on the financial viability of the contractors on the framework.

The contract for the Bronglais Lift Shaft Repair is one of the projects issued through this framework, under Construction Framework 4 West with John Weaver.

Asesiad / Assessment

Hywel Dda UHB have let 87 contracts through this framework since its inception (see Appendix 1).

The Framework was reviewed as part of the 2024/25 Capital Systems Internal Audit Review, which provided **Reasonable Assurance** when it was presented to ARAC in December 2024.

The audit objectives included:

Selection and Appointment – To ensure the appropriate application of Standing Orders, Standing Financial Instructions (SFIs), national and local procurement policies for the selection and appointment of contractors and technical advisers. To ensure the application of appropriate

competitive tender/quotation arrangements, the use of frameworks (as applicable) and the appropriateness of associated management and reporting.

Value for Money and Award – To ensure that there was an appropriate assessment of value for money (e.g. via tendering/ quotation, benchmarking etc), with formal recommendations for award. Appropriate approvals were in place, that fully considered the above and any associated limitations.

The audit sampled 10 projects and concluded the following:

Selection and Appointment
The Health Board operated a shared Construction Framework with Swansea Bay UHB which was compliant with UK/EU procurement legislation. This multi-supplier framework agreement covered provision of project and design services. All suppliers had been added to the framework following a robust and compliant tendering process. NWSSP Procurement Services, on behalf of HDUHB, establish single Call-Off Contracts and direct award is utilised for all framework agreements. In testing it was found that all contracts were direct award on rotation per the local framework, using a call off contract with single stage award via the JCT minor works or the JCT intermediate works process. A tender analysis had been undertaken for each contract including benchmarking, which mitigated the risk that the tender did not provide value for money or was inappropriately awarded from a contractor experience perspective. Challenge was observed on occasions when the tender analysis identified a higher value at tender versus market benchmarking, and a recommendation was made to revise the tender awarded accordingly.

Value for Money and Award
A Value for Money Statement is issued at each direct award from the framework highlights the following:
• "Direct award allows for quicker procurement"
• "Direct award ensures transparency in the selection process"
• "Direct award puts the services' needs first."
• "By avoiding the need for a lengthy competitive tender process, direct award frees up resources from clinical teams, estates teams and wider that would otherwise be spent on procurement information and procedures"
The contracts sampled all used direct award which was in line with the Health Board's Statement of Value for Money (excerpted above). Further there was clear evidence of evaluation to ensure Value for Money, which also considered items of a qualitative nature.

A **Substantial Assurance rating** was issued for both the selection and appointment processes and the value for money and award considerations.

This outcome reflects the robust stewardship and financial control exercised by the Discretionary Capital Design Team at HDdUHB, in line with NHS Wales standards. By leveraging the direct award mechanism within an approved framework, it has been possible to streamline procurement, and reduced costs. This approach also frees up valuable clinical and estates resources, delivering measurable efficiency gains.

The Health Board is currently working with Swansea Bay UHB and NWSSP – Procurement to establish a new framework, which will be compliant with current procurement legislation; to be available from April 2026.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is requested to **TAKE ASSURANCE** that the use of the framework and awarding of contracts is undertaken in line with procurement regulations and provides value for money.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.22 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Corporate Risk 1196 - not be able to provide safe, sustainable, accessible and kind services. This is caused by insufficient investment to ensure we have appropriate facilities, medical equipment and digital infrastructure of an appropriate standard. Score 16 Corporate Risk 1745 - of not being able to deliver safe, effective and timely services across the Health Board estate, including acute, community and mental health facilities. This risk also impacts the Health Board's nonclinical estate, educational facilities and managed practices. Risk Score 15
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	8 Estates plans
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:	Included within the report
Rhestr Termau: Glossary of Terms:	Included within the report
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:**	Capital values noted within the report. Included within individual business cases and Capital prioritisation process.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Included within individual business cases and capital prioritisation process.
Gweithlu: **Workforce:**	Included within individual business cases and capital prioritisation process.
Risg: **Risk:**	Risk assessment process is integral to the capital prioritisation process and the management of capital planning within HDdUHB also included within individual business cases and capital prioritisation process.
Cyfreithiol: **Legal:**	Included within individual business cases and capital prioritisation process.
Enw Da: **Reputational:**	Included within individual business cases and capital prioritisation process.
Gyfrinachedd: **Privacy:**	Included within individual business cases and capital prioritisation process.
Cydraddoldeb: **Equality:**	Equality assessments are included within individual business cases and capital prioritisation process when required.

APPENDIX 1

LOT 2	FRAMEWORK AWARD - CONTRACTOR ROTATION REGISTER < £200K		
Award	Contractor	Job Location and Brief Description	Date of Entry
Nr			
001	Lewis Construction	PPH DR Replacement	6/4/22
002	T Richard Jones	BGH JDR Residences	11/4/22
003	Edmunds Webster	GGH - DR Replacement	6/4/22
004	Lewis Construction	Penlan Retaining Wall	5/5/22
005	T Richard Jones	Hafen Derwen Solar Farm	25/5/22
006	Edmunds Webster	WGH - DR Replacement	14/4/22
007	Lewis Construction	CICC - Internal Protection Work	4/4/22
008	T Richard Jones	BGH - DR Replacement	4/4/22
009	Edmunds Webster	GGH - Neo Natal Folding Part.	3/4/22
010	Lewis Construction	PPH - Boundary Fencing	9/8/22
011	T Richard Jones	GGH - LPG Enablement	22/8/22
012	Edmunds Webster	GGH - Morlais Ward	23/8/22
013	Lewis Construction	GGH - MRI	9/9/22
014	T Richard Jones	BGH - Lift Shaft Support (surgical)	15/9/22
015	Edmunds Webster	PPH - Mammography Room Refurbishment	4/10/22
016	Lewis Construction	WGH - RAAC Planks: Potwash / Kitchens	30/10/22
017	T Richard Jones	WGH - Renal Drainage	29/11/22
018	Edmunds Webster	WGH - Internal Coms Room at Block 06	26/1/23
019	Lewis Construction	PPH Bryngolau Flooring	7/3/23
020	T Richard Jones	Fire Safety Improvements Cwm Seren / TCH	7/3/23
021	Edmunds Webster	GGH MRI Infrastructure Works	27/7/23
022	Lewis Construction	WGH RAAC: Urgent Propping & Temp Works	10/8/23
023	T Richard Jones	WGH RAAC: Urgent Demountable Ground Works	31/8/23
024	Edmunds Webster	WGH RAAC: Community Sites - TCH/SPH	17/10/23
025	Lewis Construction	GGH Dishwasher - Phases 1 to 9 & GGH Bathroom	17/11/23
026	T Richard Jones	WGH RAAC: Enablement Work	27/11/23
027	Edmunds Webster	ED Project - Phases 1 to 3 (Vending/GGH ED/Lighting)	11/12/23
028	Lewis Construction	Women & Children's Phase 2	16/1/24
029	T Richard Jones	GGH Pathology Reception - Phase 2 Fire	5/3/24
030	Edmunds Webster	EFAB A&E Improvement Works HBW	5/3/24
031	Lewis Construction	Solva	29/4/24
032	T Richard Jones	Dafen Health Integrated Centre - Unit 2A	29/4/24
033	Edmunds Webster	Pembroke County JDR - Kitchen & Bathroom Refurb	21/5/24
034	Lewis Construction	GGH Laundry Remedial Work	24/6/24
035	T Richard Jones	BGH Sterilizer Enablement Work	9/7/24
036	Edmunds Webster	GGH ED Refurbishment	13/8/24
037	Lewis Construction	GGH Microbiology Labs	21/8/24
038	T Richard Jones	PPH Garden Project	4/10/24
039	Edmunds Webster	WGH Chiller	20/2/25
040	Lewis Construction	PPH Fire Dampers	9/5/25
041	T Richard Jones	GGH Medical Photography	9/5/25
042	Edmunds Webster	BGH Endoscopy	9/5/25
043	Lewis Construction	Ty Bryn, Hafan Derwen	14/7/25

LOT 4			
Award	Contractor	Job Location and Description	Date of Entry
Nr			
001	T Richard Jones	BGH - CT Scanner	4/4/22
002	Lewis Construction	PPH - CT Scanner	6/4/22
003	John Weaver	HB Wide GP Improvements	5/4/22
004	T Richard Jones	BGH - DR/Flouroscopy	11/4/22
005	Lewis Construction	GGH Drainage Phases 3 & 4	23/6/22
006	John Weaver	PPH Fire Code Works - Phase 1	4/7/22
007	T Richard Jones	WGH Aseptics Remedial	19/8/22
008	Lewis Construction	MH&LD Bro Myrddin Refurb	26/9/22
009	John Weaver	PPH Fire Compliance	7/3/23
010	T Richard Jones	GGH Water Tank	7/3/23
011	Lewis Construction	PPH Bryngofal & Bryngolau Ward - Phases 1 & 2	7/3/23
012	John Weaver	SPH Fire Compliance	7/3/23
013	T Richard Jones	LCH Drainage & Remedial	7/3/23
014	Lewis Construction	BJC WGH BGH Aseptics - Phases 1 & 2	7/3/23
015	John Weaver	BGH POL Enlli Ward	7/3/23
016	T Richard Jones	HBW EFAB Generator Enablement	2/3/23
017	Lewis Construction	WGH RAAC: Ward 9	3/3/23
018	John Weaver	BGH Chemotherapy Day Unit	3/3/23
019	T Richard Jones	WGH RAAC: Ward 12	6/6/23
020	Lewis Construction	WGH RAAC: Ward 7	24/7/23
021	John Weaver	SARC at Aberystwyth	28/7/23
022	T Richard Jones	WGH RAAC: Ward 10	31/7/23
023	Lewis Construction	WGH RAAC: Wards 8	4/8/23
024	John Weaver	PPH Fire Code Works - Phase 2	4/8/23
025	T Richard Jones	WGH RAAC: Ward 11	4/8/23
026	Lewis Construction	WGH RAAC: G/F OPD A & Main Kitchens	6/8/23
027	John Weaver	BGH X-Ray Replacement Project	12/10/23
028	T Richard Jones	WGH RAAC: Ground Floor - other areas	12/10/23
029	Lewis Construction	TCH & BGH A&E Replacement Projects - Phases 1 & 2	12/10/23
030	John Weaver	EFAB POL Project - St Caradog's	5/12/23
031	T Richard Jones	WGH RAAC: OPD B, Main Corridor & SDEC	5/12/23
032	Lewis Construction	WGH RAAC: Physio, North/South Corridors & Pharmacy	5/12/23
033	John Weaver	EFAB POL Project	22/4/24
034	T Richard Jones	WG Picton Terrace Office Facility	22/4/24
035	Lewis Construction	WGH RAAC: OPD A Flat Roof & Plant Room (Tender 4)	1/5/24
036	John Weaver	BGH Roof Replacement Projects	14/5/24
037	T Richard Jones	24/25 Imaging Project at Fluro & DR WGH	4/7/24
038	Lewis Construction	24/25 Imaging Project at MRI PPH & GGH MRI	4/7/24
039	John Weaver	Cwm Seren Fire Code Works	9/7/24
040	T Richard Jones	GGH Roof Replacement - Phases 1 & 2	9/7/24
041	Lewis Construction	MH&LD Ty Bryn, Cwm Seren & St Non's - Phases 1 to 4	10/7/24
042	John Weaver	EFAB 3 - PPH Fire Code Works - Phase 3	9/12/24

043	T Richard Jones	BGH Lift Shaft Repairs	10/12/24
044	Lewis Construction	WGH Aseptics Project - Phases 3 & 4	13/12/24
045	John Weaver	Meurig Fire Stopping	13/12/24
046	T Richard Jones	Emergency Generators - Phases 1 to 4 (HBW)	13/12/24
047	Lewis Construction	Window Replacement HBW	9/5/25
048	John Weaver	PPH Chiller & UPS - Phases 1 & 2	9/5/25
049	T Richard Jones	Decarbonisation Projects at PPH - Phases 1 & 2	9/5/25
050	Lewis Construction	WGH Remedial Works to Main Elevations	19/5/25
051	John Weaver	GGH Front of House Scheme	20/5/25
052	T Richard Jones	WGH Puffin Ward - Paediatrics OPD Facility	21/5/25
053	Lewis Construction	Cwm Seren (PICU)	21/7/25

3

10:40, 0 Mins

3 - Audit Wales

3.1

10:40, 5 Mins

3.1 - Audit Wales Update Report

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

For assurance

Attachments

3.1 Audit Wales ARAC Update (12.08.25).pdf

Archwilio Cymru
Audit Wales

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

Date issued: August 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 to the committee in April 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 2024-25 Charitable Funds Accounts	Director of Finance	To provide an audit opinion on the 2024-25 Health Boards Charitable Funds Accounts.	Planning	December 2025
Audit of the 2024-25 Annual Report and Accounts	Director of Finance	To provide an audit opinion on the Health Board's 2024-25 Annual Report and Accounts.	Complete	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 2025 – 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 2025 Structured Assessment will review: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements.	Fieldwork underway	December 2025
Review of urgent and emergency care	Director of Operations	This work has examined different aspects of the urgent and emergency care system and includes analysis of national data sets to present a high-level picture of how the urgent and emergency care system is currently working.	Blog and data tool published in April 2022	

Area of work	Executive Lead	Focus of the work	Status	Planned date for consideration
		The work has examined 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 have also reviewed 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).	Part 1 – Regional and local reports issued in draft Part 2 – complete	October 2025 Presented to the committee in June 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.	Fieldwork underway	December 2025
Review of the management of outpatients (Local work 2024)	Director of Operations	This work has examined the management of outpatients, including assessing the Health Board's progress on the recommendations made in our 2015 and 2018 Review of Follow-up Outpatient Appointments.	Report being drafted	October 2025

Area of work	Executive Lead	Focus of the work	Status	Planned date for consideration
Structured Assessment 2025 Deep Dive - review of the arrangements to manage estates	Director of Allied Health Professions and Health Science	This review will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose. When undertaking this work, we will take into account the local work which examined the Health Board's arrangements for managing capital prioritisation.	Planning	April 2026
Review of cancer services	Director of Operations	This work will follow on from the review of national leadership arrangements for cancer services. Whilst the exact focus of this work is to be determined, it is likely to consider: • The progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services; • The efficacy of local plans and associated actions to recover cancer waiting lists; and • Use of the additional Welsh Government financial allocations to improve cancer services.	Planning	April 2026

Area of work	Executive Lead	Focus of the work	Status	Planned date for consideration
Review of radiology services (Local work 2025)	Director of Operations	This work will examine the effectiveness of arrangements to manage current and future demand for the Health Board's radiology services, and will assess the extent of progress made in implementing the recommendations from our 2017 radiology service review.	Project brief issued and set-up meeting held	February 2026

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
Temporary Accommodation, long-term crisis?	**July 2025**
Cost Savings Arrangements – A checklist for NHS Board Members	June 2025
The Wales Infrastructure Investment Strategy	May 2025
No time to lose: Lessons from our work under the Well-being of Future Generations Act	April 2025
The Biodiversity and Resilience of Ecosystems Duty	March 2025

Additional information

7 **Exhibit 4** provides information on corporate documents published by Audit Wales since the last committee update. There are no relevant Audit Wales consultations currently underway.

Exhibit 4 – corporate documents published by Audit Wales

Title	Publication Date
Annual Report and Accounts 2024-25	June 2025

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

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

3.2

10:45, 15 Mins

3.2 - Structured Assessment - Progress Update on Recommendations

Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Huw Thomas (Hywel Dda UHB - Director of Finance), Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience), Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health)

For assurance

Attachments

3.2 Structured Assessment Update August 2025.pdf

3.2 Appendix 1 - AW Structured Assessment Recs July 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:	12 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Structured Assessment 2022, 2023 and 2024 – Management Response Updates
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Professor Phil 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

This report provides the Audit and Risk Assurance Committee with an update on progress against the recommendations made by Audit Wales (AW) in:

- Structured Assessment 2022
- Structured Assessment 2023
- Structured Assessment 2024

Cefndir / Background

The structured assessment work undertaken by Audit Wales 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.

Asesiad / Assessment

As part of the Structured Assessment process in 2024 Audit Wales made three new recommendations and assessed the Health Board's response to the recommendations made in previous reports. Two recommendations from the 2022 Structured Assessment, and one recommendation from the 2023 Structured Assessment, were assessed as in progress, and reopened on AMaT (Audit Management and Tracking).

This report provides progress in response to these recommendations. For further detail on progress, please see Appendix 1, which has been extracted from AMaT.

Progress against these recommendations has been shared with AW as part of Structured Assessment 2025, which is now underway.

Structured Assessment 2022

Recommendation	Executive Lead	Revised Date for implementation	RAG status as at 31/07/2025
R2 (Operational structure)	Chief Operating Officer	~~31/12/2023~~ ~~30/09/2024~~ 30/06/2025	
R6 (Financial sustainability plan)	Executive Director of Finance	~~31/03/2023~~ ~~31/03/2024~~ 31/03/2025	

Structured Assessment 2023

Recommendation	Executive Lead	Revised Date for implementation	RAG status as at 31/07/2025
R3 (Performance management arrangement assurance)	Executive Director of Finance	30/06/2024	

Structured Assessment 2024

Recommendation	Executive Lead	Date for implementation	RAG status as at 31/07/2025
R1 (Improving Together Framework)	Executive Director of Finance	31/03/2025	
R2 (Quality Improvement Strategic Framework)	Executive Director of Nursing, Quality and Patient Experience	30/04/2025	
R3 (Well-being objectives and strategy refresh)	Executive Director of Public Health	31/03/2026	

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to discuss and consider progress made in respect of the recommendations from the Structured Assessments 2022, 2023 and 2024.

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)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	4. Positive futures
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 2022, 2023 and 2024 reports
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 provide progress updates 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.

Inspection Code	Inspection Title	Recommendation	Reference Number	Action	Lead Person	Original Due Date	Current Due Date	Progress Status	Comments/Updates
Audit Wales/2022/245	Audit Wales - Structured Assessment 2022	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	Audit Wales/2022/245/MD2/1	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.	Mr Andrew Carruthers	31/12/2023	31/12/2023	Fully complete (Approved)	07/07/25 Update: CCG Triumvirates now fully in place and governance arrangements implemented. Supporting OD programme launched on the 1st July 2025. Final Stage of Phase 1 is the appointment/reapporintment of Clinical Directors - the OCP process for this is in progress.
Audit Wales/2022/245	Audit Wales - Structured Assessment 2022	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 financial recovery plan for 2023 onwards, ensuring that its improvement opportunities are reflected.	Audit Wales/2022/245/MD6/1	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 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.	Mr Huw Thomas	31/03/2024	31/03/2024	Fully complete (Approved)	01/07/2025: A further updated Financial Roadmap has been collated over quarter 1, 2025/26 to lead into the 2026/27 Three Year Planning Cycle. Milestones have been set with Executive Team for reviewing (10/07/25), and agreeing to embed the recovery plan into the planning cycle for 2026/29. Latest version uploaded as evidence of progress and completion of action/recommendation, with the 2026/27 planning cycle facilitating the next update.
Audit Wales/2023/246	Audit Wales- Structured Assessment 2023- Hywel Dda University Health Board	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.	Audit Wales/2023/246/MD3/1	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.	Mr Huw Thomas	30/06/2024	30/06/2024	Fully complete (Approved)	09/07/2025:The final report was presented to ARAC in April 2025.
Audit Wales/2024/440	Audit Wales - Structured Assessment 2024 – Hywel Dda University Health Board	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: • De-escalating and supporting directorates at the highest level of escalation for extended periods; and • Coordinating support for directorates escalated over several domains (see paragraph 53).	Audit Wales/2024/440/MD1/1	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	Mr Huw Thomas	31/03/2025	31/03/2025	Fully complete (Approved)	16/05/25 - The Improving Together Framework has been now been updated. The process was agreed by Board in March 2025.
Audit Wales/2024/440	Audit Wales - Structured Assessment 2024 – Hywel Dda University Health Board	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).	Audit Wales/2024/440/MD2/1	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	Ms Sharon Daniel	30/04/2025	30/04/2025	Fully complete (Approved)	16/05/25 - The standalone annual report on Quality Improvement Activities was reported to Quality Safety and Experience Committee in April 2025.
Audit Wales/2024/440	Audit Wales - Structured Assessment 2024 – Hywel Dda University Health Board	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).	Audit Wales/2024/440/MD3/1	The well-being objectives will be reviewed as part of the long-term strategy refresh	Ardiana Gjini	31/03/2026	31/03/2026	In progress	Work is being progressed alongside the A Healthier Mid and West Wales Strategy Refresh

3.3

11:00, 0 Mins

3.3 - Review of Urgent and Emergency Care (Discharge Planning and Impact of Patient Flow)

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

DEFERRED to 14 October 2025 meeting

For assurance

3.4

11:00, 0 Mins

3.4 - Review of Investment in Digital Systems

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

DEFERRED to 9 December 2025 meeting

For assurance

3.5

11:00, 0 Mins

3.5 - Review of the Management of Outpatients

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

DEFERRED to 14 October 2025 meeting

For assurance

4

11:00, 10 Mins

4 - BREAK

5

11:10, 0 Mins

5 - NWSSP – Audit and Assurance Services - Internal Audit

5.1

11:10, 5 Mins

5.1 - Internal Audit Plan Progress Report

James Johns (NWSSP - Internal Audit)

For assurance

Attachments

5.1 SBAR IA Plan Progress Report August 2025.pdf

5.1 IA Plan Progress Report August 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:	12 August 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 2025/26 and outcomes from audit work.

Cefndir / Background

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

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

Asesiad / Assessment

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

Argymhelliad / Recommendation

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

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

August 2025

Audit & Assurance Services
Internal Audit Progress Report

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

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 2025/26 Internal Audit Plan. The report also includes details of the progress with the delivery of individual audits, outcomes from finalised audits and any updates required to the plan.

2. Outcomes from Finalised Audits

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

ASSIGNMENT	ASSURANCE RATING
Corporate Risk Ophthalmology	 Reasonable
Sickness Management	 Limited
Nursing Management	 Limited

3. Planning and Delivery Update

3.1 Audit work at the start of 2025/26 has progressed well with three audits finalised along with a number of others at the fieldwork and planning stages.

3.2 The assignment status schedule for the 2025/26 plan is set out at Appendix A. The schedule includes at this stage an initial timeline for audit assignments as we look to use a flexible approach with our delivery through the year in order to ensure effective management of the available resources.

3.3 As a result of ongoing planning discussions, the time in the plan for Estates & Facilities will be utilised for some further work around Cleaning Standards later in the year. Other aspects of Estates & Facilities will be picked up in other planned reviews including Operational Governance.

3.4 Regular meetings with the Director of Corporate Governance have continued, along with meetings taking place with Executive Directors and

senior managers in relation to audits currently being planned and delivered. The UHB Board meetings and some Committees have been observed. Ongoing liaison meetings with Counter Fraud, Audit Wales and Health Inspectorate Wales have also continued.

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

Audit Output	Planned start	Planned ARAC	Executive Lead/Responsible Director	Progress Status	Assurance	H	M
Joint Committee with SBUHB	Q3/4	Apr	Corporate Governance				
Operational Governance Arrangements	Q2/3	Dec	Chief Operating Officer				
Level Three / Four Directorates	Q2/3	Dec	Chief Operating Officer				
Nursing Management	**Q1/2**	**Aug**	**Nursing, Quality Safety & Experience**	**FINAL**	**Limited**	**1**	**2**
Estates/Facilities Directorate - Cleaning Standards	Q3/4	May	Allied Health Professionals & Health Science				
Medical Workforce Stabilisation	Q3/4	April	Medical				
Validation of Emergency Departments performance and waiting time data	Q1/2	Oct	Chief Operating Officer	wip			
Staff Sickness Management	**Q1/2**	**Aug**	**Workforce & OD**	**FINAL**	**Limited**	**1**	**2**
Commissioning– Long Term Agreement	Q2	Oct	Strategy & Planning	planning/ wip			
Commissioning – Third Sector	Q3/4	May	Chief Operating Officer	planning			
Decision making for high cost drugs	Q2/3	Feb	Finance	planning			

Risk of increasing fragility in primary care contractor services due to external factors	Q2/3	Oct	Chief Operating Officer	planning			
GP Out of Hours	Q3/4	Apr	Chief Operating Officer	planning			
Corporate Risk Ophthalmology	**Q1/2**	**Aug**	**Chief Operating Officer**	**Final**	**Reasonable**	**-**	**2**
Vaccination & Immunisation	Q1/2	Oct	Public Health	wip			
Patient Experience	Q3/4	Apr/may	Nursing, Quality Safety & Experience				
Complaints	Q3	Apr	Nursing, Quality Safety & Experience				
Infection Prevention & Control	Q3/4	Apr/may	Nursing, Quality Safety & Experience				
Health & Safety	Q3/4	Feb	Allied Health Professionals & Health Science				
Theatre Stock System Implementation	Q3	Feb	Chief Operating Officer				
Human Tissue Authority	Q2	Oct	Allied Health Professionals & Health Science	planning			
IRMER	Q3/4	Apr/may	Allied Health Professionals & Health Science	planning			
Medical Devices Regulations	Q2/3	Dec	Chief Operating Officer	planning			

Escalation Governance	Q3/4	Feb	Corporate Governance /CEO	planning			
Managed Practices	Q1/2	Dec	Chief Operating Officer	planning			
Follow up and agreed Action Implementation Tracking -			Corporate Governance	wip			
Cyber Security	Q2/3	Dec	Finance	planning			
Departmental / Local IT systems management	Q3	Feb	Finance				
Estates Assurance - Space Utilisation	Q2/3	Feb	Strategy & Planning				
Major Infrastructure Investment Plan (MIIP)	Q3/4	April	Strategy & Planning				
Control of Contractors	Q1/2	Oct	Chief Operating Officer	wip/initial draft			
Integrated Audit & Assurance Plans (SSU)– Withybush General Hospital Fire – Phase 2; and Glangwili General Hospital Fire – Phase 2	IAAPs		Strategy & Planning				

Office details: Audit & Assurance Services West Team

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Webpage: Audit & Assurance Services - NHS Wales Shared Services Partnership

5.2

11:15, 20 Mins

5.2 - Standards of Cleanliness Internal Audit - Action Plan Progress

James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science), Elin Brock (Hywel Dda UHB - Head of Research, Innovation & Improvement), Simon Chiffi (Hywel Dda UHB - Head of Operations)

For assurance

Attachments

5.2 Standards of Cleanliness IA Update ARAC August 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:	12 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Standards of Cleanliness Internal Audit and Action Plan
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	James Severs, Executive Director of Allied Health Professions and Health Science
SWYDDOG ADRODD: REPORTING OFFICER:	Simon Chiffi, Head of Operations (Estates and Facilities)

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 provide the Audit and Risk Assurance Committee (ARAC) with an interim update for assurance that progress is being made in relation to the internal audit report on Standards of Cleanliness for 2024/25.

The Committee is being asked to note the content of this interim update report and take assurance that progress is being made to complete actions by the deadlines provided.

Cefndir / Background

On 24 June 2025, the Audit and Risk Assurance Committee (ARAC) received the internal audit report on Standards of Cleanliness for 2024/25. This was a follow up review to assess progress in implementing the management actions identified in the previous internal audit report.

The internal audit assessment for both the 2023/24 and 2024/25 resulted in limited assurance.

At ARAC on 24 June 2025, it was agreed that an interim update be presented to ARAC and QSEC for assurance that the management actions identified for the 2024/25 internal audit report were on track.

Asesiad / Assessment

There are 6 management actions for the Heath Board to address in response to the internal audit assessment 2024/25, which include 2 high priority actions and 4 medium priority actions.

In order to demonstrate progress of actions, enabling actions for the Estates and Facilities Clinical Care Group and internal audit management actions have been identified and separated below:

Estates and Facilities Clinical Care Group - Enabling Actions

Strengthening Leadership Capacity
Assistant Director (1.0 WTE) has been seconded into the Facilities Service to increase senior leadership capacity while senior leadership structure is reviewed.
Consultant Practitioner of Infection Prevention has been seconded into the Facilities Service to provide expert advice and senior leadership from an Infection Prevention and Control perspective to improve operational standards and compliance.

Strengthening Governance
In June 2025, a new 'Cleaning Standards Sub-Group' was established to monitor progress of the management actions identified from the internal audit report. The weekly meeting is chaired by an Assistant Director and has representation from Nursing and Facilities teams.

The group has an agreed terms of reference, operationally reporting twice monthly via the Estates and Facilities Integrated Governance Group, to ensure issues relating to operational delivery are identified and resolved at the earliest opportunity, and from an assurance perspective reporting via Infection, Prevention Strategic Steering Group (IPSSG) with Board level oversight from QSEC.

Internal Audit - Management Actions

The table below shows progress of management actions from internal audit.

Agreed Action	Timescale	Progress update	On track to achieve timescale
1.Review the governance for IPC to align with the new Clinical Care Group Structure, including a review of the terms of reference and reporting arrangements for the Environmental Hygiene Group.	31 Oct 25	IP&C reports are now being presented to each Clinical Care Group focusing on Quality, Health and Safety with representation from the IP&C team present at each meeting. On 15 July 2025, Estates and Facilities Clinical Care Group agreed for the Chair of the Environmental Hygiene Group (EHG) will report to the Estates and Facilities Clinical Care Group on Quality, Health and Safety. On 18 July 2025, the EHG recognised the need to review its Terms of Reference. The Executive Director of Allied Health Professions and Health Science (responsible for Facilities) and Executive Director of Nursing, Quality and Patient Experience (responsible for IPC) will meet to review governance with arrangements with governance team in August 2025. Governance Review Meeting has been scheduled for 11 August 2025 with Executive Director of Allied Health Professions and Health Science and the Executive Director of Nursing, Quality and Patient Experience alongside IP&C and Facilities colleagues to review and agree IP&C reporting and agree a way forward for the governance structures.	

2.Training compliance plans are being developed for each site, this will identify the training to be provided and timescales for achieving compliance. Compliance will be monitored through the Estates Facilities Care Group governance structures.	31 Aug 25	Each site has a specific training compliance plan. These are being owned and monitored by dedicated training supervisors that are based at each site and held on an MS Teams Channel for each site. Training supervisors are currently updating their plans to ascertain current compliance and trajectories for achieving compliance. These plans will be submitted to the Cleaning Standards Subgroup by week commencing 11 August and presented to the Estates and Facilities Clinical Care Group (Quality, Health & Safety) by the Head of Facilities on 19 August 2025.	
3.A plan and trajectory for rolling out the new model of cleaning provision across all sites will be developed.	31 Aug 25	A Workforce Stabilisation Group was established in February 2025 to review the current model of cleaning provision across the Health Board and develop ideas for improvement. Roll-out plans and the trajectory for Prince Philip Hospital (PPH) and Glangwili Hospital (GGH) were developed and presented to the Executive Team on 2 June 2025. Following feedback from Trade Union Representatives and the Executive Team, these plans are currently being updated to include more staff engagement and an evaluation of a trial that took place in PPH to separate ward-based catering and cleaning duties. The plans and trajectories for Bronglais Hospital (BGH) and WGH are currently being developed, following a piece of work to map and scope out existing ways of working as well as a review of rosters. The plans and trajectories for each site will be presented to the Estates and Facilities Clinical Care Group on 19 August 2025.	
4.Spot checks will be undertaken as part of the cleaning audit process to ensure compliance with the cleaning schedules. We will continue working towards a digital cleaning schedule for all wards on Synbiotix.	31 Jul 25	Cleaning schedules have been developed for each area across all sites. To ensure that these are implemented and monitored appropriately, a Cleaning Schedule Compliance Standard Operating Procedure (SOP) has been developed and approved by the Environmental Hygiene Group (EHG). The new SOP will also be presented to the Estates and Facilities Clinical Care Group for approval on 19 August 2025. The SOP includes quarterly spot checks to be undertaken by the Quality Assurance Manager as well as weekly monitoring by Monitoring Supervisors to record the completion of cleaning schedules.	

		Although work continues to progress towards a digital cleaning schedule for all wards on Synbiotix, the Cleaning Standards Sub-Group acknowledges the need to formalise this plan and gain the necessary input from other teams to ensure progress is made in a timely manner. The Facilities Project Manager has produced a project plan to continue working towards a digital cleaning schedule utilising Synbiotix which will be discussed and presented at the Estates and Facilities Clinical Care Group on 4 August 2025.	
5.Following the successful trial of a designated auditing supervisor at PPH this is now being implemented at the other three acute hospital sites. New model of cleaning provision (see key finding 3) will seek to improve cleaning standards and audit scores.	31 Jul 25	All 4 acute hospital sites have a dedicated auditing supervisor in place.	
6.As per key finding 1, governance structures and reporting arrangements will be reviewed to align with the new CCG structure. We will seek to incorporate the role of the existing Synbiotix meetings into the Environmental Hygiene Group and include Estates representation on this group. This links to key finding 1 – review of the governance arrangements.	31 Oct 25	Governance Review Meeting has been scheduled for 11 August 2025 with Executive Director of Allied Health Professions and Health Science and the Executive Director of Nursing, Quality and Patient Experience alongside IP&C and Facilities colleagues to review and agree IP&C reporting and agree a way forward for the governance structures. On 18 July 2025 at Environmental Hygiene Group (EHG), it was agreed to incorporate the current Synbiotix meetings into the monthly EHG meetings as standing agenda items. EHG will continue to monitor Environmental Cleaning matters and the Estates Operational Management Team will discuss Estates-based concerns. The data from both Groups will be formally presented within the performance reports that the Estates and Facilities Clinical Care Group scrutinises monthly by the Head of Facilities and Head of Maintenance and Engineering.	

Further to the management actions outlined above, there are other significant pieces of work being undertaken to add value to the form and function of the facilities service across the Health Board. Examples of the work which will support the overarching improvement to the facilities service are outlined below:

Facilities Induction

The Facilities Team is working with the Learning and Development Team to develop a fit for purpose induction process for all new starters into the Domestic Team. Funding has been secured from Health Education Improvement Wales (HEIW) to support the recruitment of an Education and Development Officer on a fixed-term basis to support the design, delivery and evaluation of a new induction programme for facilities staff across the Health Board. This will align well with the training plans that have now been developed for each site and will enable a proactive approach to training and development for all domestic staff.

New Facilities Manager Role

Following review of the leadership and management structures within the facilities service, it has been identified that there is a significant lack of leadership capacity within the facilities function. This has a detrimental impact on the leaders in post, but also the ability to undertake core management duties, for example, ensuring appropriate supervision of team members/ PADRs and timely management of absence. The Facilities Manager (4.0 WTE, Band 8a) role will provide local leadership to local teams across the Health Board and will report via the Head of Facilities. Recruitment plan is underway, with interviews scheduled for late September 2025.

Supervisory Role Review

The Facilities Team is currently reviewing the Domestic Supervisor (Band 3) role and responsibilities. A Task and Finish Group has been established to review the job description and person specification, undertake a review of the rota and working patterns, facilitate focus groups with supervisors as well as triangulating with the rich data collated via our Organisational Development Relationship Manager. A report, with recommendations, will be presented to the Executive Director of Allied Health Professions and Health Science by 31 August 2025.

Standard Operating Procedures (SOP's)

The Health Board approved an Environmental Hygiene Policy in 2024, which sets out details for providing cleaning services and assessing environmental cleanliness, in line with the National Standards for Cleaning in NHS Wales (2009). In order to ensure its effective implementation, a suite of SOP's need to be developed, approved and implemented. These will provide guidance and support to operational staff, with clear expectations and processes in areas such as Auditing and Monitoring, Training and Induction, Stock, Products and Equipment and Use of The Cleaning Manual.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to **TAKE ASSURANCE** that progress is being made to implement the actions arising from the 2024/25 internal audit report on Standards of Cleanliness.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1 The Committee shall review the adequacy of the UHB's strategic governance and assurance arrangements and processes for the 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) that supports the achievement of the organisation's objectives.

	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)	1. Safe 2. Timely 3. Effective 6. Person-Centred
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	1. Leadership 2. Culture and valuing people 4. Learning, improvement and research 5. Whole systems persepctive
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:	Environmental Hygiene Policy in 2024
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:	Not applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	Contained within the body of the report
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Contained within the body of the report
Gweithlu: **Workforce:**	Contained within the body of the report
Risg: **Risk:**	Contained within the body of the report
Cyfreithiol: **Legal:**	Contained within the body of the report
Enw Da: **Reputational:**	Contained within the body of the report
Gyfrinachedd: **Privacy:**	Contained within the body of the report
Cydraddoldeb: **Equality:**	Contained within the body of the report

5.3

11:35, 10 Mins

5.3 - Corporate Risk: Ophthalmology (Reasonable Assurance)

James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care), Victoria Coppack (Hywel Dda UHB - Service Delivery Ophthalmology Ophthalmology & Neurology)

For assurance

Attachments

5.3 Corporate Risk Ophthalmology Final IA Report.pdf

Corporate Risk: Ophthalmology

Final Internal Audit Report

2025/26

Hywel Dda University Health Board

Reasonable Assurance

Contents

Review Reference	HDU-2526-14
Fieldwork	June – July 2025
Executive Sign Off	August 2025
Audit Committee	August 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

Review of the key controls in place to manage and mitigate the risk of the inability to provide a full range of ophthalmology services across the Health Board. The audit will focus on the risk, controls and gaps in controls identified within risk 1664 relating to ophthalmology services.

Overview

We have concluded **reasonable** assurance on this area, recognising that whilst progress has been made in the implementation of key controls and addressing the identified gaps in controls, significant work is still required to fully address risk 1664. The governance and oversight arrangements for Ophthalmology services demonstrate a structured and proactive approach to performance monitoring, risk assessment, and the implementation of targeted actions to address service challenges and enhance patient outcomes. We have identified two findings requiring management action – these are summarised below with full details provided in the Findings & Agreed Action Plan on page 2.

- The majority of the reported key controls are at varying stages of implementation, with some overlap of the identified key controls. **[Finding 1 – Medium]**
- Review and revision of completed gaps in control to ensure risk 1664 accurately reflects the current implementation status. **[Finding 2 – Medium]**

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Controls to address the ophthalmology service issues have been identified, with appropriate actions to address any gaps in control	1, 2	**Reasonable**
2	Effective arrangements are in place to monitor performance, action implementation and ensure any barriers to achievement of targets are escalated where appropriate	-	**Substantial**

Management Actions

2

Medium Priority

Themes

Risk Types

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: Controls to address the ophthalmology service issues have been identified, with appropriate actions to address any gaps in control	Reasonable

Overview / Summary of Observations

Key Controls

The key controls currently in place within risk 1664 are defined as the *existing controls and processes in place to manage the risk.* Risk 1664 comprises of seventeen key controls; a comprehensive review of the supporting documentation and evidence has confirmed that six of the seventeen key controls are fully implemented and operating as reported.

For the remaining eleven key controls, while notable progress has been made, the level of implementation varies across the individual key controls. Where some of the key controls progress has advanced, others remain in earlier stages of development and implementation. Furthermore, testing has identified areas of overlap among some of the key controls. Therefore, to effectively address the significant challenges and risks associated with ophthalmology, the existing key controls should be reviewed and refined to ensure all key controls are fully implemented and operating as intended. **Finding 1**

Gaps in Control

Gaps in control are defined as *where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working*. Risk 1664 includes four gaps in controls, which have been broken down into eight *further actions necessary to address the controls gaps* together with the corresponding progress and status of each gap. The documentation and information provided supports the reported progress in addressing all eight actions.

Testing identified an overlap between the documentation provided to support the key controls currently reported as in place and the evidence used to demonstrate progress in addressing identified control gaps. In addition, two of the actions have been deemed as completed on risk 1664.
Therefore, where progress has been attained in addressing the gaps in controls and various processes have been implemented, consideration should be given to the revision of the controls identified and reported within risk 1664 to ensure an accurate reflection of the current position. **Finding 2**

	Key Findings	Risk & Impact	Agreed Management Action
1	**Key Controls** While six of the seventeen key controls have been fully implemented and are operating as reported within risk 1664, testing has identified that the remaining eleven controls are at varying stages of implementation. In addition, notable overlaps were identified across some of the key controls. Further work is required, including a comprehensive review and refinement of the key controls, to ensure that all are fully implemented, operational, and supported by appropriate evidence.	Delayed access to services resulting harm to patients and/or poor patient experience. Reputational Damage to Health Board.	**Agreed Action:** Undertake a review and refinement of the key controls reported under risk 1664 to reflect the progress achieved and the current implementation status. Including the revising of the key controls to ensure they are clearly defined, consolidated where appropriate, outlining the next steps required for full implementation, and distinguishing between short-term and longer-term key controls.

			Expected Evidence of Implementation: Revision of Risk 1664. Recording and transcript of the meeting with the Head of Assurance and Risk.
		Medium Priority	**Officer:** Service Delivery Manager, Ophthalmology & Neurology **Target Implementation Date:** 31 August 2025
	Theme: Reporting	Control Operation	
2	**Gaps in Controls** Testing identified an overlap between the documentation provided to support the key controls currently reported as in place and the evidence used to demonstrate progress in addressing identified control gaps. In addition, two of the actions have been deemed as completed on risk 1664. Therefore, where progress has been attained in addressing the gaps in controls and various processes have been implemented, the controls identified and reported within risk 1664 should be refined and revised to ensure an accurate reflection of the current position.	Delayed access to services resulting harm to patients and/or poor patient experience. Reputational Damage to Health Board.	**Agreed Action:** Refine and revise the gaps in controls reported under risk 1664 ensuring they accurately reflect the current position, taking into account the progress made in addressing identified gaps in control and the implementation of new processes. This will include updating both the documented gaps in controls and recognising newly implemented processes as key controls.
			Expected Evidence of Implementation: Revision of Risk 1664. Recording and transcript of the meeting with the Head of Assurance and Risk.
		Medium Priority	**Officer:** Service Delivery Manager, Ophthalmology & Neurology **Target Implementation Date:** 31 August 2025
	Theme: Reporting	Control Operation	

Objective 2: Effective arrangements are in place to monitor performance, action implementation and ensure any barriers to achievement of targets are escalated where appropriate	**Substantial**

Overview / Summary of Observations

Monthly submissions of the Eye Care Outcome Measures dashboard are provided to Welsh Government (WG), covering key performance areas including new and follow-up waits, R1 attendances, waiting list positions, and overall appointment volumes. These submissions are supported by internal reports and data extracts, which included validation pivots, open pathway summaries, and activity data. In addition, supplementary reports were provided detailing HRF coding across outpatient and surgical stages, as well as a further performance tracker aligned to Ministerial Measures. These submissions are reviewed retrospectively as part of the Executive and Improving Together (EIT) sessions.

Weekly performance dashboards are maintained and linked to broader performance tools such as IRIS dashboards, DNA reports, RTT snapshots, and outpatient KPIs. In response to WG directives, Hywel Dda University Health Board (HDUHB) has established the Eye Care Collaborative

Group to strengthen regional oversight, coordination, and strategic development of eye care services across the region. Additionally, HDUHB and Swansea Bay University Health Board (SBUHB) have established the Regional Joint Committee (RJC), with the inaugural meeting held in January 2025. A key development under this framework is the establishment of the Regional Eye Care Programme, formally initiated in November 2024. This programme addresses the growing pressures on ophthalmology services across South West Wales, including rising demand, workforce shortages, and service fragility. A dedicated Regional Eye Care Programme Board has been formed to lead the design and implementation of a sustainable, integrated model of care.

Regular meetings and sub-group sessions have been held to advance workstreams across key sub-specialties, including glaucoma, cataracts, medical retina, and vitreoretinal services. These meetings have focused on aligning clinical pathways, addressing operational challenges, and identifying opportunities for regional service expansion and consultant recruitment.

A review of papers for the Strategic Development and Operational Delivery Committee (SDODC) now retired and the Strategy and Planning Committee (SPC) confirmed that both forums have received regular updates on key ophthalmology areas. These include performance against the R1 Ophthalmology Pathways and R1 High-Risk Patient metrics, as part of the Targeted Intervention (TI) updates. In addition, both committees are presented with progress reports on the implementation of recommendations from the ophthalmology Getting It Right First Time (GRIFT) programme, together with updates from the Regional Collaboration for Health (ARCH) Portfolio regarding the Eye Care Programme.

Integrated Performance Assurance Reports (IPARs) were routinely presented to SDODC, SPC, and the Health Board. These reports detailed ophthalmology performance metrics, including waiting times, service challenges, and the actions and initiatives in place to address them. The February 2025 IPAR specifically highlighted key indicators such as appointment attendance rates and patient waiting activity levels.

Additionally, a broader review of SDODC, SPC, and Health Board papers identified several other relevant documents relating to ophthalmology, including the Clinical Services Plan, Strategic Plan, Planning Objectives, Annual Plan, Planned Care updates, and the Eye Health Needs Assessment.

It is evident from a review of the meeting minutes, agendas, presentations, reports etc provided for a number of meetings held that monitoring of performance, implementation of new processes, action plans and next steps, together with the highlighting and reporting of risks and mitigations are actively discussed, with appropriate action taken and the escalation and discussion of arising issues and constraints.

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]

5.4

11:45, 20 Mins

5.4 - Sickness Management (Limited Assurance)

James Johns (NWSSP - Internal Audit), Lisa Gostling (Hywel Dda UHB - Director of Workforce & OD/Deputy CEO), Heather Hinkin (Hywel Dda UHB - Assistant Director People Management)

For assurance

Attachments

5.4 Staff Sickness Management Final IA Report.pdf

Sickness Management

Final Internal Audit Report

2025/26

Hywel Dda University Health Board

Limited Assurance

Contents

Review Reference	HDU-2425-08
Fieldwork	June-July 2025
Executive Sign Off	July 2025
Audit Committee	August 2025
Executive Lead	Lisa Gostling, Director of Workforce & OD
Audit Team	James Johns, Head of Internal Audit
	Sophie Corbett, Deputy Head of Internal Audit

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Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

Sickness absence represents a significant cost to the health board directly and indirectly that has an adverse effect upon employees and on the level of service that the organisation provides. Effective monitoring of all forms of absence, and a consistency of approach, are essential if absence levels are to lower and be maintained at, or below, the target levels set by Welsh Government.

Hywel Dda had the fourth highest sickness absence rate in NHS Wales for 2024[1]. June 2025 Workforce Information Metrics report a **12-month rolling sickness absence rate of 6.56%** and **in-month rate of 6.01%.**, Anxiety, stress and depression are the leading cause of sickness absence.

This review seeks to provide the Health Board with assurance over the arrangements in place for managing sickness absence in accordance with the NHS Wales Managing Attendance at Work Policy.

Overview

The Health Board demonstrates a commitment to staff wellbeing with a wide range of accessible wellbeing services and initiatives available to staff. Training resources to support compliance with the NHS Wales Managing Attendance at Work Policy are available to staff although training is not mandatory and uptake is not monitored. The areas visited during the review spoke highly of the support, advice and guidance they receive from Workforce in managing sickness absence.

However, sample testing revealed widespread non-compliance with the key requirements of the NHS Wales Managing Attendance at Work Policy, with missing and/or late documentation and failure to act on review prompts for frequent absences. This has resulted in an overall conclusion of **Limited** assurance. Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Management of sickness absence for nursing staff has been reviewed separately as part of the Nursing Management audit – the findings of both reviews are consistent, highlighting that the management of sickness absence remains a significant challenge for the Health Board.

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Compliance with the *All Wales Managing Absence at Work Policy*	1	**Limited**
2	Appropriate training for managers who have a responsibility for managing sickness absence	2	**Reasonable**
3	Mechanisms in place to promote and support staff wellbeing and evaluation of their effectiveness by Workforce and OD	-	**Substantial**
4	Adequate reporting mechanisms to monitor and manage sickness absence, including reasons for sickness, at both service and board level	1	**Reasonable**

[1]Source: Stats Wales Sickness Absence Percentage Absent by Organisation and Date

Management Actions

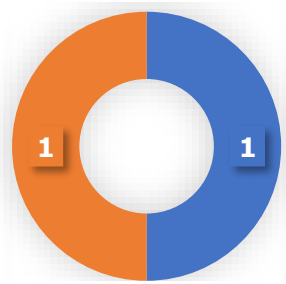
1

High Priority

1

Medium Priority

Themes



Resourcing

Training & Development

Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: Compliance with the *All Wales Managing Attendance at Work Policy*	Limited

Overview / Summary of Observations

The NHS Wales Managing Attendance at Work Policy ('the Policy') provides guidance to staff on managing staff sickness absence. It is available via the staff intranet, and we confirmed that staff working in the areas visited during the audit were aware of the policy and how to access it.

Sample testing was undertaken to test compliance with the key requirements of the Policy (summarised below). Our sample comprised 91 long and short-term absence episodes for 20 employees during the period 1 April 2024 – 31 May 2025. Notably, only two employees (eight episodes) sampled were fully compliant with the key controls tested – all were within PPH Blood Sciences. No documentation was provided for 12 episodes. The findings of our review of the remaining 79 episodes are outlined below. **[Finding 1]**

For any period of sickness absence between 1-7 calendar days an employee must complete a self-certification form, and submit doctors fit note certificates from the 8th calendar day of absence onwards. 19% of absences did not have sufficient evidence of self-certification and/or fit notes.

The Return-to-Work meeting is fundamental to the management of sickness absence and policy states that it should be conducted on the first day of return or as early as possible after return. 89% had a Return to Work completed, although 27% had not been completed within a week of the return and in many cases the associated documentation was dated several months later.

Managers are required to proactively manage absence where the pattern or frequency gives rise to concern, with the Policy outlining three review prompts. 48% of the sickness episodes triggering a review prompt did not have evidence of appropriate action and escalation in line with Policy. In some cases, this was due to managers discretion although the rationale for this was not always clear.

Workforce representatives engage with heads of service to support and advise on sickness management practices, and there are examples of Workforce-led ad hoc deep-dive reviews of sickness management within hotspot areas, although resource and capacity is limited so there is no planned programme of reviews. **[Finding 1]**

	Key Findings	Risk & Impact	Agreed Management Action
1	**Absence Management** Sample testing identified widespread non-compliance with the key requirements of the NHS Wales Managing Attendance at Work Policy, including: • Absence of any documentation in support of some episodes • Failure to undertake Return to Work interviews, or significant delays in completion • Absence of sufficient self-certificates and/or fit notes covering the whole of the absence • Failure to identify and act on review prompts	Failure to manage sickness absence in line with Policy Increased/prolonged sickness absences resulting in: • Increased workforce and financial pressure. • Detrimental impact on staff wellbeing, patient safety and experiences.	**Agreed Action:** Development of a planned programme of sickness absence reviews, led by service managers with appropriate support from Workforce, to assess compliance with policy requirements and understand and address the root causes of non-compliance. Heads of service will be held accountable for non-compliance. Outcomes of the reviews will be reported via the CCG governance structures to provide assurance over the effectiveness of sickness management arrangements. **Expected Evidence of Implementation:** Planned programme of sickness absence reviews. Evidence of completion, remedial actions and follow up demonstrating improvement.

		High Priority	**Officer:** Lisa Gostling – Director of Workforce & OD
	Theme: Resourcing	Control Design	**Target Implementation Date:** 30 September 2025

Objective 2: Appropriate training for managers who have a responsibility for managing sickness absence — Reasonable

Overview / Summary of Observations

There is a core training session on compliance with the NHS Wales Managing Attendance at Work Policy as part of the ESR catalogue available to staff online and can be accessed via the Learning and Development page on SharePoint. The pre-recorded slide show presentation covers the key aspects of the Policy and is designed to meet the needs of employees at Bands 3-7 who manage sickness absence/attendance in their teams as well as Trade Union representatives. There is also a 'bitesize' training video on conducting effective return-to-work interviews with accompanying links to documentation mentioned in the video.

In most areas visited staff stated that they had received training in relation to the Policy. Training is not mandatory and due to the delivery methods monitoring of uptake is not feasible. **[Finding 2]**

Discussions with staff highlighted positive feedback regarding the support from Workforce and their readiness to provide advice and guidance in managing sickness absence as needed. Workforce also provide face to face bespoke training if requested or required by wards and departments. Workforce Advisors engage regularly with service area managers, particularly where sickness rates are high, to provide targeted guidance, support and training if needed. Training requirements are also considered as part of the ad hoc deep-dive reviews.

	Key Findings	Risk & Impact	Agreed Management Action
2	Two areas visited did not recall having undertaken any training in sickness absence management. Training is not mandatory and due to the delivery methods monitoring of uptake is not feasible, emphasising the importance of ongoing promotion of available training and reliance on Workforce Advisors to identify training needs within their respective service areas.	Failure to manage sickness absence in line with Policy Increased/prolonged sickness absences resulting in: • Increased workforce and financial pressures • Detrimental impact on staff wellbeing, patient safety and experience	**Agreed Action:** Workforce & OD will strengthen the promotion of available sickness absence management training through Viva Engage and Workforce Advisors/Managers, who will work with their respective service areas to identify and address training needs. The Learning and Development Manager will explore the feasibility of recognising completed training as contributing towards Continuing Professional Development (CPD), to encourage uptake.
			Expected Evidence of Implementation: Evidence of regular and ongoing promotion of sickness management training
		Medium Priority	**Officer:** Heather Hinkin - Assistant Director, Workforce & OD
	Theme: Training & Development	Control Design	**Target Implementation Date:** 30 September 2025

Objective 3: Mechanisms in place to promote and support staff wellbeing and evaluation of their effectiveness by Workforce and OD — Substantial

Overview / Summary of Observations

Staff wellbeing is a key priority for 2025/26, as outlined in the Health Board's Annual Plan: Strategic Objective 1 is *Putting people at the heart of everything we do*. Our review found that the Health Board demonstrates a strong commitment to supporting a happy and healthy workforce, recognising its importance to organisational effectiveness.

A review of the Wellbeing, Safety and Trust portal on the staff intranet confirmed access to a wide range of internal support services, including:

- *Staff Psychological Wellbeing Service (SPWBS)* – offering toolkits, stress risk assessments, and guides to prevent burnout.
- *Occupational Health Service* and *Wellbeing at Work Webinars.*
- *Vivup (Employee Assistance Programme)* – providing one-to-one psychological support.
- *SilverCloud* – online CBT self-help programmes.
- Tailored support for managers, including personal wellbeing consultations.

The *Recovery in Nature Programme,* offering ecotherapy retreats and nature days facilitated by SPWBS, has shown positive outcomes in improving mental health and reducing burnout. An evaluation was presented to PODCC in May 2025, providing assurance on delivery against Strategic Objective 1.

A SBAR presented to PODCC in February 2025 highlighted rising workplace stress and increased self-referrals to SPWBS during 2022–24. Feedback and clinical data indicated positive mental health impacts. Client satisfaction data also shows that the therapeutic work helps staff to avoid going on sick leave, to return to work and sustain their presence at work following an absence. However, concerns were noted regarding access delays and limited session availability due to vacancies, which may constrain service effectiveness.

Objective 4: Adequate reporting mechanisms to monitor and manage sickness absence, including reasons for sickness, at both service and board level — Reasonable

Overview / Summary of Observations

Service areas are provided with monthly summary absence management metrics reports which include sickness statistics from Workforce Intelligence. Performance dashboards are also available online to monitor sickness and absences.

Sickness metrics have been discussed at the Business, Planning & Performance & People sessions of the Clinical Care Group Integrated Governance Groups for our sample of areas reviewed. Whilst we found no sickness related matters that required escalation to the IQFPD via the Alert, Advise, Assure templates for the areas reviewed, we observed examples of escalation within other service areas including an SBAR on the fragility of the Theatre service due to critical staffing levels due in part to high sick rates, presented to the IQFPD on 14th May 2025.

Whilst there is evidence of reporting of sickness rates, there is no monitoring and reporting on the effectiveness of sickness management and compliance with the Policy. The outcomes of sickness absence reviews **[Finding 1]** should feed into service level governance structures to ensure that areas of weakness are escalated, respective service leads held to account and issues addressed.

Workforce information metrics are presented to every meeting of the People, Organisational Development & Culture Committee (PODCC) and show sickness absence figures, with a more detailed performance assurance and workforce metrics report presented biannually. An *Analysis of Increased Workplace Stress at Hywel Dda University Health Board* was presented to the February PODCC committee to better understand sickness absences attributed to anxiety/depression/stress, potential areas for further analysis, next steps and areas of focus. It was agreed that a progress report would be scheduled for November 2025.

An update on Performance Assurance and Workforce Metrics was presented to the Board in May 2025, confirming that a new target has been set to reduce the Health Board's 12-month rolling sickness absence rate, which stood at 6.60% for 2024/25. Anxiety, stress, and depression remain the leading causes of absence across most directorates, consistent with trends observed in other NHS organisations.

An increase in stress-related sickness absence has been recognised as a corporate risk (Risk 1821) with a current score of 12. Actions to mitigate this risk are in place and are actively overseen by the PODCC.

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 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 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]

5.5 **12:05, 20 Mins**

5.5 - Nursing Management (Limited Assurance)

James Johns (NWSSP - Internal Audit), Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience), Janice Cole-Williams (Hywel Dda UHB - Assistant Director of Nursing), Helen Humphreys (Hywel Dda UHB - Head of Nursing for Professional Standards and Regulation)

For assurance

Attachments

5.5 Nursing Management Final IA Report.pdf

Nursing Management

Final Internal Audit Report

2025/26

Hywel Dda University Health Board

Limited Assurance

Contents

Review Reference	HDU-2526-04
Fieldwork	June 2025
Executive Sign Off	29 July 2025
Audit Committee	August 2025
Executive Lead	Sharon Daniel, Director of Nursing, Quality & Patient Experience
Audit Team	James John, 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

Effective staff rostering processes are fundamental to ensuring that services have appropriate staffing levels and skills mix to maximise the quality of care provided and reduce the risk of harm to patients. The Health Board's *Rostering Policy* sets the standard for the creation and management of staff rosters. Effective absence management is key to efficient rostering, to maximise available resources and mitigate the need for reliance on additional staffing through overtime, bank and agency which incur additional costs.

In November 2024, a Nursing Management audit (HDU-2425-16) was undertaken to provide assurance on the adequacy of systems in place for rostering and absence management, concluding Limited assurance overall. This review is a further full audit of the systems and controls covered in the previous review, together with expanded coverage across the Health Board.

Overview

The findings of this review are broadly consistent with the 2024/25 review. We observed an improving trend in rostering controls and practices, although compliance with the NHS Wales Managing Attendance at Work Policy deteriorated. Our findings in relation to sickness management are consistent with the wider Staff Sickness Management review (ref HDU-2526-08), emphasising that the issues identified are not specific to nursing and that the management of sickness absence remains a significant challenge for the Health Board.

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

- widespread non-compliance with the key requirements of the NHS Wales Managing Attendance at Work Policy, with missing and/or late documentation and failure to act on review prompts for frequent absences
- further improvement required in the management of annual leave utilisation
- clarification and refinement of the agency escalation approval requirements

Full details of matters arising are detailed within the Findings & Agreed Action Plan on page 3.

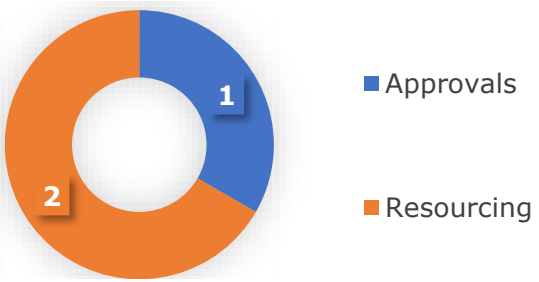
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The Health Board utilises efficient rostering practices, including appropriate absence planning and management processes, to maximise available resources and minimise use of overtime or temporary staffing.	1,2	**Reasonable**
2	Absence is managed in accordance with applicable Health Board and national policies and procedures.	3	**Limited**
3	Rosters are subject to appropriate review and scrutiny to identify and address issues or areas for improvement.	-	**Substantial**

Management Actions

1	2
High Priority	Medium Priority

Themes



Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: The Health Board utilises efficient rostering practices, including appropriate absence planning and management processes, to maximise available resources and minimise use of overtime or temporary staffing	Reasonable

Overview / Summary of Observations

The Rostering Policy sets out how the Health Board will manage staff rostering to ensure services have safe staffing levels and appropriate skill mix to maximise the quality of patient care and reduce risk. The E-Rostering SharePoint site offers a comprehensive suite of guidance documents and videos to support staff in implementing and adhering to rostering processes and policy requirements. Heads of Nursing, Senior Nurse Managers and Roster Managers participated in a series of training sessions undertaken in July/August 2024. A pre-recorded training session is also available on SharePoint.

Analysis of rostered annual leave usage instances where rosters had been signed off despite annual leave being outside of the tolerance range, reducing contingency for unplanned absence or surge. In some cases, agency/bank/overtime had been utilised to backfill shifts where annual leave exceeded the 18% upper tolerance. **[Finding 1]** Whilst this finding is consistent with the previous audit undertaken in 2025, the number of instances identified has significantly reduced (despite a larger sample size) and there was notably less reliance on temporary staff solutions (and in particular agency) to backfill – suggestive of greater stability in establishments and an improving trend in rostering practices.

A standard operating procedure setting out the escalation process for *Booking Registered Nurse or Health Care Support Workers Additional Hours, Bank Overtime & Agency* was issued in April 2025. The order of priority for additional staffing requirements and authorisation is summarised in Table 3 in Appendix A. Escalation to agency requires approval by the Head of Service/Nursing. Sample testing identified that only 16% of agency shifts reviewed had been escalated to agency in Allocate (i.e., 'approved') by the Head of Nursing. The SOP permits approval by a 'nominated deputy' but is not clear on who the nominated deputy should be. **[Finding 2]**

	Key Findings	Risk & Impact	Agreed Management Action
1	**Annual Leave Utilisation** Analysis of rostered registered and unregistered annual leave usage for the four-week period 19 May – 15 June 2025 identified that rosters for six of the eight sampled wards had been signed off despite annual leave being outside of the tolerance range [see Table 1 in Appendix A]. Extending the analysis to include additional staff usage for the same wards and period identified instances where agency/bank/overtime had been utilised to backfill shifts where annual leave exceeded the 18% upper tolerance [see Table 2 in Appendix A].	Inefficient rostering processes potentially resulting in: • Increased workforce pressures and unnecessary use of temporary staff resource • Detrimental impact on staff wellbeing, patient safety and experience	**Agreed Action:** Completion and implementation of the Unavailability Dashboard (due to be launched August 2025) which will enable greater oversight and monitoring of annual leave utilisation in the context of staff unavailability due to sickness absence, study leave, parental leave etc. **Expected Evidence of Implementation:** Launch of Unavailability Dashboard; improved compliance with AL utilisation tolerance

		Medium Priority	**Officers:** Sharon Daniel - Director of Nursing, Quality & Patient Experience; Helen Humphreys, Head of Nursing for Professional Standards & Regulation **Target Implementation Date:** 30 September 2025
	Theme: Resourcing	Control Operation	
2	**Escalation / Approval of Agency Requests** Escalation to agency requires approval by the Head of Service/Nursing. Sample testing of 25 shifts escalated to agency since implementation of the new SOP in April 2025 identified that only 16% of agency shifts reviewed had been escalated to agency on Allocate (i.e., 'approved') by the Head of Nursing. The SOP permits approval by a 'nominated deputy,' although there is ambiguity about which role(s) this could or should be, and it contradicts the intention of the SOP which is to ensure tight grip and control over agency use through senior management approval. In keeping with this it would be prudent to escalate rather than delegate approval, in the absence of the Head of Nursing.	Non-compliance with escalation and approval processes, potentially resulting in inappropriate use of temporary staffing, placing additional financial pressure on the Health Board.	**Agreed Action:** The SOP will be updated to require, in the absence of the Head of Nursing, delegated approval by the Deputy Head of Nursing or escalation to the Assistant Director of Nursing, Quality & Patient Experience, emphasising that this should be the exception rather than the norm. The feasibility of restricting the system permissions to escalate shifts to agency to only the Deputy/Head of Nursing and Assistant Director of Nursing, Quality & Patient Experience to enforce compliance with this will be explored.
			Expected Evidence of Implementation: Updated SOP; restricted system permissions to escalate shifts to agency
		Medium Priority	**Officer:** Janice Cole-Williams - Assistant Director of Nursing, Quality & Patient Experience; Helen Humphreys, Head of Nursing for Professional Standards & Regulation **Target Implementation Date:** 30 September 2025
	Theme: Approvals	Control Design	

Objective 2: Absence is managed in accordance with applicable Health Board and national policies and procedures	Limited

Overview / Summary of Observations

The NHS Wales Managing Attendance at Work Policy ('the Policy') provides guidance to staff on managing staff sickness absence. It is available via the staff intranet, and we confirmed that staff working in the areas visited during the audit were aware of the policy and how to access it.

Sample testing was undertaken to test compliance with the key requirements of the Policy. Our sample comprised 183 long and short-term absence episodes for 32 employees during the period 1 April 2024 – 31 May 2025. No documentation was available for 35 episodes. The findings of our review of the remaining 148 episodes are outlined below. **[Finding 3]**

For any period of sickness absence between 1-7 calendar days an employee must complete a self-certification form, and submit doctors fit note certificates from the 8th calendar day of absence onwards. 22% of absences did not have sufficient evidence of self-certification and/or fit notes.

The Return-to-Work meeting is fundamental to the management of sickness absence and policy states that it should be conducted on the first day of return or as early as possible after return. 76% had a Return to Work completed, although 41% had not been completed within a week of the return to work and in many cases the associated documentation was dated several months later.

Managers are required to proactively manage absence where the pattern or frequency gives rise to concern, with the Policy outlining three review prompts. 50% of the sickness episodes triggering a review prompt did not have evidence of appropriate action and escalation in line with Policy. In some cases this was due to managers discretion although the rationale for this was not clear.

Notably, only three employees (15 episodes) sampled were fully compliant with the key controls tested - all were within Ward 9 PPH, where we also observed good practice with a simple, organised approach to record keeping.

Workforce representatives engage with Heads of Nursing to support and advise on sickness management practices, and there are examples of Workforce-led ad hoc deep-dive reviews of sickness management within hot spot areas, although resource and capacity is limited so there is no planned programme of reviews. During our Ward visits staff demonstrated a clear understanding of the requirements of the Policy, indicating that non-compliance may be due to lack of capacity/service pressures or in some cases potentially related to culture. **[Finding 3]**

Key Findings		Risk & Impact	Agreed Management Action
3	**Absence Management** Sample testing identified widespread non-compliance with the key requirements of the NHS Wales Managing Attendance at Work Policy, including: • Absence of any documentation in support of some episodes • Failure to undertake Return to Work interviews, or significant delays in completion • Absence of sufficient self-certificates and/or fit notes covering the whole of the absence • Failure to identify and act on review prompts	• Increased workforce and financial pressure. • Detrimental impact on staff wellbeing, patient safety and experiences.	**Agreed Action:** The good practice identified at PPH Ward 9 will be process-mapped into a guidance document and shared with all Heads of Service/Nursing for implementation within their respective areas. Development of a planned programme of sickness absence reviews, led by service areas with appropriate support from Workforce, to assess compliance with policy requirements and understand and address the root causes of non-compliance. Ward / Department Managers will be held

			accountable for non-compliance, with overall responsibility escalating through Senior Nurse Managers to Heads of Nursing.
			Expected Evidence of Implementation: Process map / guidance document for best practice in sickness management record keeping, and evidence of sharing across the Health Board. Planned programme of sickness absence reviews. Evidence of completion, remedial actions and follow up demonstrating improvement.
		High Priority	**Officer:** Sharon Daniel - Director of Nursing, Quality & Patient Experience; Lisa Gostling – Director of Workforce & OD
	Theme: Resourcing	Control Operation	**Target Implementation Date:** 30 September 2025

Objective 3: Rosters are subject to appropriate review and scrutiny to identify and address issues or areas for improvement	**Substantial**

Overview / Summary of Observations

Rosters are reviewed and approved by the Ward Manager and Senior Nurse Manager. For areas with high variable pay, the E-Rostering Team are responsible for final review and approval of rosters, liaising with Senior Nurse Managers to resolve any issues prior to roster publication. A review checklist is completed for each roster and responsibility for final approval is only returned to the ward when there is improvement in rostering practices/efficiency. Sample testing of roster approval identified no significant issues.

Appendix A

Table 1: Annual leave utilisation outside of tolerance

Week	Y Banwy		Dewi		PPH Ward 9		WGH Ward 8		WGH Ward 12		BGH Dyfi		GGH Theatres		WGH Ward 7	
	RN	HCSW	RN	HCSW	RN	HCSW	RN	HCSW	RN	HCSW	RN	HCSW	RN	HCSW	RN	HCSW
1 19/05/2025	7.70%	23.80%	14.00%	12.70%	15.40%	12.40%	13.40%	5.70%	13.70%	14.80%	24.40%	0.00%	13.90%	9.20%	14.60%	20.00%
2 26/05/2025	14.70%	17.60%	14.00%	12.70%	14.00%	14.00%	15.90%	11.00%	13.20%	15.30%	13.20%	15.30%	17.40%	12.70%	15.10%	20.20%
3 02/06/2025	14.70%	4.10%	14.00%	13.50%	13.80%	10.30%	7.10%	3.40%	11.30%	15.00%	0.00%	6.40%	16.30%	11.60%	13.10%	13.60%
4 09/06/2025	15.30%	10.20%	14.00%	14.60%	12.10%	12.00%	10.40%	8.60%	11.70%	15.00%	22.20%	18.70%	9.70%	10.20%	13.90%	11.50%
	Annual leave outside of tolerance range [<11% or >18%]															

Table 2: Additional staff utilisation where annual leave exceeds 18% upper tolerance

Ward	Week	RN / HCSW	AL %	Total %	WTE Used			
					Agency	Bank	Overtime	Total
BGH Dyfi	19/05/2025	RN	24.4	37.6	5.74	0.2	0.29	6.23
WGH Ward 7	26/05/2025	RN	15.1	12.6	0	1.33	1.86	3.19
		HCSW	20.2	15.2				
BGH Dyfi	09/06/2025	RN	22.2	39.1	3.39	2.93	0	6.32
		HCSW	18.7	28.2				

Table 3: order of priority for additional staffing requirements and authorisation requirements

Source *(priority order)*	**Timeline**	**Authorisation**
Bank	6 weeks before shift	Ward Manager
Additional Hours	6 weeks before shift	
Overtime	5 days before shift	Senior Nurse Manager or Equivalent
Agency - sickness	Up to 72hrs before shift	Head of Service/Nursing or nominated deputy
Agency – other	Up to 24hrs before shift	
Agency – out of hours	Up to 24hrs before shift	Site Manager (acute & community hospitals); Out of Hours Team (MH inpatient wards)

Appendix B

Assurance Opinion

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

Prioritisation of Findings

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

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

6

12:25, 0 Mins

6 - Financial Focus

6.1

12:25, 10 Mins

6.1 - Financial Assurance Report

Huw Thomas (Hywel Dda UHB - Director of Finance)

For assurance

Attachments

6.1 SBAR Financial Assurance Report ARAC August 2025.pdf

6.1 Financial Assurance Report ARAC August 2025.pdf

6.1 Financial Assurance Report - Appendices.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:	12 August 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, Head of Accounting and Statutory Reporting

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) requires assurance on a number of financial areas as outlined in the body of the report.

Cefndir / Background

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

Asesiad / Assessment

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

Alert:

a) The Committee is alerted to breaches of Standing Financial Instructions (SFIs), in respect of retrospective purchase orders, which are reported in Appendix 1c. Where these breaches occur, they are reviewed by local NWSSP Procurement for appropriate re-education and the relevant director is informed.

Advise:

a) While the level of staff overpayments increased, the average recovery period continues to decrease, compared with the previous two months. The target is to have no overpayments; however, the total overpaid during May and June 2025 represents 0.16% of the average monthly net pay costs.

b) There were no individual losses exceeding £5,000 in May and June 2025. However, there were losses and write offs in the period totalling £44,657, a reduction on the previous two month period.

Assure:

a) Activity ongoing to reduce non-compliance with No PO, No Pay. The Health Board actively enforces the No PO, No Pay policy and, whilst there have been zero invoices paid without a purchase order, preventative control checks are in place to ensure that proactive management minimises the potential for non-compliance in the future and any delays for vendor payment. This preventative control is called invoices on hold (IOH). The Core Accounting Team within Finance monitors 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.

b) Public Sector Payment Policy (PSPP) compliance remains on target for delivery for the year - the target is to pay 95% of all non-NHS invoices within 30 days. The Core Accounting Team is continually pursuing budget holders to authorise invoices promptly as e-mail requests from NWSSP Accounts Payable are often ignored. The team has 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.

c) Single Tender Actions (STAs) and contracts awarded are carefully controlled. No STAs have been made since March 2024.

d) Compliance with employment taxes – internal discussions ongoing to ensure compliance with National Minimum Wage (NMW) regulations.

Argymhelliad / Recommendation

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

- **DISCUSS** the breaches of Standing Financial Instructions (SFIs) as detailed in Appendix 1c
- **DISCUSS** the staff overpayments as detailed in Appendix 2 and seek assurance that actions to control them are sufficiently embedded
- **DISCUSS** losses as detailed in Appendix 3
- **TAKE ASSURANCE** from the actions taken to reduce the instances of non-compliance with the No PO, No Pay policy; to ensure Public Sector Payment Policy (PSPP) compliance; to manage Single Tender Actions (STAs) and ensure National Minimum Wage (NMW) compliance
- **SCRUTINISE** the award of contracts listed in Appendix 1a and 1b.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.4 The Committee's principal duties encompass the following: 2.4.2 Seek assurance that the systems for financial reporting to Board, including those of budgetary control, are effective, and that financial systems processes and controls are operating.

	3.10 The Committee will be responsible for reviewing the UHB's Standing Orders and Standing Financial Instructions and Scheme of Delegation annually, (including associated framework documents as appropriate), monitoring compliance, and reporting any proposed changes to the Board for consideration and approval. 3.13 Approve the writing-off of losses or the making of special payments within delegated limits. 3.15 Receive a report on all Single Tender Actions and extensions of contracts.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	BAF SO9-PR20 BAF SO10-PR33
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Monitoring returns to Welsh Government based on the Health Board's financial reporting system. Activity recorded in the AR and AP modules of the Oracle business system and activity recorded in the procurement Bravo system.
Rhestr Termau: Glossary of Terms:	AP - Accounts Payable AR – Accounts Receivable BGH – Bronglais General Hospital CAT – Core Accounting Team CF – Counter Fraud COS – Contracted Out Service VAT EOY – End of Year ERs NI – Employers National Insurance

	GGH – Glangwili General Hospital HMRC – His Majesty's Revenue and Customs IFRS – International Financial Reporting Standards NWSSP – NHS Wales Shared Services Partnership PID – Patient Identifiable Data PO – Purchase Order POL – Probability of Loss PPH – Prince Philip Hospital PSPP – Public Sector Payment Policy SFI – Standing Financial Instructions SLA – Service Level Agreement STA – Single Tender Action VAT – Value Added Tax WGH – 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

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

6.1 Financial Assurance Report for the period 1 May to 30 June 2025
Audit and Risk Assurance Committee

12 August 2025

Compliance requirements for ARAC - Overview

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Requirement	Reporting	Frequency	Status	Reference
Scheme of delegation changes	• Exception reporting for approval	As and when	Compliant	N/a – no changes
Compliance with Purchase to Pay requirements	• Breaches of the No PO, No Pay policy/Instructions for noting	Bi-monthly	Assure Committee	Schedule 2a
	• Public Sector Payment Policy (PSPP) compliance	Bi-monthly	Assure Committee	Schedule 2a
	• Tenders awarded for noting	Bi-monthly	Assure Committee	Schedule 2b
	• Single tender action	Bi-monthly	Assure Committee	Schedule 2b
	• Breaches of Standing Financial Instructions (SFIs)	Bi-monthly	Alert Committee	Schedule 2b
Compliance with Income to Cash requirements	• Overpayments of staff salaries and recovery procedures for noting	Bi-monthly	Advise Committee	Schedule 3
Losses & Special payments and Write offs	• Write off schedule • Approval of losses and special payments	Bi-monthly	Advise Committee	Schedule 4
Compliance with Capital requirements	• Scheme of delegation approval for capital	Following approval of annual capital plan	Compliant	N/a – no changes
Compliance with Tax requirements	• Compliance with VAT requirements	Bi-monthly	Compliant	N/a – no changes
	• Compliance with employment taxes	Bi-monthly	Assure Committee	Schedule 5
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	Compliant	Schedule 5

2a. Compliance with Purchase to Pay requirements

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

IOH

May and June 2025
No. 119; Value £1,342k*

March and April 2025
No. 119; Value £905k

Cumulative to end June 2025
No. 71; Value £725k

Cumulative to end of April 2025
No. 75; Value £432k

PSPP

Non – NHS (target > 95%)
May 2025 – 98.02%
June 2025 – 96.09%

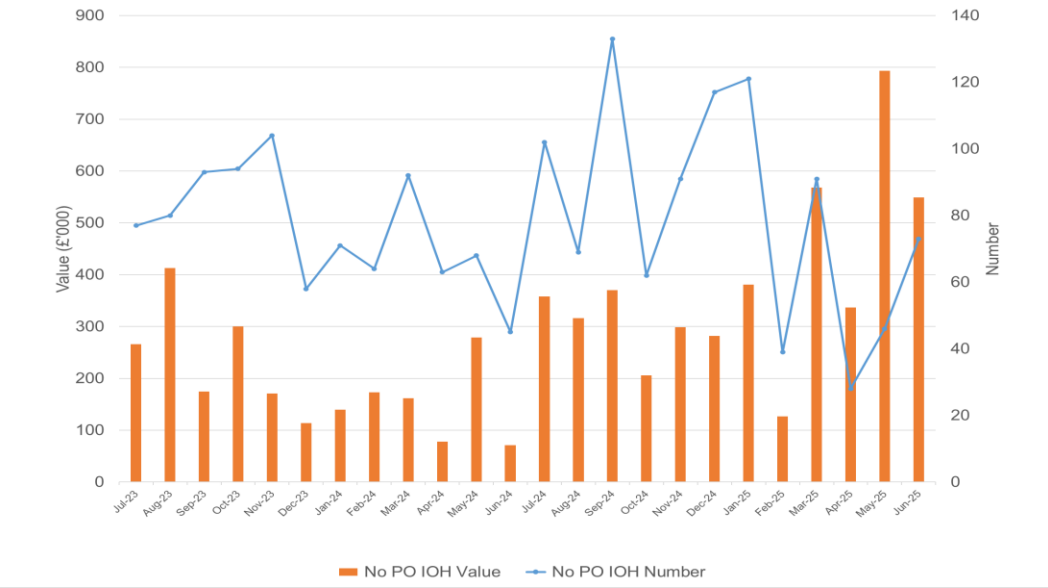
Cumulative to 30 June 2025
96.79%

NHS (no target)
May 2025 – 66.93%
June 2025 – 86.83%

Cumulative to 30 June 2025
80.16%

* Includes 3 invoices (value £617k) in respect of Ceredigion County Council – Further Faster and 50 Day Challenge

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



Reducing invoices on hold

Supplier and Health Board Non-Compliance exceeding £20,000	No. of invoices	Value £
Suppliers		
Ceredigion County Council	8	679,201
Royal Mail Group Plc	8	38,912
Clinical Care Groups/Executive function		
Operational Allied Health and Health Sciences	1	309,289
Digital	1	42,513
Primary Care, Community Strategy and LTC	6	36,970
Planned and Specialist Care	9	32,235

2b. Compliance with Purchase to Pay requirements

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

STA

May and June 2025
No. 0; Value £0

March and April 2025
No. 0; Value £0

Tenders Awarded (>£25k)

May and June 2025
No. 5; Value £3,697,239

March and April 2025
No. 26; Value £6,563,622

Consultancy

May and June 2025
Number = 0; Value = £0

March and April 2025
Number = 0; Value = £0

Top 5 Tenders Awarded (>£25k)

Supplier	Description	Value £	Department
SpaMedica Ltd	Outsourcing of cataract procedures	2,447,530	Planned Care
Practice Plus Group	Outsourcing T&O	647,338	Planned Care
Edina Ltd	Upgrades to CHP Units	381,877	Estates
Leica Microsystems UK Limited	GGH cellular pathology managed service extension	150,460	Cellular Pathology
ORCHA Health Ltd	Digital health app library	70,034	Digital
Total		**3,697,239**	

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

Contracts Awarded	Number	Value £	Details
Post competitive tender	1	2,447,530	**Appendix 1a**
Direct awards via Framework agreement	3	867,831	**Appendix 1a**
VEAT	1	381,877	**Appendix 1a**
Total	**5**	**3,697,239**	
Consultancy Contracts	**-**	**-**	
Breaches of SFIs	**1**	**5,000**	**Appendix 1c**
Contract Awards reported retrospectively	**3**	**383,835**	**Appendix 1b**

3. Compliance with Income to Cash

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Salary Overpayments

May and June 2025
No. 44; Value £61,827
(Appendix 2)

March and April 2025
No. 29; Value £46,830

Debt balance as at 30 June 2025: £224k with average recovery period of 5 months

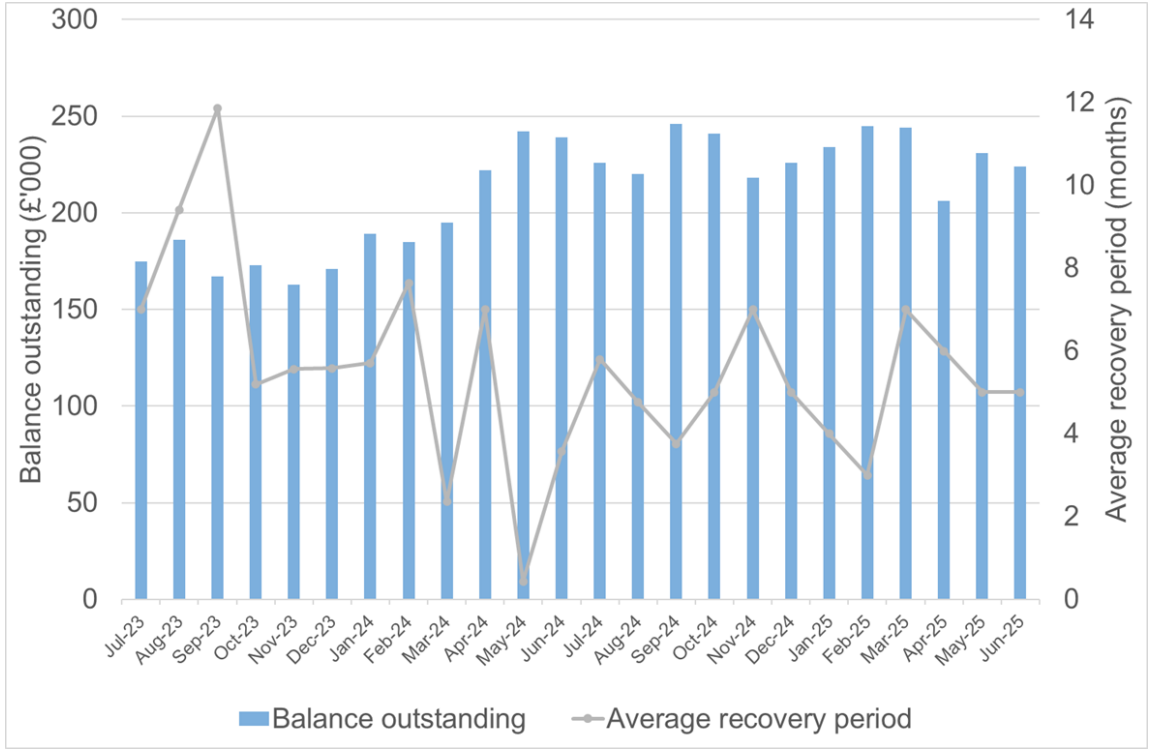
30 April: £206k; average recovery period of 6 months

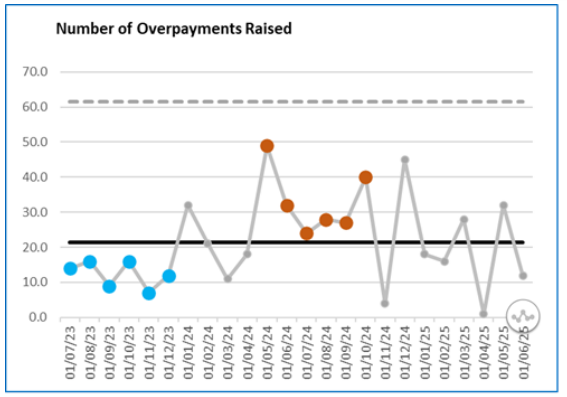
	June	April
Avge no of invoices raised	21	20
Avge value	£29k	£27k
Avge no paid	16	15
Avge value	£27k	£26.5k

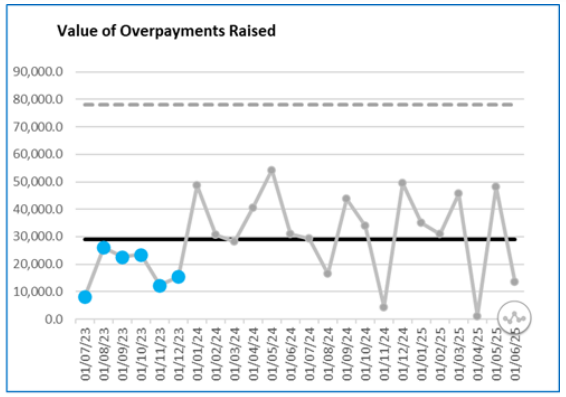
Underpayments in May and June 2025 - £14,792

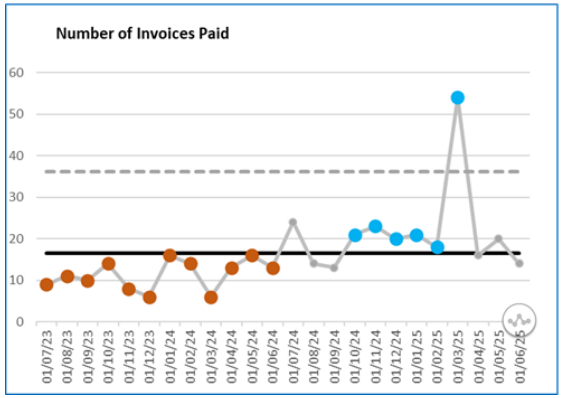
March and April 2025 - £18,511

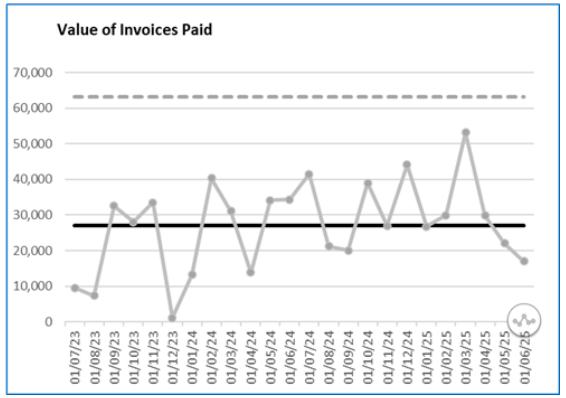
Trend of aged overpayments and recoveries











4. Losses and Special Payments

Losses £5k and over requiring ARAC Approval	**May and June 2025 £Nil** *March and April 2025 £38,651*	**Losses under £5k approved by DoF and CEO**	**May and June 2025 £44,657 (Appendix 3)** *March and April 2025 £68,440*

Losses – Requiring Approval from ARAC	**£**
N/a as no losses £5k and over in period	Nil
All Other Losses	
Ex gratia	59
Overpayments of salaries, salary sacrifice, accommodation, Wagestream etc	4,550
4b Other causes* - expired stock, wastage, breakages	40,048
Total Losses	**44,657**

*** 4b Other causes**
In accordance with the Health Board's Losses and Special Payments Procedure (Procedure number: 066) category 4b is defined as: 4) Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to: a. culpable causes e.g. theft, fraud, arson or sabotage whether proved or suspected, neglect of duty or gross carelessness b. other causes

5. Other Areas

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Compliance with Capital Requirements

There are currently no live capital projects requiring a Project Bank Account (PBA).

The next project meeting the threshold for a PBA is likely to be the Withybush Fire Upgrade Phase 2 project, however this is currently at business case stage; the Project Team are aware of the requirement and will include this in the tender specifications for the project.

Compliance with Tax Requirements

Compliance with VAT Requirements - No updates or issues to report.

Compliance with Employment Tax Requirements

Internal discussions between Finance and Workforce colleagues are ongoing in respect of NMW compliance and further updates will be provided as appropriate.

Compliance with reporting requirements

On 24 June the Committee approved the 2024/25 Audited Annual Accounts for onward ratification by the Board. This was provided by the Board on 26 June 2025.

The Audited Annual Accounts were submitted to Welsh Government prior to the 30 June 2025 reporting deadline.

6.1 Financial Assurance Report for the period 1 May to 30 June 2025 Audit and Risk Assurance Committee

12 August 2025

Appendices

Appendix 1a: Contracts awarded

Contracts awarded post competitive tender										
Period Covered by this report			01/05/2025	30/06/2025						
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-59020	SpaMedica Ltd	Outsourcing of Cataracts Procedures	01/07/2025	31/03/2026	£2,447,530	Planned Care	No	29/05/2025	Y	Following a competitive tender, SpaMedica Ltd were awarded a 9-month contract for the Outsourcing of Cataracts Procedures. An option to extend the contract for a further 12 months is included in the award.

Direct awards via Framework Agreement											
Period Covered by this report				01/05/2025	30/06/2025						
Reference	Framework Used & Reference	Supplier	Description	One off or Period		Value, exc VAT	Department	Prof Services	Date of Board Approval (if applicable)	Compliant	Comment
				Start	End						
HDD-DCO-21-20	NHSSC Laboratory Diagnostics, Point of Care Testing and Pathology Managed Services Framework (2023/S 000-028831)	Leica Microsystems UK Limited	Cellular Pathology Manged Service Extension – Glangwili General hospital (GGH)	01/06/2025	30/11/2025	£150,459	Cellular Pathology	No	N/A	Y	An extension to a direct award has been awarded to Leica Microsystems UK Limited for 6 months. The contract is for a Cellular Pathology Manged Service at GGH. This contract award does not allow for a further extension.
HDD-DCO-21-12	G Cloud12 (RM1557.12)	ORCHA Health Ltd	Digital Health App Library	01/07/2025	01/06/2027	£70,034	Digital	No	N/A	Y	An extension to a direct award has been awarded to ORCHA Health Ltd for 24 months. The contract is for a Digital Health App Library. This contract award does not allow for a further extension.

HDDA-DCO-59375	AW Framework Agreement for Provision of Clinical, Surgical and Diagnostics Procedures (PRO-OJEULT-5077)	Practice Plus Group	Outsourcing T&O	23/06/2025	30/09/2025	£647,338	Planned Care	No	N/A	Y	A direct award via the AW Framework Agreement for Provision of Clinical, Surgical and Diagnostics Procedures has been awarded to Practice Plus Group for Outsourcing T&O for 4 months. This contract award does not allow for an extension.

Direct awards via VEAT/Transparency process											
Period Covered by this report			**01/05/2025**	**30/06/2025**							
Reference	**Supplier**	**Description**	**One off or Period**		**Value, exc Vat**	**Department**	**Professional Services**	**Date of Board Approval (if applicable)**	**Compliant**	**Comment**
			Start	**End**						
HDDA-VEA-25-01	Edina Ltd	Upgrades of CHP Units	01/06/2025	31/12/2025	£381,877	Estates	No	N/A	Y	A VEAT/Transparency Notice was issued to confirm that Edina Ltd were awarded a 6-month contract for Upgrades of CHP Units. The contract award does not allow for an extension.

Appendix 1b: Contract Awards Reported Retrospectively

Awards Reported Retrospectively (in excess of £25,000)												
Period Covered by this report				01/05/2025	30/06/2025							
Month/Year Awarded	Reference	Supplier	Description	One off or Period		Value, exc Vat	Department	Procurement Process	Professional Services	Date of Board Approval (if applicable)	Compliant	Comment
				Start	End							
March 2025	HDD-DCO-24-31	Softcat Plc	Automation Anywhere Licence	31/03/2025	30/03/2028	£63,086	Digital	Direct Award	No	N/A	Y	In the month of March 2025, a contract was awarded to Softcat Plc for a term of 36 months, for an Automation Anywhere Licence. This contract does not allow for an extension. The procurement process utilised was Direct Award.
March 2025	HDD-DCO-24-33	Softcat Plc	Biztalk Server Configuration	01/04/2025	01/04/2026	£60,631	Digital	Direct Award	No	N/A	Y	In the month of March 2025, a contract was awarded to Softcat Plc for a term of 12 months, for a Biztalk Server Configuration

												requirement. This contract does not allow for an extension. The procurement process utilised was Direct Award.
April 2025	HDDA-DCO-24-32	CP Plus Ltd	Car Park Management for GGH, PPH and WGH	01/04/2025	31/03/2026	£260,118	Transport	Direct Award	No	N/A	Y	In the month of April 2025, a contract was awarded to CP Plus Ltd for a term of 12 months, for Car Park Management for GGH, PPH and WGH. This contract award does not allow for an extension. The procurement process utilised was Direct Award.

Appendix 1c: Breaches of SFIs

Breaches of Standing Financial Instructions (all)						
Period Covered by this report			01/05/2025		30/06/2025	
Month/ Year	**Supplier**	**Description**	**Value, exc Vat**	**Directorate**	**Comment**	**Action Taken**
June 2025	Francis Taylor Building	Legal Fees - Linked to Asbri Planning Work for North Dock Planning Appeal	£5,000.00	Public Health	In the month of June 2025, a retrospective purchase order was raised to Francis Taylor Building for the payment of Legal Fees - Linked to Asbri Planning Work for North Dock Planning Appeal. The total value of the purchase order was £5,000.00. This breach of Standing Financial Instructions sits within the Public Health Directorate.	Escalated for Re-Education, and Relevant Director Informed for Awareness and Action

Appendix 2: Overpayment of Salaries

	Period covered by this report: 1 May 25 – 30 June 25		
Ref	**Reason for Overpayment**	**Value (£)**	**Number of invoices**
1	Processing Error	2,317.59	12
2	Late Notification of Changes	12,041.42	15
3	Late Notification of Termination	19,095.35	18
4	Late Notification of Absence	27,135.51	6
5	Incorrect Information Supplied to Payroll	1,237.30	2
		61,827.17	**44**

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

	Period covered by this report:		1 May 2025 to 30 June 2025
Ref	**Losses and Special Payments Category**	**Value (£)**	**Explanation**
	N/a – no losses over £5k		
	Total Losses (for approval)		

Appendix 3b: Losses and Special Payments over £1,000 to £5,000

2025/26	WRITE OFF LIST		
	Period covered by this report:	1st May to 30 June 2025	
	Losses and Special Payments Category	**Value (£)**	**Explanation**
	OVERPAYMENT OF SALARIES	1,247.22	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
	Total Write Off	**1,247.22**	
	4b Other	1,494.06	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1,582.80	P03-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	1,602.72	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1,603.80	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2,136.00	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2,871.06	P03-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	3,075.00	P03-26 WDA - HDUHB~~E EXPIRED STOCK WDA
	4b Other	4,747.83	P02-26 Withybush Hospital~~W EXPIRED STOCK WGH
	Total Other/Ex Gratia	**19,113.27**	
	Total	**20,360.49**	

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

2025/2	WRITE OFF LIST		
	Period covered by this report:	1st May to 30 June 2025	
	Losses and Special Payments Category	**Value (£)**	**Explanation**
	OVERPAYMENT OF SALARIES	0.04	UNDERPAID OF INVOICE
	OVERPAYMENT OF SALARIES	0.04	UNDERPAID OF INVOICE
	ACCOMMODATION	0.15	UNDERPAID OF INVOICE
	ACCOMMODATION	0.98	UNDERPAID OF INVOICE
	WAGESTREAM	35.97	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
	OVERPAYMENT OF SALARIES	43.31	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
	SALARY SACRIFICE	119.01	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
	OVERPAYMENT OF SALARIES	165.50	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
	WAGESTREAM	165.82	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
	SALARY SACRIFICE	356.52	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
	OVERPAYMENT OF SALARIES	691.93	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
	OVERPAYMENT OF SALARIES	779.79	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
	SALARY SACRIFICE	943.38	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
	Total Write Off	**3,302.44**	
	4b Other	- 40.95	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	- 30.00	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	- 19.58	P02-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	- 17.84	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	- 5.28	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	- 3.02	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	- 0.25	P03-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	0.02	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.02	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.03	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.03	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.03	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.03	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.04	P02-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.04	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.05	P02-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.05	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.05	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.05	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.06	P03-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.07	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.07	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.09	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.09	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.09	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.10	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	0.11	P02-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	0.14	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.14	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.19	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	0.19	P03-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	0.20	P02-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.23	P02-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	0.24	P02-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	0.24	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.26	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	0.30	P03-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	0.31	P02-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.31	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.33	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.34	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.35	P02-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	0.36	P03-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	0.42	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.42	P03-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	0.45	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.60	P02-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	0.71	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.71	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH

	4b Other	0.71	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.71	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.73	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.86	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	0.86	P03-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	0.90	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.93	P02-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.96	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	1.04	P02-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	1.08	P03-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	1.20	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.22	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.43	P02-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	1.43	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.47	P02-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	1.51	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	1.57	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.60	P02-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	1.60	P03-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	1.74	P02-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	1.83	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.98	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.04	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.04	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.17	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.17	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.17	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.27	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	2.29	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.52	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.52	P03-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	2.59	P02-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	2.63	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.83	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	3.00	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	3.36	P03-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	3.44	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	3.44	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	3.50	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	11 EX-GRATIA	3.50	Travel costs for cancelled appointment - BRD
	4b Other	3.79	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	3.95	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	4.08	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	4.21	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	4.34	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	4.54	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	4.55	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	4.55	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	4.67	P02-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	4.76	P03-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	4.78	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	4.78	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	4.78	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	4.83	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	5.04	P02-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	5.08	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	5.12	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	5.14	P03-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	5.21	P02-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	5.30	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	5.35	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	11 EX-GRATIA	5.50	Travel costs for cancelled appointment - Mr E (Urology)
	4b Other	5.66	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	5.80	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	6.07	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	6.24	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	6.37	P02-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	6.38	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	6.61	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	6.69	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	6.82	P03-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	6.95	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	7.02	P02-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	7.17	P03-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	7.23	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH

	11 EX-GRATIA	7.50	Travel costs for cancelled appointment - KW
	4b Other	7.56	P02-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	7.68	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	7.79	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	7.84	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	7.87	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	8.06	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	8.09	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	8.26	P03-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	8.26	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	8.26	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	8.27	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	8.40	P02-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	8.40	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	8.54	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	8.64	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	8.68	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	8.93	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	9.00	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	9.10	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	9.36	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	9.46	P02-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	9.60	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	9.78	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	10.20	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	10.20	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	10.32	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	10.68	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	10.68	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	10.70	P02-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	10.70	P02-26 WDA - HDUHB~~E EXPIRED STOCK WDA
	4b Other	11.23	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	11.53	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	11.94	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	12.05	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	12.46	P03-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	12.73	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	12.96	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	13.06	P02-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	14.16	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	15.00	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	11 EX-GRATIA	15.50	Travel costs for cancelled appointment - NE (T&O)
	4b Other	15.79	P02-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	15.96	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	16.25	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	16.25	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	16.25	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	16.52	P03-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	16.78	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	16.80	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	18.00	P02-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	18.37	P03-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	19.09	P02-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	19.40	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	19.46	P03-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	19.73	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	20.83	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	20.94	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	20.94	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	21.05	P02-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	21.15	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	21.15	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	21.22	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	21.22	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	21.34	P02-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	22.35	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	22.43	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	22.51	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	24.65	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	25.14	P02-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	25.20	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	25.34	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	25.40	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	11 EX-GRATIA	27.00	Travel costs for cancelled appointment - CK
	4b Other	27.45	P02-26 Prince Philip Hospital~~P EXPIRED STOCK PPH

	4b Other	27.72	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	29.57	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	29.90	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	30.58	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	30.80	P02-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	31.20	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	32.04	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	32.26	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	33.72	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	33.74	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	33.84	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	34.60	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	35.68	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	35.93	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	35.93	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	35.97	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	36.00	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	36.78	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	37.44	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	37.50	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	38.28	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	38.40	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	39.09	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	39.78	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	40.24	P03-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	41.40	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	43.68	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	44.69	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	44.88	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	45.96	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	47.94	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	48.05	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	49.12	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	51.28	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	51.30	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	51.59	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	51.59	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	51.98	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	52.41	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	53.10	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	55.64	P03-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	56.56	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	56.94	P02-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	57.30	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	57.89	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	58.97	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	60.00	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	60.17	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	61.11	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	61.78	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	62.40	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	64.80	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	67.20	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	67.46	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	71.96	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	72.60	P02-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	73.68	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	78.07	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	78.75	P02-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	78.95	P03-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	79.63	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	80.61	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	83.32	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	83.59	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	84.26	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	86.72	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	89.04	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	91.00	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	91.20	P02-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	96.34	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH

4b Other	97.20	P02-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	101.64	P02-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
4b Other	113.81	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	115.94	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	120.00	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	120.00	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	120.14	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	134.40	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	143.94	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	144.00	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	159.30	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	164.91	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	166.80	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	166.98	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	169.48	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	169.56	P02-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
4b Other	170.10	P03-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
4b Other	178.85	P03-26 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	180.00	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	191.60	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	193.45	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	221.76	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	225.56	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	226.56	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	232.68	P02-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
4b Other	234.25	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	238.80	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	264.00	P03-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
4b Other	266.50	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	285.60	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	288.36	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	293.34	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	300.56	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	302.40	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	320.30	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	331.51	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	345.90	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	366.05	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	372.63	P02-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
4b Other	382.50	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	390.00	P02-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	407.68	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	443.52	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	534.34	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	576.72	P03-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	602.50	P03-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	637.20	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	881.28	P02-26 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	918.00	P02-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	964.61	P03-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
4b Other	994.80	P02-26 Glangwili Hospital~~G EXPIRED STOCK GGH
Sub total	**20,994.14**	
Total	**24,296.58**	

6.2

12:35, 5 Mins

6.2 - Counter Fraud Update

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

For information

Attachments

6.2 SBAR Counter Fraud Update ARAC August 2025.pdf

6.2 Counter Fraud Update ARAC August 2025.pdf

6.2 Appendix A - Case Analysis.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:	12 August 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:	1. Striving teams
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

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

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

HYWEL DDA UNIVERSITY HEALTH BOARD

COUNTER FRAUD UPDATE

For Presentation 12 August 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	2025/26 Resource (days)	Resource Used as at 31/07/2025	Resource Used (%) as at 31/07/2025)
STRATEGIC GOVERNANCE	40	11	28
INFORM AND INVOLVE	85	25	30
PREVENT AND DETER	130	41	32
HOLD TO ACCOUNT	185	51	28
TOTAL	**440**	**128**	**30**

Work Area	*Summary of work areas completed*
Inform and involve	• All new inductees are required to complete the Health Board's induction programme and the Counter Fraud mandatory training e-learning package. • Counter Fraud content was delivered to Nurses by way of presentations on the Medicines Management programme. In addition, this last quarter has seen presentations delivered to optometrists covering the Carmarthenshire, Ceredigion and Pembrokeshire areas, engaging with all clusters, raising awareness of fraud in the NHS and the need for greater collaborative working to reduce instances to an absolute minimum. • Following receipt of a national risk alert received in connection with individuals impersonating Registered Nurses and Qualified Healthcare Support Workers for financial gain, an awareness campaign was undertaken by Counter Fraud in partnership with Nurse Bank. This involved the issuing of guidance to all Agency Nurse users around the importance of local inductions and engagement visits by both Local Counter Fraud and Nurse Bank at various sites, where such agency workers are frequently used. • In response to recent staff communication developments, which include the introduction of Viva Engage, Counter Fraud have been posting weekly alerts, which include information of emerging fraud risks, news articles and useful information around prevention of fraud.in the last three months, we have uploaded 12 posts, which have been viewed 5005 times. This has proven to be a far more effective way of engaging with employees and has generated online conversations and referrals. • Counter Fraud currently sit on the quarterly HDdUHB Local Intelligence Network (LIN), at which advice is provided on current fraud trends associated with Controlled Drugs. Where applicable, relevant advice, including raising awareness of Fraud in the NHS, is provided.

Prevent and deter	• Earlier in the year, a Fraud Risk Assessment was undertaken in connection with a Fraud Prevention Notice linked to the impersonation of Agency employed Registered Nurses and Healthcare Support Workers. In recent weeks, further alerts from NHS England have identified that this issue remains prevalent; therefore, a review of the risk will take place, and the effectiveness of the Health Board's controls reviewed by way of two 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. 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. Both actions are now complete. An updated Risk Assessment has been issued to the Senior Workforce Manager for Bank and E-rostering, and a copy has been appended to the In-Committee report. The service will now be asked to consider sharing with relevant sub committees. Action 2, which involved a pro-active exercise, was completed week ending Friday 25 July 2025 and involved both Local Counter Fraud and Nurse Bank visiting key sites where agency and bank workers were due to work over a three-day period. The exercise identified: ➢ On Wednesday 23 July 2025, 26 Agency / Bank workers were deployed to Prince Philip Hospital. Of these, 18 were HDdUHB Bank Healthcare Support Workers (HCSW), 7 were HDdUHB Bank

Registered Nurses and there was 1 Agency-supplied Registered Nurse. These workers were spread over 12 locations / wards.

Each location was visited and the senior Nurse on duty spoken to. Enquiries revealed that staff had been undertaking ID checks in line with guidance. There were instances where the worker was new to the ward, therefore local inductions were undertaken. Senior staff were aware of recent guidance around the checking of ID and local inductions.

Note: On attending one location, Counter Fraud were advised that the Agency worker on duty was new to the ward and a local induction had taken place. During this process, the Senior Nurse Manager identified that the Agency worker arrived without appropriate workwear and without their physical ID card. This was escalated with Nurse Bank prior to Counter Fraud arrival and further checks made.

To mitigate any risks of an unknown person working on site, Counter Fraud undertook further identification checks, and the worker's identity was confirmed.

The agency who allocated the work to the Registered Nurse concerned were contacted and notified of the issue. A reminder was issued to all agencies that, should staff present without physical ID / appropriate workwear, then they would be refused entry onto the ward.

- On Thursday 24 July 2025, 55 Agency / Bank workers were deployed to Glangwili General Hospital. Of these, 28 were HDdUHB Bank Healthcare Support Workers (HCSW), 20 were HDdUHB Bank Registered Nurses and 7 were Agency-supplied Registered Nurses. These workers were spread over 20 locations / wards. The 7 agency-supplied Registered Nurses had all been deployed to Theatres.

  On visiting the wards / locations concerned, no concerns were identified, and staff were apprised of the need to undertake local inductions for all new agency or bank workers. Upon visiting Theatres, Counter Fraud Identified that of the 7 agency workers, 2 were new to the unit and as such required a local induction, which in line with procedure, would include ID checks.

The unit confirmed that they were aware of this requirement, having received recent communication around the need to undertake local inductions for all new starters; however, on this occasion they had undertaken their own local induction, which did not include the checking of ID.

Subsequent checking of ID was undertaken and both were in order. The Senior Nurse Manager was apprised of events and will now ensure that relevant procedures are followed.

- On Friday 25 July 2025, 27 Agency / Bank workers were deployed to Withybush General Hospital. Of these, 18 were HDdUHB Bank Healthcare Support Workers (HCSW) and 9 were HDdUHB Bank Registered Nurses. These workers were spread over 11 locations / wards. There were no agency bookings on this date.

  Again, on visiting the wards / locations concerned, no concerns were identified, and staff were apprised of the need to undertake local inductions for all new agency or bank workers.

- Counter Fraud have undertaken a review of the Counter Fraud, Bribery and Corruption Policy and amended to include the introduction of the new offence of Failure to Prevent Fraud. Other minor amendments have been made, a summary of which has been documented in a standalone item on the agenda.
- Counter Fraud have assisted in the review of one financial procedure and relevant advice provided.
- To better understand fraud risks, trends and potential areas of further monitoring, Counter Fraud have undertaken an analysis of all referrals, both crime and non-crime recorded and closed across various directorates and departments between the 01 April 2024 and 28 July 2025.

  The report includes trends over time, types of allegations received, including the relevant legislation it applies to, subject types, geographic distribution, and breakdowns by directorate and site location. Key insights include:

  - A steady number of fraud cases are reported month by month.

	➢ Fraud by False Representation is the most common offence, followed by Theft and Failure to Disclose. Allegation types associated with these referrals include leave related concerns, such as working whilst sick, working whilst on suspension, unauthorised absence, incorrect booking of leave and TOIL abuse. ➢ Employees are the primary subjects in most cases, followed by service users and contractors. ➢ Carmarthenshire accounts for the highest number of cases, followed by Pembrokeshire and Ceredigion. ➢ The Nursing and Midwifery directorate has the highest number of allegations, followed by Estates and Primary Care. ➢ Glangwili General Hospital and Primary Care sites are the most frequently cited locations. A detailed visual breakdown report of allegations by directorate, department and location is included to support future targeted risk mitigation, and has been appended to this report, Appendix A refers. This type of analysis is in its infancy; however, further work will be undertaken throughout the year to improve how these are presented.
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.

Report Provided by:
Ben Rees - Lead Local Counter Fraud Specialist
For presentation; 12 August 2025

Report agreed by:
Huw Thomas
Director of Finance

Fraud Case Analysis Report

Executive Summary

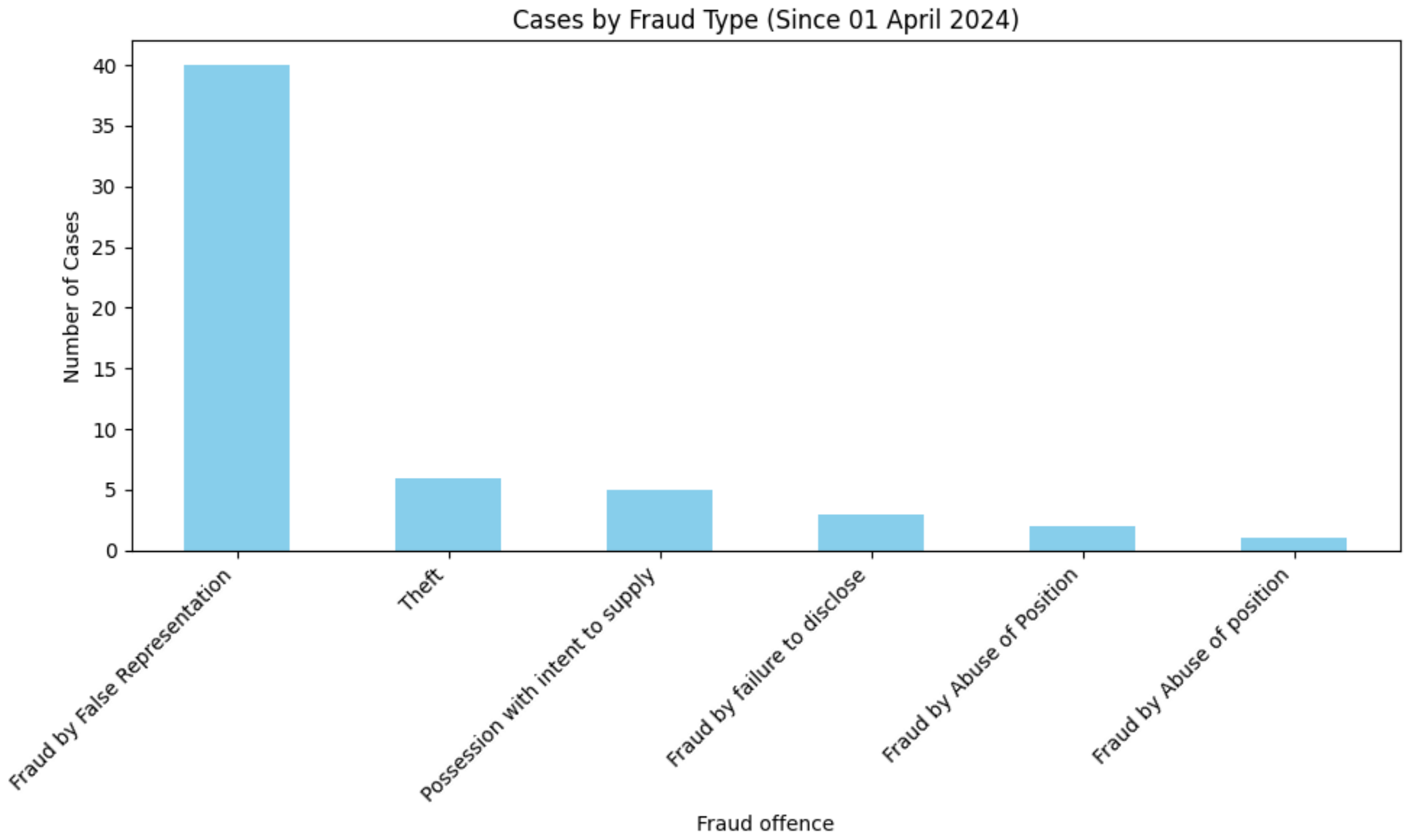
This report provides an overview of fraud cases investigated across various directorates and departments between 01 April 2024 and 28 July 2025. It includes trends over time, types of fraud offences, subject types, geographic distribution, and breakdowns by directorate and site location. The report also highlights specific allegation types and their distribution.

The report only includes details of closed cases, and not all resulted in criminal activity being substantiated. Key insights include:

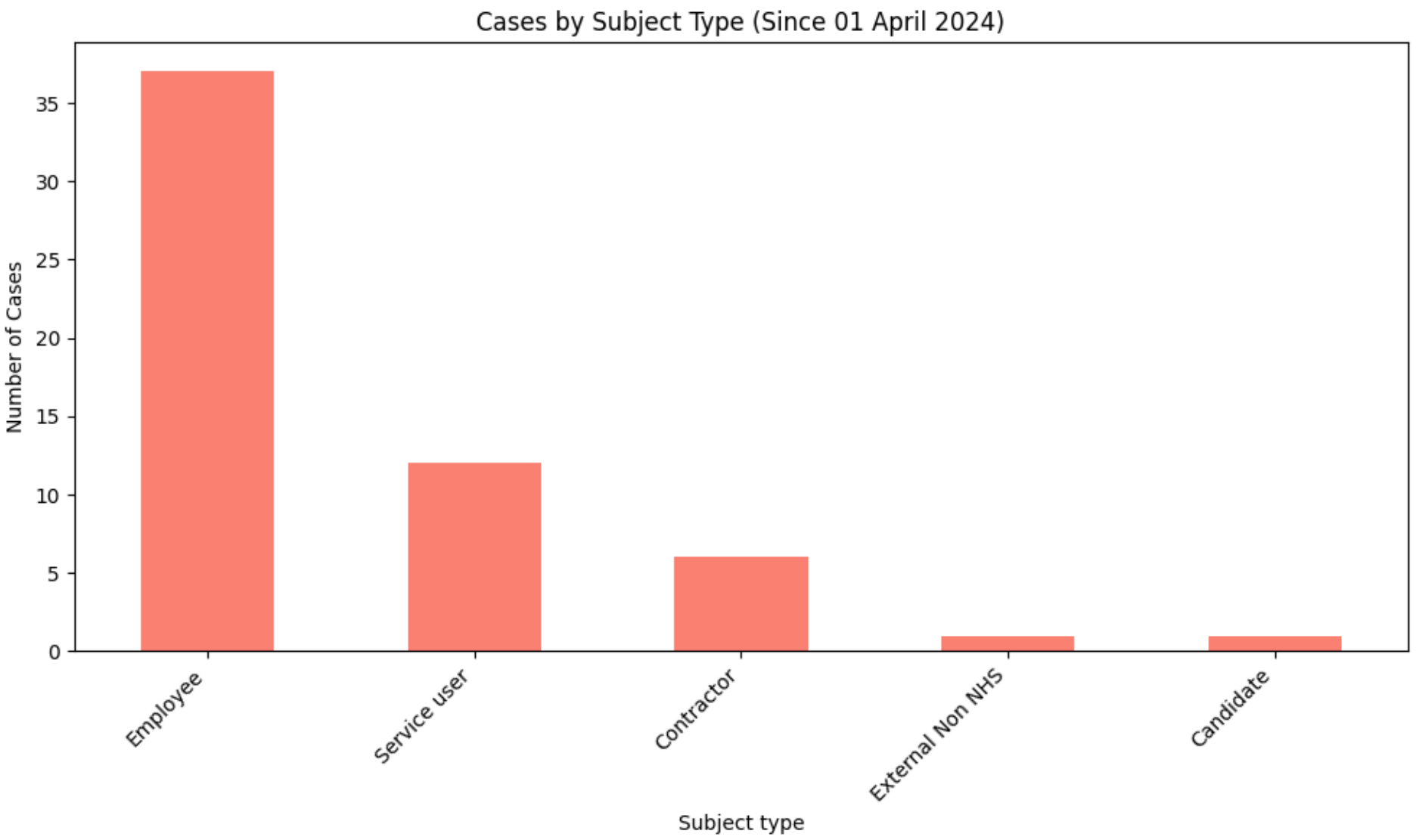
- A steady number of cases of fraud are reported month by month.
- Fraud by False Representation is the most common offence, followed by Theft and Failure to Disclose. Allegation types associated with these referrals include leave related concerns, such as working whilst sick, working whilst on suspension, unauthorised absence, incorrect booking of leave and TOIL abuse.
- Employees are the primary subjects in most cases, followed by service users and contractors.
- Carmarthenshire accounts for the highest number of cases, followed by Pembrokeshire and Ceredigion.
- The Nursing and Midwifery directorate has the highest number of allegations, followed by Estates and Primary Care.
- Glangwili General Hospital and Primary Care sites are the most frequently cited locations. A detailed breakdown of allegations by directorate/department is included to support targeted risk mitigation.

Visual Insights

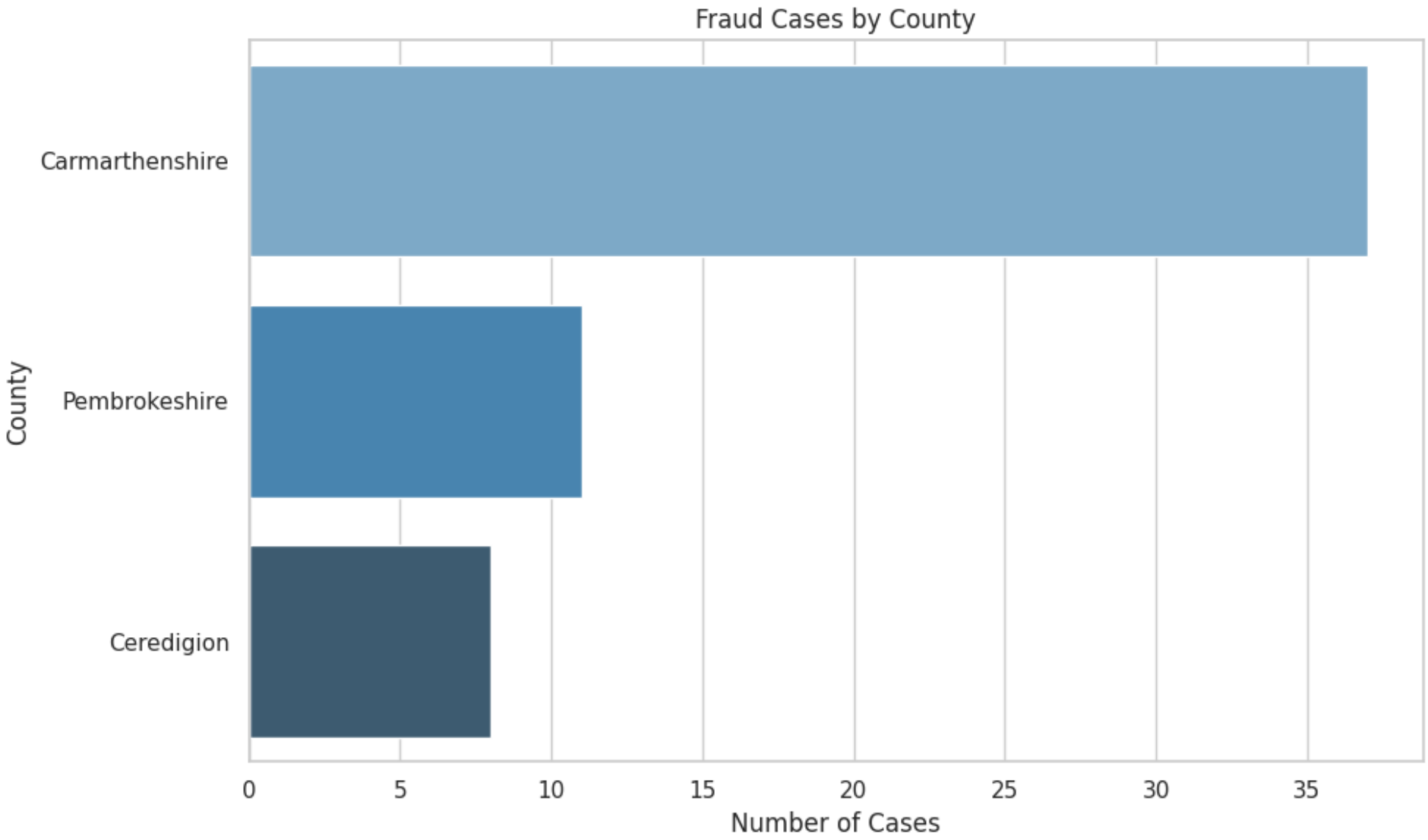
Cases by Fraud Type



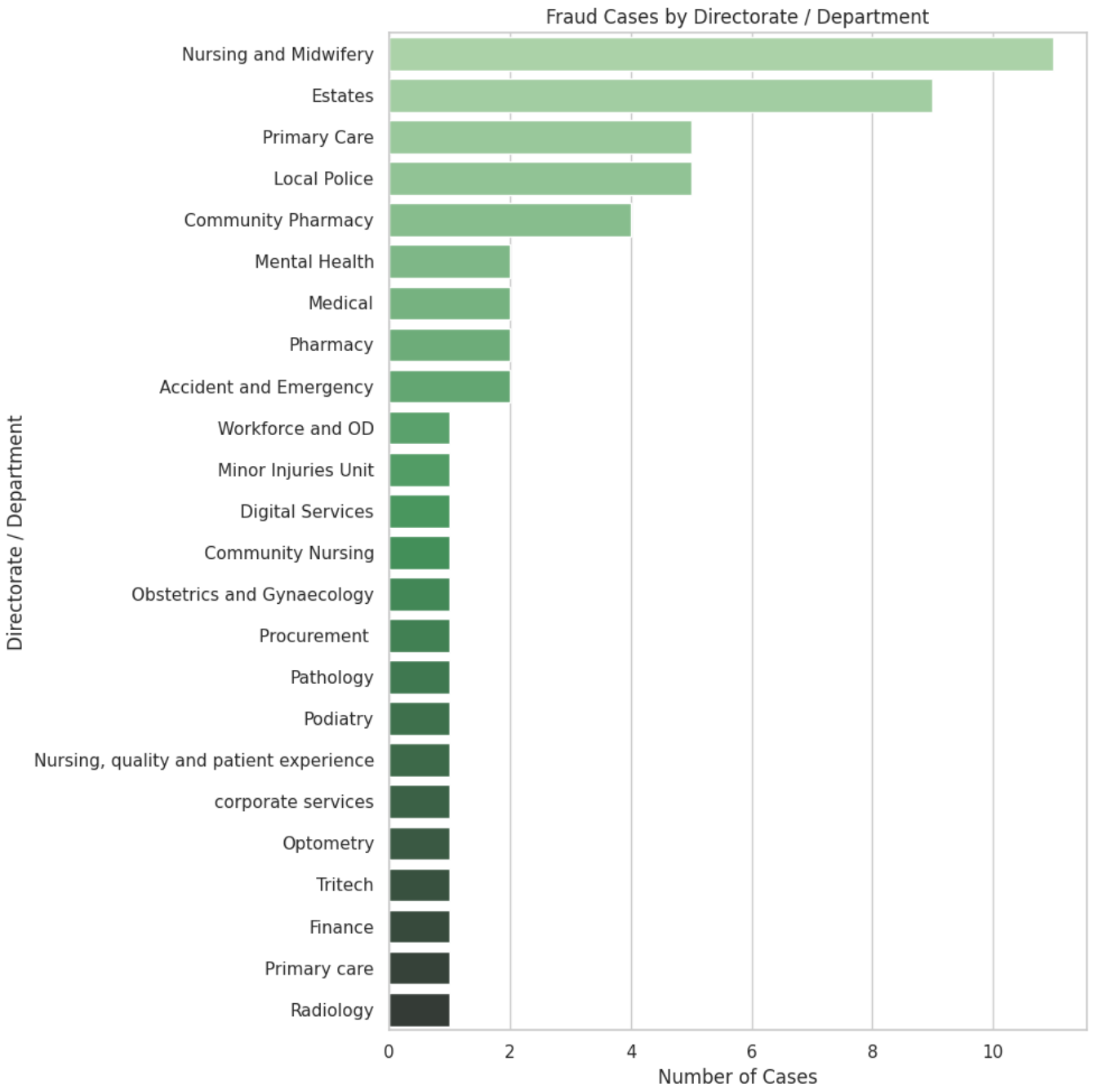
Cases by Subject Type



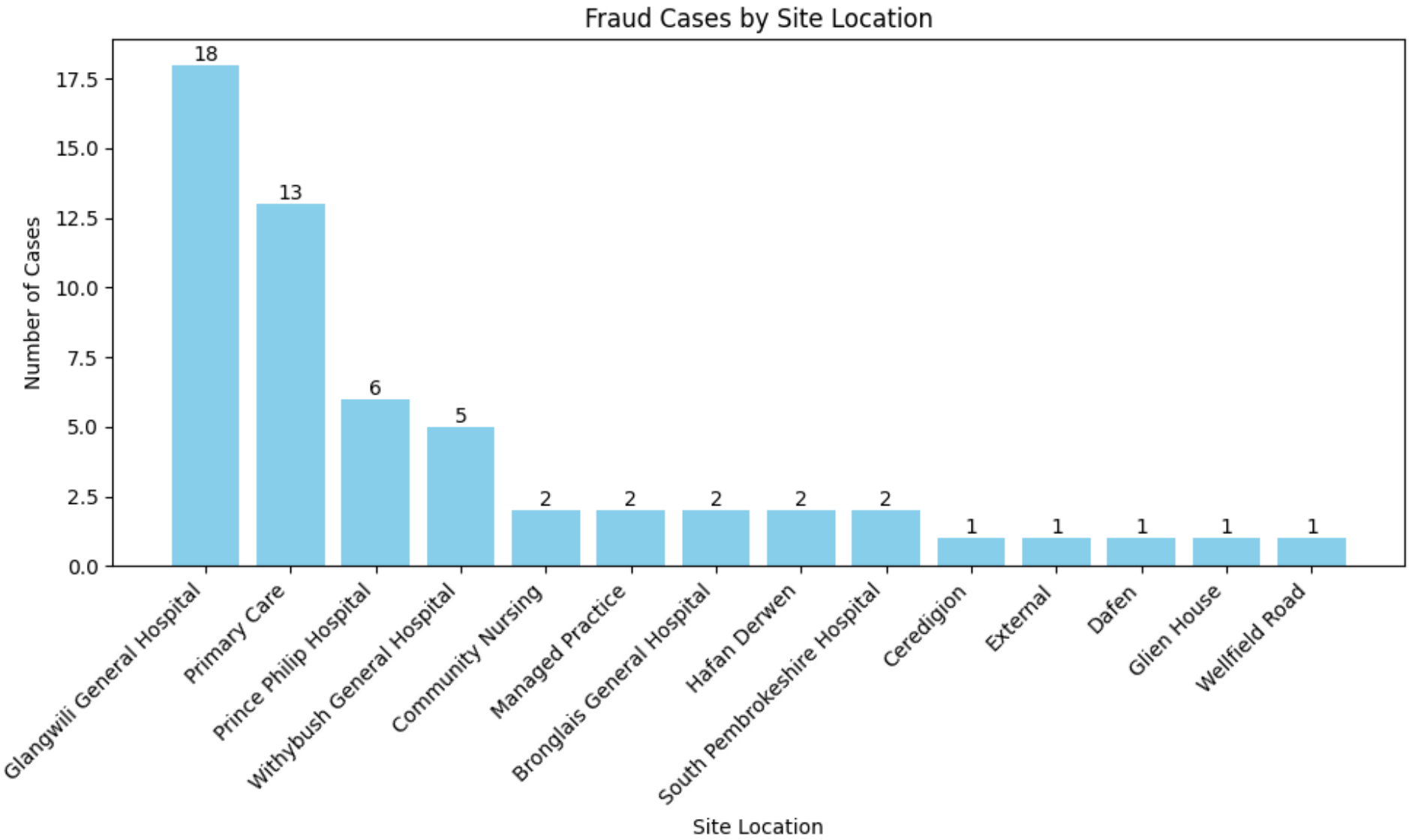
Fraud Cases by County



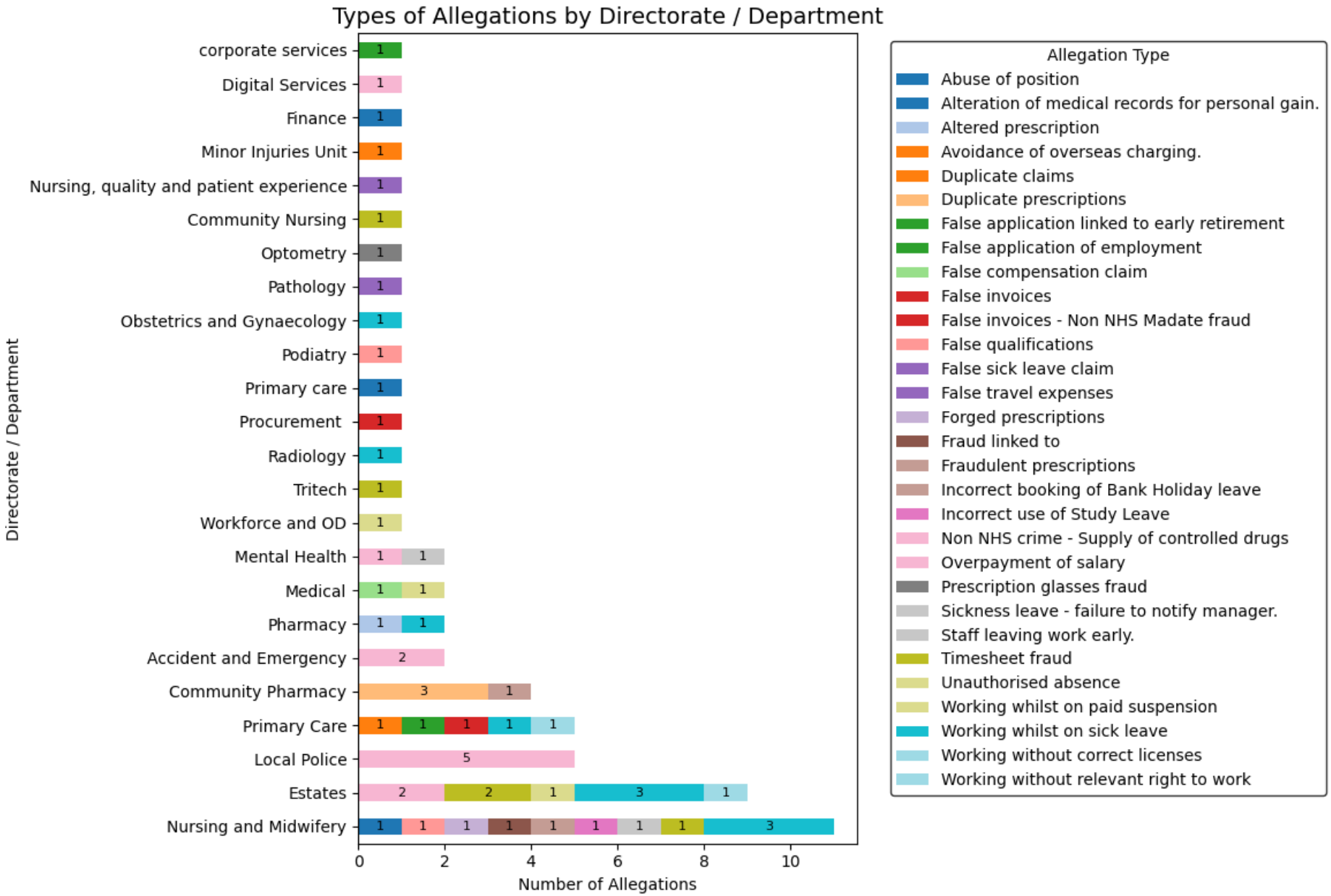
Fraud Cases by Directorate / Department



Fraud Cases by Site Location



Types of Allegations by Directorate / Department



6.3

12:40, 0 Mins

6.3 - Counter Fraud, Bribery and Corruption Policy Review

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

For approval

Attachments

6.3 SBAR Counter Fraud Policy August 2025.pdf

6.3 815 - Counter Fraud, Bribery and Corruption Policy.pdf

6.3 EqIA Screening 815 - Counter Fraud Bribery and Corruption Policy.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:**	12 August 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Counter Fraud, Bribery and Corruption Policy Review
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)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

A review of the Health Board's Counter Fraud, Bribery and Corruption Policy (815) has been undertaken, and minor amendments have been made, which include:

- The inclusion of the Economic Crime and Corporate Transparency Act 2023 - Failure to Prevent Fraud. This update includes a summary of the offence, offence examples and actions required by the Health Board to mitigate risks.
- A rework / update of current legislation and how they impact Counter Fraud Activity.
- A rewording of how parallel sanctions impact Counter Fraud Investigations, including the inclusion of a flow chart, outlining individual responsibilities.

In light of the above, the Audit and Risk Assurance Committee (ARAC) is being requested to approve the relevant changes.

Cefndir / Background

Brief summary of the Policy:
To inform all staff of the reporting procedures and subsequent action following the referral of any suspicion of fraud. To promote the deterrent and detection of fraud committed against the Hywel Dda University Health Board.

Scope:
This is an Organisation wide policy which relates to all forms of fraud, bribery and corruption and is intended to provide direction and guidance for employees on what fraud is in the NHS, our responsibilities as employees to prevent fraud, bribery, and corruption, and how to report it.

The Policy highlights each individual's role, including that of the Director of Finance, Fraud Champion, and Local Counter Fraud Specialist.

This policy applies to all employees of the Health Board, regardless of position held, as well as to consultants, vendors, contractors, and/or any other parties who have a business relationship with the Health Board.

Reason(s) for developing the Policy and subsequent review:
The Health Board is required to comply with Welsh Government Directions on Counter Fraud Measures and the Government Functional Standard 013 (GovS013) for Counter Fraud. Both the WG measures and GOVS013 Standards require the Health Board to have a Counter Fraud, Bribery and Corruption policy.

A review of the existing policy identified the need to include information on the recently introduced legislation under the Economic Crime and Corporate Transparency Act 2023, which created the new corporate offence of failure to prevent fraud following a Law Commission paper in June 2022 that sought ways to improve the law, to ensure that corporations are effectively held to account for committing serious crimes.

Under the offence, an organisation may be criminally liable where an employee, agent, subsidiary, or other 'associated person' commits a fraud intending to benefit the organisation and the organisation did not have reasonable fraud prevention procedures in place. A report on the new legislation and how it may impact the Health Board was provided to the Committee in December 2024.

Other minor amendments have been made to the wording of some paragraphs, inclusion of a parallel sanction flow chart and general formatting of the policy document, which included an updated Equality Impact Statement.

Owning group:
ARAC.

Asesiad / Assessment

At present, the Health Board has in place a Counter Fraud, Bribery and Corruption Policy. This was previously approved by relevant bodies, including the Audit and Risk Assurance Committee, thus complying with Welsh Government Directions on Counter Fraud Measures and the Government Functional Standard 013 (GovS013) for Counter Fraud (GovS013), therefore mitigating any risk associated with non-compliance.

Failure to have such a policy in place puts the Health Board at risk of breaching said standards, in addition to potentially exposing the Health Board to a risk that it does not have suitable measures in place to prevent:

1. Bribery and Corruption, an offence under Section 7 of the Bribery Act 2010.
2. Fraud, an offence under the Economic Crime and Corporate Transparency Act 2023.

The revised policy improves on the existing policy, reducing the risk of non-compliance against the above standards and strengthens the argument that the Health Board has in place suitable measures to reduce Fraud, Bribery and Corruption within the organisation.

Changes to the Policy are minimal, the overall scope remains; however, additional text relating to the new legislation has been added.

Due to the inclusion of new information and amendments made, the policy underwent a process of global review, which included notifying and requesting comment from both local and local partnership forums.

The Policy will be promoted within the Health Board's ongoing programme of fraud awareness. The strategy for the fraud awareness programme is contained in the annual Counter Fraud Work Plan.
Argymhelliad / Recommendation The Audit and Risk Assurance Committee is invited to **REVIEW** and **APPROVE** the Health Board's Counter Fraud, Bribery and Corruption Policy (815).

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

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Legislation and national policy.
Rhestr Termau: Glossary of Terms:	Contained within the policy document.

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	In line with HB guidance, the policy underwent internal consultation for two weeks. In addition to the this, the document was also shared with the Staff Partnership and Local Partnership forums for comment.

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.

Counter Fraud, Bribery and Corruption Policy

Policy information

Policy number: 815
Classification: Corporate
Supersedes: 198 and previous versions
Version number: 3
Date of Equality Impact Assessment: 08/07/2025

Approval information

Approved by: Audit and Risk Assurance Committee
Date of approval:
Date made active:
Review date:

Summary of document:
To inform all staff of the reporting procedures and subsequent action following the referral of any suspicion of fraud. To promote the deterrent and detection of fraud committed against the Hywel Dda University Health Board (UHB).

Scope:
This is an Organisation wide policy which relates to all forms of fraud, bribery and corruption and is intended to provide direction and guidance for employees on what fraud is in the NHS, what everyone's responsibility is to prevent fraud, bribery, and corruption, and how to report it.
This policy applies to all employees of the UHB regardless of position held, as well as to consultants, vendors, contractors, and/or any other parties who have a business relationship with UHB.

To be read in conjunction with:
435 – AW Raising Concerns (Whistleblowing) Policy (opens in a new tab)
201 – AW Disciplinary Policy (opens in a new tab)
248 – Standards of Behaviour Policy (opens in a new tab)
156 – Risk Management Policy (opens in a new tab)

Patient information:

Owning group:
Finance

Executive Director job title:
Director of Finance

Reviews and updates:

1.0 – New Policy - 30.4.2019
2.0 – Full Review Process, Considering Government Functional Standard 013 For Counter Fraud – 16.08.2022
2.1 – Minor Change to Reference within Document.
3.0 – full review

Keywords

Fraud, Loss, Reporting, Staff Response, Concern

Glossary of terms

UHB – Hywel Dda University Health Board
WG – Welsh Government
WOD - and Workforce and Organisational Development
LCFS - Local Counter Fraud Specialist
FCRL - Fraud and Corruption Reporting Line
CFS Wales – Counter Fraud Services Wales.
NHSCFA – NHS Counter Fraud Authority
CPIA - Criminal Procedure Investigation Act – 1996
UK – United Kingdom

Table of Contents

Introduction

One of the basic principles of a public sector organisation is the appropriate use of public funds. Hywel Dda University Health Board ('the UHB') is committed to reducing the level of fraud, bribery, and corruption within the NHS to an absolute minimum and keeping it at that level. The UHB will seek the appropriate disciplinary, regulatory, civil, and criminal sanctions against those who commit these crimes and will seek to recover losses wherever possible to free up public resources for better patient care.

To achieve this goal the UHB fully accepts that it must comply with the Statutory Authorities which have been introduced by both the UK and Welsh Governments, a summary of which can be found in Appendix A. By ensuring that the above Statutory Authorities are followed, the UHB can demonstrate that it is fully committed to ensuring that the criminal investigation process it has in place, is designed to support the Criminal Justice System in delivering safe and robust prosecutions.

The NHS CFA definition of NHS fraud is used for the purposes of this Policy, which states:

'On a basic level, fraud is deception carried out for personal gain, usually for money. Fraud can also involve the abuse of a position of trust. By 'NHS fraud' we mean any fraud where the NHS is the victim.'

Bribery and corruption can be broadly defined as the offering or acceptance of inducements, gifts, favours, payment, or benefit-in-kind which may influence the action of any person. Corruption does not always result in a loss. The corrupt person does not need to benefit directly from their deeds; however, they may be unreasonably using their position to give some advantage to another.

This Policy provides clear guidance for staff considering reporting concerns of fraud, bribery and corruption which may have been perpetrated against the interests of the UHB and is accompanied by the response plan for action where suspicious activity is suspected or detected and/or may be reported.

The Executive Team have adopted a zero-tolerance approach towards fraud, bribery, and corruption; this document is approved by the Audit, Risk and Assurance committee as outlining the UHB"s policy in dealing with fraud, bribery, and corruption.

The UHB believes that most people who work in and use the NHS are honest and professional; however, fraud committed even by a small minority is unacceptable as it ultimately leads to a reduction in the resources available for patient care, treatment, and services. All employees and workers should apply best practice to prevent fraud, bribery, or corruption against the UHB and wider NHS. The Local Counter Fraud, Bribery and Corruption policy should be used by staff as a guide to apply best practice.

All employees and workers have a responsibility to comply with all applicable laws and regulations relating to ethical business behaviour, procurement, personal expenses, conflicts of interest, confidentiality, and the acceptance of gifts (including bequests in patients' Wills that become known to staff) and hospitality. This means, in addition to maintaining the normal standards of personal honesty and integrity, all employees should always:

- Make appropriate and timely declarations on the UHB's Declaration of Interest and Gift & Hospitality electronic registers, relating to any self-employment or other employment or where any outside interest, offers by patients, suppliers or third parties may be considered as a cause for concern or may be considered to create a conflict of interest against the UHB.
- Avoid acting in any way that might cause others to allege or suspect them of dishonesty.
- Behave in a way that would not give cause for others to doubt that the UHB's employees deal fairly and impartially with official matters.
- Be alert to the possibility that others might be attempting to deceive.
- Employees and workers are also expected to act in accordance with the standards laid down by their Professional Bodies where applicable.

If an employee or worker suspects that fraud, bribery, or corruption has taken place against the UHB or wider NHS, they have a duty to ensure it is reported by contacting the Local Counter Fraud Specialist directly or by using the other reporting methods outlined in this policy.

Policy Statement

This policy is required to demonstrate compliance with the WG Directions in Countering Fraud in the NHS, and the promotion and implementation of the policy is monitored by the Audit, Risk and Assurance Committee through the Annual Counter Fraud Workplan.

Statement of the Hywel Dda University Health Board:
The Board is absolutely committed to maintaining an honest, open, and well-intentioned atmosphere within the UHB. It is also committed to the elimination of any fraud within the organisation, and to the rigorous investigation of any such cases.

The Board wishes to encourage anyone having reasonable suspicions of fraud to report them. Therefore, it is also the Board's policy, which will be rigorously enforced, that no employee will suffer in any way as a result of reporting reasonably held suspicions. For these purposes "reasonably held suspicions" shall mean any suspicions other than those that are raised maliciously.

The UHB has a duty to protect individuals and the UHB from false, malicious, or vexatious expressions of concern. Disciplinary action may be taken against any member of staff who is discovered:

A. To have made allegations falsely and maliciously,
B. To have externally disclosed the information before using the internal procedures which have been established,
C. To have victimised employees or deterred them from raising a concern.

In order to endorse this commitment, the UHB has an approved 435 - All Wales Raising Concerns (Whistleblowing) Policy *(opens in a new tab)* for dealing with such cases, which protects the individual and ensures that matters are fully and thoroughly investigated.

Scope

This is an Organisation wide policy which relates to all forms of fraud, bribery and corruption and is intended to provide direction and guidance for employees on what fraud is in the NHS, what everyone's responsibility is to prevent fraud, bribery, and corruption, and how to report it.

This policy applies to all employees of the UHB regardless of position held, as well as to consultants, vendors, contractors, and/or any other parties who have a business relationship with UHB.

Aims

This policy aims to:

- Safeguard public funds by reducing fraud, bribery, and corruption within the UHB.
- Foster a culture of integrity, transparency, and accountability across the organisation.
- Ensure compliance with legal and regulatory obligations related to the prevention, detection, and investigation of fraud, bribery, and corruption.
- Protect staff and workers who suspect fraud, bribery, or corruption, providing a safe reporting process in accordance with the All-Wales Procedure for NHS Staff to Raise Concerns and the Public Interest Disclosure Act (1998).
- Preserve resources for their intended purpose of delivering high-quality patient care.
- Minimise fraud, bribery, and corruption to the lowest possible level and maintain that standard.

Objectives

The objectives of this policy are to:

- Enhance understanding of fraud, bribery, and corruption through comprehensive training and guidance.
- Provide clarity on operational arrangements, including collaboration with NHS Counter Fraud Service Wales and the NHS Counter Fraud Authority (NHS CFA).
- Establish clear roles and responsibilities to ensure accountability.
- Ensure compliance with the Government Functional Standard GovS 013: Counter Fraud, relevant legal frameworks, and ethical obligations, including but not limited to:
    - The Criminal Procedure and Investigations Act (CPIA) 1996
    - The Fraud Act 2006
    - The Bribery Act 2010
    - The Economic Crime and Corporate Transparency Act 2023
    - The Police and Criminal Evidence Act 1984 Codes of Practice
    - Welsh Government Directions to NHS Bodies on Counter Fraud Measures.

Further information on the above legislation can be found in Appendix A.

Common examples of Fraud, Bribery and Corruption offences can be found in Appendix B.

Counter Fraud Strategy

Creating a Strong Counter Fraud, Corruption and Bribery Culture

The UHB has a responsibility to protect the organisation and its resources. Stakeholders must work together to raise awareness of the UHB's zero tolerance approach to fraud, corruption, and bribery, to report concerns and enforce the message that such matters are not acceptable within the NHS and will be dealt with accordingly.

The most effective deterrent will come from within the NHS, those who value the service provided and disapprove of those who abuse the system through fraud, corruption, bribery, and other dishonest acts. In addition, publicity surrounding counter fraud, corruption and bribery work will deter some who perpetrate or consider perpetrating related offences. The UHB will publicise successful investigation outcomes both internally and externally as appropriate to aid the deterrent effect.

Proactive Prevention and Detection

The UHB will ensure (through 'fraud proofing') that its systems, policies, and processes are sufficiently robust so that the risk of fraud, corruption and bribery is reduced to a minimum. Checks will be conducted in areas identified to be most at risk to fraud, corruption, or bribery to proactively detect instances that might otherwise be unreported.

All staff must be aware of and comply with the UHB's Standing Financial Instructions and Standing Orders, the Standards of Behaviour Policy (opens in a new tab) for conflicts and declarations of interest (incorporating gifts, hospitality, and commercial sponsorship) and the associated requirement to declare other interests.

Professional Investigation of Detected Fraud, Corruption and Bribery

Criminal offences of fraud, corruption or bribery will be investigated in a professional, objective, and timely manner by an accredited NHS Counter Fraud Specialist appointed by the UHB. Investigations will be conducted in accordance with all applicable legislation including:

- Welsh Government directions to Counter Fraud in the NHS in Wales
- Data Protection Act 2018 (DPA)
- The Police and Criminal Evidence Act 1984 (PACE)
- The Criminal Procedure and Investigations Act 1996 (CPIA)
- The Public Interest Disclosure Act 1998. (PIDA)
- The NHS CFA Fraud and Corruption Manual
- Attorney General's Revised Guidelines for Disclosure

There is a likelihood that most cases where employees or workers are under investigation for fraud, bribery or corruption will have a disciplinary investigation which will run parallel. For this reason, it is important to ensure effective joint working between the Local Counter Fraud Specialist (LCFS), Workforce and Organisational Development (WOD) representative and if applicable, the appointed disciplinary investigation officer.

The criminal and disciplinary investigations must be conducted separately and by different people. Criminal investigations must be conducted in accordance with PACE, the CPIA, and other relevant criminal legislation; disciplinary investigations must be carried out in accordance with the All-Wales Disciplinary Policy or Upholding Professional Standards in Wales, which follows the ACAS Code of Practice on Disciplinary and Grievance Procedures and relevant employment law.

The criminal investigation may be given precedence over the disciplinary investigation if there is a risk of serious prejudice to the former from running the two processes concurrently. However, there may be a compelling public interest in suspending or removing an individual from their post before the conclusion of the criminal case; in this situation, a case conference should be held to discuss the circumstances and relevant disclosure issues. Information may be shared between the LCFS and WOD representative where and when it is lawful and appropriate.

A parallel investigations flowchart can be found in Appendix C.

Effective Sanctions

Where fraud, corruption or bribery offences are committed, criminal sanctions (including prosecution) will be pursued. Civil proceedings may be initiated to recover fraudulently obtained money or assets, including associated interest and costs. Actions such as freezing assets or recovering losses may also be taken. Employees of the UHB found to have committed such offences will also be dealt with in accordance with internal disciplinary procedures and referred to professional bodies where appropriate.
Multiple sanctions may be pursued simultaneously for the same incident. Each case is evaluated individually, considering its unique facts and merits.

Seeking Redress

In cases investigated by the Local Counter Fraud Team or NHS Counter Fraud Service Wales, where losses are identified, financial recovery will always be considered. Recovery efforts aim to return resources lost to fraud, bribery, or corruption to the NHS for their intended use-delivering high-quality patient care and services. Redress options include:

- Confiscation or compensation orders.
- Civil repayment agreements.
- Local settlements between the organisation and the offender.
- Recovery from ongoing salary payments.

In more significant cases, the NHS Counter Fraud Service Wales may seek restraining or confiscation orders under the Proceeds of Crime Act 2002 (POCA) to recover financial benefits.

Recovery efforts will begin promptly once a loss is identified. Collaboration between departments may be necessary to select the most appropriate recovery option. In some cases, with guidance from the LCFS and approval from the Executive Director of Finance and NHS Counter Fraud Service Wales, it may be decided that no further recovery action will be taken.

Risk Assessment and Identification

To ensure that risks are appropriately identified, managed, and addressed, risk assessments related to fraud, bribery and corruption will be carried out. All identified risks will be investigated by the Local Counter Fraud Team and mitigating measures recommended wherever possible.
The management of risk will be conducted in line with the UHB Risk Management Framework.
The lead LCFS/ Head of Local Counter Fraud Service will provide assurance around risk related to fraud, bribery and corruption to the Executive Board and Audit Committee and identify mitigation plans via the Counter Fraud Annual Workplan.
Any risks identified will be referred to the Audit Committee and the relevant directorate.

Roles and Responsibilities

Chief Executive

The Chief Executive has overall responsibility for ensuring compliance with Welsh Government Directions to NHS Bodies on Counter Fraud Measures 2006 issued by the Welsh Assembly Government. The Chief Executive shall further ensure that action to counter fraud and corruption is taken in accordance with the NHS Executive Counter Fraud and Corruption Manual, and in accordance with the Table annexed to Directions, which sets out the respective operational and liaison responsibilities.

The Chief Executive may delegate the day-to-day operational involvement in relation to the counter fraud activity to the Director of Finance, who shall liaise and reach agreement with the NHS Counter Fraud Service (Wales) and/or LCFS before any decision is reached on the referral of a case of fraud or corruption to the Police or any other external body for investigative action.

Director Of Finance

The Director of Finance is responsible for monitoring compliance with Welsh Government Directions to NHS Bodies on Counter Fraud Measures and with any other instructions issued by the NHS CFA or NHS CFS Wales.

The Director of Finance has day to day responsibility for monitoring and ensuring compliance with Directions, and also ensuring that action to counter fraud and corruption is taken in accordance with the NHS Counter Fraud and Corruption Manual and in accordance with the Table annexed to Directions, which sets out the respective operational and liaison responsibilities of Local Health Boards, the Welsh Government (WG), NHS Counter Fraud Authority and the NHS Counter Fraud Service Wales.

The Director of Finance is the accountable individual and member of the Executive Team who has a clearly defined responsibility for the strategic management of, and support for counter fraud and counter fraud, bribery, and corruption work within the UHB.

The Director of Finance will, depending on the outcome of initial investigations, inform appropriate senior management of suspected cases of fraud, bribery, and corruption, especially in cases where the loss may be significant or where the incident may lead to adverse publicity.

The Director of Finance retains corporate responsibility for the strategic management of the UHB 's Local Counter Fraud Service and may delegate the operational management of the Local Counter Fraud Service team to their deputy.

The Head of Local Counter Fraud Service will retain direct access to the Director of Finance as and when required, to ensure compliance with Welsh Government Directions to NHS Bodies on Counter Fraud Measures.

The Head of Local Counter Fraud will meet privately with the Chair of the Audit Committee and independent members, to ensure compliance with good governance arrangements and emerging risks of fraud, bribery or corruption facing the UHB.

Audit, Risk and Assurance Committee
The role of the Audit, Risk and Assurance Committee is to receive reports of counter fraud activity and to monitor compliance with the Welsh Assembly Government Directions 2006. The UHB must effectively seek to promote the counter fraud agenda and ensure that the appropriate action is taken when an allegation of fraud is received.

The Audit, Risk and Assurance Committee will approve the annual Counter Fraud Work Plan.

Head of Internal Audit
The Head of Internal Audit will ensure that any detected systems weaknesses are reported to the LCFS so that they can be examined pro-actively to detect fraud.

Internal Auditors will inform the LCFS of any instances of potential or suspected fraudulent activity identified during their work or from other sources.

Internal Audit and LCFS will work together in line with the agreed Internal Audit and LCFS Liaison Protocol.

Workforce and Organisational Development
Close liaison between the LCFS and Workforce and Organisational Development ('WOD') are essential to ensure that any parallel sanctions (i.e., criminal, civil and disciplinary) are applied effectively and in a coordinated manner. A liaison protocol between the LCFS and WOD will be agreed for this purpose. WOD staff will liaise closely with managers and the LCFS from the outset if an employee is suspected of being involved in fraud, bribery, or corruption, in accordance with agreed liaison protocols. A parallel investigations flowchart can be found in Appendix C.

WOD staff are responsible for ensuring the appropriate application of the UHB's internal disciplinary procedures. In the event of an investigation, the Workforce team will advise those involved in matters of employment law and in procedural matters, such as disciplinary and complaints procedures, as required.

In instances where an internal investigation is being undertaken and fraud, bribery or corruption is suspected WOD staff must inform the LCFS immediately.

Referral to Professional Regulatory Bodies will be considered where applicable. The Professional Regulatory Body concerned will in such instances be requested to commence external disciplinary proceedings to investigate if the Fitness to Practice of the registered professional has been impaired and if appropriate sanctions should be applied.

Trade Unions/Professional Associations

Where staff face allegations of Fraud Act offences Trade Unions/Professional Associations may be able to support staff with access to legal representation if the staff member is invited to attend a Police Officer and Criminal Evidence Act 1984 interview under caution.

Local Counter Fraud Specialist

The UHB employs a Local Counter Fraud Service team which is led by a Head of Local Counter Fraud Service who has managerial responsibility for the team. The Head of Local Counter Fraud will take forward all counter fraud work locally in accordance with Welsh Government Directions to NHS Bodies on Counter Fraud Arrangements and the NHS CFA Quality Assurance Programme which includes the annual submission of the Counter Fraud Functional Standard Return (CFFSR).

NHS CFA validate the CFFSR to provide assurance to the Cabinet Office of the NHS including the UHB's compliance with the Government Functional Standard 013 for Counter Fraud (GovS013). The LCFS will work with key colleagues and stakeholders to promote and advance counter fraud, bribery, and corruption work, to develop an anti-fraud, bribery, and corruption culture, to effectively identify and respond to system weaknesses and to investigate allegations of fraud, bribery, and corruption.

The Local Counter Fraud Service team represent the UHB when dealing with fraud matters. This includes undertaking work across all areas of activity and in accordance with all components of Functional Standard GovS013.

The Local Counter Fraud Service team will adhere to the Counter Fraud Professional Accreditation Board (CFPAB) Principles of Professional Conduct as set out in the "NHS CFA Counter Fraud Manual."

The Local Counter Fraud Service team and CFS Wales have responsibility for undertaking fraud investigations within NHS Wales and ensuring that all appropriate sanctions are considered and imposed which may include criminal prosecution, civil proceedings or disciplinary sanction, or a combination of all three sanctions. All cases considered for prosecution will be discussed by the Head of Local Counter Fraud Service and the Head of CFS Wales. The approval of the Executive Director of Finance will be required before the case is referred, via CFS Wales to the Specialised Fraud Division of the Crown Prosecution Service.

The Local Counter Fraud Service team will undertake a programme of proactive counter fraud work as agreed in the Annual Counter Fraud Workplan, which is approved by the Audit Committee to prevent and detect cases of fraud, bribery, and corruption. Where system weaknesses are identified, appropriate fraud proofing recommendations will be made to ensure that the UHB is protected in the future and that good governance procedures are in place.

Any fraud referrals which are received which involves more than one NHS health body, cross border enquiries or offences involving Bribery and Corruption, will be referred to the Head of CFS Wales for investigation. The Local Counter Fraud Service team may be asked for practicality to assist in such cases.

The Head of Local Counter Fraud Service will be entitled to attend Audit Committee meetings to provide formal written progress reports on all counter fraud activity undertaken within the UHB and to report the number of cases where fraud, bribery or corruption alleged, and investigations are being undertaken.

The Local Counter Fraud Service team will report to the Audit Committee and the NHS CFA, details of system weaknesses which are identified during criminal fraud investigations or other proactive counter fraud work undertaken which have fraud-related implications.

To embed zero-tolerance to NHS fraud and ensure a strong counter fraud culture, the Audit Committee and Executive Team agreed that Fraud Awareness is to be made mandatory for all UHB staff. An e-Learning module relating to the awareness, of fraud, bribery, and corruption, is available to staff for completion. The LCFS should be a senior employee who is authorised to treat enquiries confidentially and anonymously, if so, requested by the employee contacting them. The LCFS will be professionally trained and will have achieved accreditation.

Counter Fraud Service Wales

The NHS CFS Wales team provide specialist criminal investigation and financial investigation services to all Health Bodies in Wales. The CFS Wales team consists of experienced investigators who deal with large scale, cross-border, complex frauds, and all issues involving bribery or corruption against NHS Wales.

The team work closely with other investigative bodies including the Police and provide support and guidance to the network of LCFS who are based at Health Bodies in Wales. The Head of CFS Wales can be contacted by calling telephone number 01495 334101 direct or by e-mail to graham.dainty@nhscfswales.gov.uk

The Head of CFS Wales is responsible for liaison between the NHS CFA and all the LCFS employed or contracted by Health Boards and Trusts within Wales and is responsible for managing the NHS CFS Wales team.

Additionally, CFS Wales are responsible for reviewing all local investigation files, evidence and witness statements submitted for the consideration of the Specialised Fraud Division of the Crown Prosecution Service.

The Head of CFS Wales is responsible for ensuring that local investigations are conducted in accordance with legislative guidelines and within the components of the Government Functional Standard GovS013 and guidance provided in the NHS Counter Fraud Manual, to the highest standards in respect of all allegations of fraud, bribery, or corruption against NHS Wales.

The Head of CFS Wales provides support and advice to all key stakeholders in Wales including Welsh Government, Health Boards and Trusts, Executive Directors of Finance, Audit Committees, and the individual Local Counter Fraud Service teams operating in NHS Wales. Counter Fraud Service (CFS Wales) is hosted by NHS Wales Shared Service Partnership (NWSSP) and operationally managed by NHS Counter Fraud Authority ('NHSCFA').

NHS Counter Fraud Authority

The NHS Counter Fraud Authority (NHS CFA) is a health authority charged with identifying, investigating and preventing fraud and other economic crime within the NHS and the wider health group. As a health authority focused entirely on counter fraud work, the NHS CFA is independent from other NHS bodies and directly accountable to the Department of Health and Social Care (DHSC).

To ensure compliance with the Government Functional Standard 013, NHS CFA set out the NHS requirements. The UHB will ensure compliance with these requirements and will submit an annual Counter Fraud Functional Standard Return, detailing compliance with each component.

The UHB will also work in line with the NHS CFA Fighting Fraud Strategy, the framework of which will shape the contents of the UHB's Annual Counter Fraud Workplan.

Fraud Champion

The Fraud Champion's role forms part of the UHB's counter fraud provision and is to strengthen the fight against fraud and raise awareness within the organisation. Having a Fraud Champion is an essential part of the Government Functional Standard GovS013.

The Fraud Champion is committed in joining the fight and promoting a zero-tolerance approach to NHS fraud and when aimed against the UHB. The role of the Fraud Champion is to:

- Promote and raise awareness of fraud, bribery, and corruption within the organisation.
- Understand the threat posed by fraud, bribery, and corruption by monitoring the intelligence provided as part of NHS CFA's strategic intelligence assessment.
- Understand the level and quality of counter fraud provision received by the organisation by using the benchmarking information provided by NHS CFA, and raise any successes, concerns, or opportunities for improvement with the Executive Director of Finance and/or Audit Committee Chair.
- Support counter fraud colleagues in ensuring that all information relating to fraud is recorded and reported (if this is not undertaken, then it could impact on the NHS organisation as well as the healthcare sector involved, as potential fraud alerts may not be shared).
- Contribute to the sharing of information and best practice on counter fraud via NHS CFA's extranet when this becomes available.

- Raise awareness of fraud at a strategic level and support the work that Local Counter Fraud Specialists already undertake.
- Facilitate and support fraud awareness and fraud prevention work within the organisation and ensure that everyone knows how to recognise and report fraud.
- Ensure that fraud risks are recorded and managed in line with the organisation's 156 - Risk Management Policy.(opens in a new tab).
- Escalate any fraud concerns to the Executive Director of Finance and/or Audit Committee Chair.

UHB Management

Managers are responsible for ensuring that policies, procedures, and processes within their local area are adhered to and kept under review. They have a responsibility to ensure that staff are aware of fraud, bribery and corruption and understand the importance of protecting the UHB from it. They are also responsible for the enforcement of disciplinary action against staff who do not comply with policies and procedures.

Managers at all levels have a responsibility to ensure that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively. Managers are therefore the first line of defence against fraud, bribery, and corruption.

All instances of actual or suspected fraud, bribery or corruption which come to the attention of a manager must be reported to the LCFS immediately. It is appreciated that some employees will initially raise concerns with their manager. In such cases, managers must not attempt to investigate the allegation themselves; they have a clear responsibility to refer concerns to the LCFS instead.

Managers have a responsibility to ensure that the LCFS or other persons authorised to carry out investigations have access to premises, records, data, and staff who may have relevant information as soon as practical, or within 7 working days of the request for information or access, or an application under the Data Protection Act 2018 and UK General Data Protection Regulation Act 2018.

Managers must understand, when drafting new procedures, processes, or controls for their area of work, any responsibility which may change or have effect on financial resources. It is recommended that managers seek appropriate advice from the Local Counter Fraud Service team, with a view to fraud proofing new procedures, processes, and controls to ensure these are robust and provide the best defence to any improper use or loss of public funds.

Managers at all levels have a responsibility to ensure that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively. The responsibility for the prevention and detection of fraud, bribery, and corruption therefore primarily rests with managers, but requires the co-operation of all employees.

All Staff Responsibility

This section is intended to cover all employees and workers which may include Consultants, vendors, contractors, and those with a business relationship with the UHB.

All employees and workers are required to comply with the UHB's policies and procedures. Breach of the UHB's policies and procedures may render staff liable to disciplinary action and when economic crime is suspected will lead to a referral to the Local Counter Fraud Service team for investigation. This may lead to a criminal prosecution, dismissal and financial recovery of NHS losses which may include loss of NHS Pension rights.

All employees and workers have a duty to protect the assets of the UHB. Assets include buildings, equipment, vehicles, monies, information, and goodwill.

All employees and workers have a duty to ensure that public funds are safeguarded, whether they are involved with cash or payment systems, receipts or dealing with contractors or suppliers.

All employees and workers should apply best practice to prevent fraud, bribery, or corruption against the UHB and wider NHS. The Local Counter Fraud, Bribery and Corruption policy should be used by staff as a guide to apply best practice.

All employees and workers of the UHB have a right and a duty to bring to their manager's attention, any matter which they consider to be damaging to the interests of patients, members of the public or other staff. However, where these concerns relate to potential fraud, bribery or corruption, the report should be made to the Local Counter Fraud Specialist or the NHS CFA via the details noted in Appendix D.

It is not usually possible for informants to be made aware of the outcome of any investigation unless the matter is progressed criminally through the criminal justice system, in which case the proceedings will be in the public domain.

These arrangements do not replace UHB's procedures for handling complaints, grievances, incident reporting or matters reported through the All Wales NHS staff to Raise Concerns Procedure (opens in a new tab) (Public Interest Disclosure Act 1998).

Reporting Concerns

All employees / workers have a responsibility to report concerns of Fraud, Bribery and Corruption. It is imperative therefore that all employees and workers feel confident to report any concerns without a risk to themselves. To support this policy, the UHB has adopted the AW Raising Concerns (Whistleblowing) Policy (opens in a new tab).
Details of how to report your concerns can be found in Appendix D or via the UHB Counter Fraud Intranet pages (click here for further information).

The UHB Counter Fraud Team may receive reports from a number of sources which may include but is not limited to:

- Direct reports from staff/workers, patients, or members of the public or stakeholders
- Direct anonymous reports via telephone, email, or letter
- Reports via the NHS CFA reporting line or online reporting tool
- Reports made directly to the NHS Counter Fraud Service Wales
- Self-generated during preventative work

All reports will be taken seriously and dealt with appropriately. The Local Counter Fraud Team will triage each report, and a decision will be made by the Head of Local Counter Fraud Service for the UHB on how the investigation will proceed.

There will be no recriminations against staff that report reasonably held suspicions. Victimising or deterring staff from reporting concerns is a serious disciplinary matter.

Training

The LCFS will promote fraud, corruption, and bribery awareness through the delivery of face-to-face presentations, the provision of mandatory eLearning modules and/or the distribution of newsletters and other materials. Should staff require any other assistance, or advice, they should contact the LCFS.

Implementation

Implementation is in accordance with the Counter Fraud work plan monitored by the Audit, Risk and Assurance Committee and audited by WAO and NHSCFA.

Appendix A – Statutory authority and associated legislation

FRAUD
The NHS CFA definition of NHS fraud is used for the purposes of this Policy:
'On a basic level, fraud is deception carried out for personal gain, usually for money. Fraud can also involve the abuse of a position of trust. By 'NHS fraud' we mean any fraud where the NHS is the victim.'

Fraud Act 2006
The act came into force on 15 January 2007 and focusses on the dishonest behaviour of the suspect and their intent to make a financial gain or cause a loss. The introduction of the offences under the Fraud Act 2006 made it no longer necessary to prove that a person had been deceived. The Fraud Act 2006 identifies the following main offences:

- Section 2: Fraud by false representation (active fraud; lying about something using any means e.g., by words or actions taken)
- Section 3: Fraud by failing to disclose information (passive fraud; not saying something when you have a legal duty to do so)
- Section 4: Fraud by abuse of position (abusing a position where there is an expectation to safeguard the financial interests of another person or organisation)

Additional offences under the Fraud Act 2006 can be found at
http://www.legislation.gov.uk/ukpga/2006/35/contents

It should be noted that all offences under the Fraud Act 2006 occur where the act or omission is committed dishonestly and with intent to cause a gain or loss. The dishonest behaviour to cause the gain or loss does not have to succeed, the mere exposure to the risk of loss is sufficient, as long as the intent is present.

Economic Crime and Corporate Transparency Act 2023 - Failure to Prevent Fraud
This offence will hold organisations to account for fraud committed by their employees, agents, subsidiaries or other "associated persons" who provide services for or on behalf of the organisation, where the fraud was committed with the intention of benefiting the organisation or their clients. It does not need to be demonstrated that the organisation's senior managers or directors ordered or knew about the fraud. The offence will not extend to individual liability for persons within the organisations who may have failed to prevent the fraudulent behaviour. However, this does not preclude the employee or agent who committed the base fraud, or anyone who encouraged or assisted them, being prosecuted for the base fraud in addition to the corporate being prosecuted for failing to prevent it.
The offence is set out in sections 199-206 and Schedule 13 of the Economic Crime and Corporate Transparency Act 2023. HDdUHB does meet the scope for an organisation as defined within the Act and if found guilty, the organisation can receive an unlimited fine.

Where fraud is committed within the organisation, HDdUHB will have a reasonable defence of reasonable fraud prevention procedures. If a case comes to court, the onus will be on the organisation to prove that it had reasonable procedures in place to prevent fraud at the time that the fraud was committed. In accordance with established case law, the standard of proof in this case is the balance of probabilities. The fraud prevention framework put in place by relevant organisations should be informed by the following six principles:

- Top level commitment
- Risk assessment
- Proportionate risk-based prevention procedures
- Due diligence
- Communication (including training)
- Monitoring and review.

Bribery and Corruption

This can be broadly defined as the offering or acceptance of inducements, gifts, favours, payment, or benefit-in-kind which may influence the action of any person. Corruption does not always result in a loss. The corrupt person does not need to benefit directly from their deeds; however, they may be unreasonably using their position to give some advantage to another.

It is a common law offence of corruption to bribe the holder of a public office, and it is similarly an offence for the office holder to accept a bribe.

In July 2011, the Bribery Act 2010 came into force reforming the criminal law of bribery, enabling simpler prosecution of offences.

The relevant sections of the Bribery Act are: -

Section 1 – Offences of bribing another person.
Section 2 – Offences related to being bribed.
Section 6 – Bribing a foreign public official; and
Section 7 – Failure of commercial organisations to prevent bribery.

Very simply, bribery is defined as accepting an incentive to do something which they would not normally do. For example.

- If a person were responsible for recruiting an individual and they were offered and accepted tickets to an event by one of the candidates to give them preferential treatment; or
- If a person was responsible for purchasing goods or services and they were offered and accepted a meal by a supplier to accept a contract.

In these examples both the person offering a bribe and the person accepting it would be guilty of committing an offence under the Bribery Act 2010.

The Bribery Act 2010 brought in a new corporate offence under Section 7 which states that an organisation is guilty of an offence if a person associated with the organisation bribes another

person or receives a bribe to obtain an advantage. It is a defence for the organisation to prove that it had in place adequate policies and procedures designed to prevent persons from undertaking such conduct.

The UHB has put in place measures to discharge its Section 7 liability. The main UHB policy in relation to this is the 248 - Standards of Behaviour Policy which sets out the UHB's policy in relation to declaration of interests and receipt of gifts, hospitality, honoraria and/or sponsorship.

Theft Act 1968
The legal definition of theft is: "A person is guilty of theft if he dishonestly appropriates property belonging to another person with the intention of permanently depriving the other of it."

Any suspicions of theft should be recorded on Datix for review by the UHB Security and Case Manager.

The Criminal Procedure Investigation Act (CPIA) 1996
This Act of Parliament lays down the procedures which must be followed by the UHB Disclosure Officer, during a criminal investigation to ensure that investigations are conducted properly and ensuring that the correct level of disclosure, to ensure that verdicts which are reached in court are safe and robust.

The Police and Criminal Evidence Act – 1984, Codes of Practice
This Act lays down the statutory codes of practice governing key areas of investigatory procedure and to which criminal investigators lawfully must adhere to, in the UK.

Welsh Government Directions to NHS Bodies on Counter Fraud Measures
The Directions provide the requirements which are to be put in place by Health Boards in Wales, to ensure that successful Counter Fraud Measures are introduced and maintained.

Government Functional Standard GovS013
The GovSO13 was published by the Cabinet Office in June 2020 and exists to create a coherent, effective, and mutually understood way of doing business within government organisations and across organisational boundaries, and to provide a stable basis for assurance, risk management, and capability improvement. Compliance against these standards is overseen by the Counter Fraud Authority and details of these requirements can be found via the following link, https://cfa.nhs.uk/government-functional-standard and a summary of each of the twelve components can be found below:

The purpose of the Functional Standard is to set the expectations for the management of fraud, bribery and corruption risk in government organisations and means that the whole counter fraud community in the public sector is working to a common counter fraud standard. NHS funded services will be required to provide NHSCFA with details of their performance against the Functional Standard annually.

The Functional Standard provides guidance to organisations on the arrangements for undertaking assurance and sets out a number of specific component requirements namely:

Component 1: Accountable individual

Have an accountable individual at board level who is responsible for counter fraud, bribery, and corruption.

Component 2: Counter fraud bribery and corruption strategy
Have a counter fraud, bribery, and corruption strategy.

Component 3: Fraud bribery and corruption risk assessment
Have a fraud, bribery, and corruption risk assessment process.

Component 4: Policy and response plan
Have a policy and response plan for dealing with potential instances of fraud, bribery, and corruption.

Component 5: Annual action plan
Have an annual action plan that summarises key actions to improve capability, activity, and resilience in that year.

Component 6: Outcome-based metrics
Have outcome-based metrics summarising what outcomes they are seeking to achieve that year.

Component 7: Reporting routes for staff, contractors, and members of the public
Have well established and documented reporting routes for staff, contractors, and members of the public to report suspicions of fraud, bribery and corruption and a mechanism for recording these referrals and allegations.

Component 8: Report identified loss.
Report identified loss from fraud, bribery, corruption and error and associated recoveries to the NHSCFA in line with the agreed government definitions.

Component 9: Access to trained investigators
Have agreed access to trained investigators that meet the agreed public sector skill standard.

Component 10: Undertake detection activity.
Undertake activity to try and detect fraud in high-risk areas where little or nothing is known of fraud, bribery, and corruption levels, including loss measurement activity where suitable.

Component 11: Access to and completion of training
Ensure all staff have access to and undertake fraud awareness, bribery, and corruption training as appropriate to their role.

Component 12: Policies and registers for gifts and hospitality and Conflicts of Interest
Have policies and registers for gifts and hospitality and conflicts of interest.

Appendix B – Examples of NHS Fraud, Bribery & Corruption Offences

Fraud

Examples of these crimes may include but are not limited to:

- Submitting false or forged timesheets
- Working elsewhere in NHS contracted hours.
- Falsifying travel and/or expense claims
- People working for other agencies whilst off sick from the NHS.
- Patient falsification of prescription claims forms.
- Outside agencies duplicating invoices for payment by the NHS
- Contractors claiming payment for merchandise they have not delivered.
- The unauthorised selling of NHS property or assets

Warning Signs to consider which may indicate Fraud can include the following:

- Altered documents (correcting fluid, different pen, or handwriting)
- Duplicate claim forms
- Claim form details not readily checkable.
- Changes in normal patterns, of e.g. cash takings or travel claim details.
- Erratic text or difficult to read narrative or with details missing.
- Delay in completion or submission of claim forms
- Lack of vouchers or receipts in support of expense claims, etc.
- Staff seemingly living beyond their means.
- Staff under constant financial or other stress
- Staff choosing not to take annual leave (and so preventing others becoming involved in their work), especially if solely responsible for a 'risk' area.
- Complaints from public or staff
- Always working late
- Refusal of promotion
- Insistence on dealing with a particular individual.

Bribery and Corruption

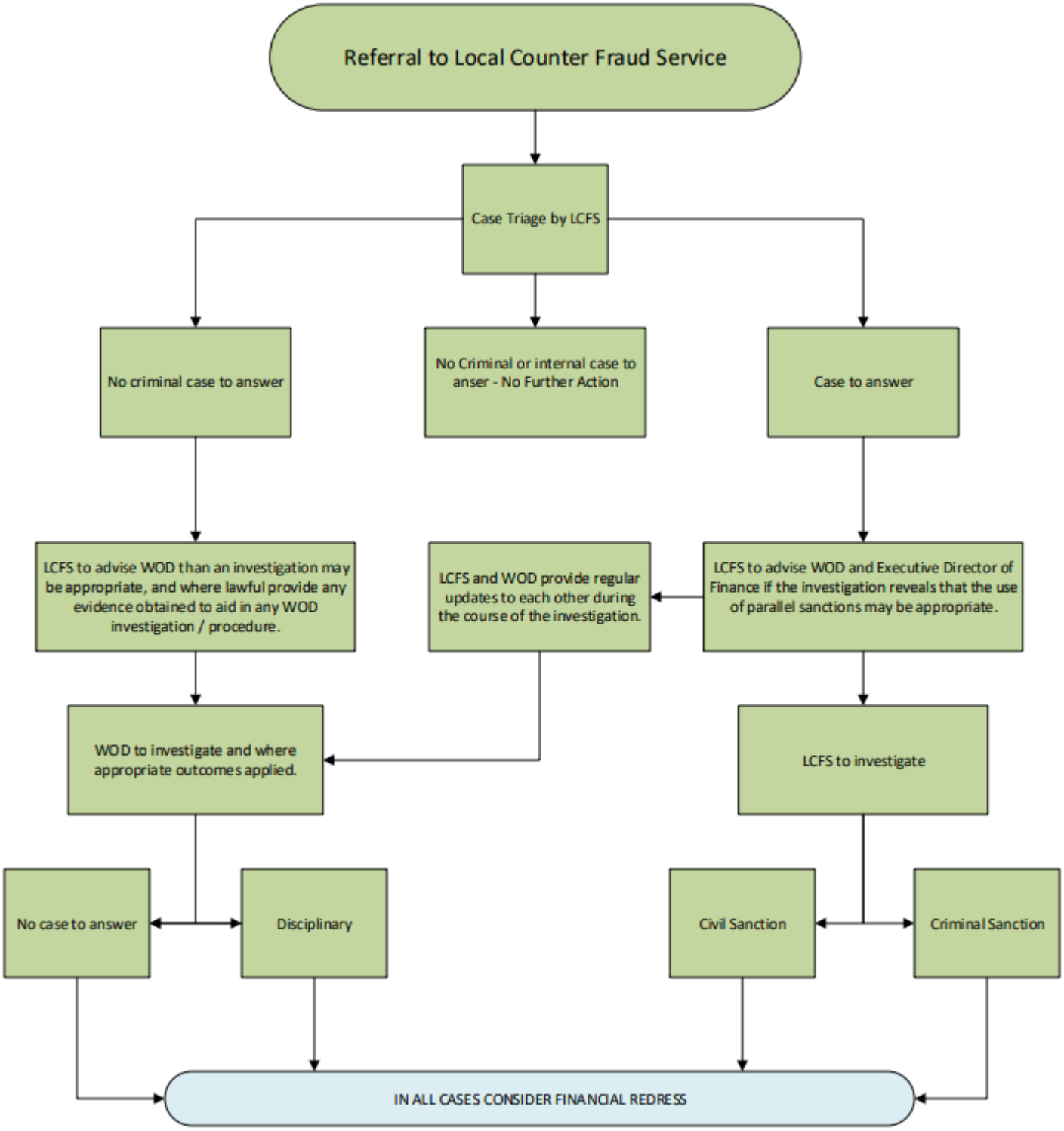
Warning signs which may suggest Bribery or Corruption can include the following:

- Abnormal cash payments
- Pressure exerted for payments to be made urgently or ahead of schedule.
- Payments being made through a third-party country - for example, goods or services supplied to country 'A' but payment is being made, usually to a shell company in country 'B.'
- An abnormally high commission percentage being paid to a particular agency. This may be split into two accounts for the same agent, often in different jurisdictions.
- Private meetings with public contractors or companies hoping to tender for contracts.
- Lavish gifts being received.
- An individual who never takes time off even if ill, or holidays, or insists on dealing with specific contractors himself or herself.

- Making unexpected or illogical decisions accepting projects or contracts
- The unusually smooth process of cases where an individual does not have the expected level of knowledge or expertise.
- Abuse of the decision process or delegated powers in specific cases
- Agreeing contracts not favourable to the organisation either because of the terms or the time period
- Unexplained preference for certain contractors during tendering period
- Avoidance of independent checks on the tendering or contracting processes
- Raising barriers around specific roles or departments which are key in the tendering or contracting processes.
- Bypassing normal tendering or contracting procedures
- Invoices being agreed more than the contract without reasonable cause.
- Missing documents or records regarding meetings or decisions
- Company procedures or guidelines not being followed.
- The payment of or making funds available for high value expenses or school fees (or similar) on behalf of others.

(This is not an exhaustive list. For other types of fraud, corruption or bribery offences please contact the LCFS for advice).

Appendix C – Parallel Investigations Flowchart



Appendix D – Acting on Suspicions – Do's and Don'ts

Do you have concerns about fraud taking place in the NHS? If so,	
DO **Note your concerns as soon as possible.** Record details such as the nature of your concerns, names, dates, times, locations, details of conversations and potential witnesses. Time, date and sign your notes. **Report your suspicions.** Please report your concerns. You can do this by reporting direct to your LCFS, online via the Counter Fraud Authority or by calling Crimestoppers. Reports can be made anonymously or in person. **Provide as much information as possible.** All reports are assessed for content and accuracy. It is important that you provide as much information as possible (date, time, location, witnesses, evidence etc.) as this will give the LCFS the best start in looking into the matter and may provide valuable intelligence to help improve overall understanding of NHS fraud. **Know that confidentiality will be respected.** There are several ways to report suspected fraud, bribery or corruption against the NHS including reporting anonymously, if you chose to report in this way. You may also report as a Whistle-blower.	**DO NOT** **Confront The Suspect or Convey Concerns to Anyone Other Than Those Authorised.** Never attempt to question a suspect yourself; this could alert a fraudster or accuse an innocent person. **Do not discuss your suspicions or concerns with other people.** If you are unsure about what to do if you suspect a fraud, discuss your suspicions with your LCFS. **Try to Investigate the matter yourself.** Never attempt to gather evidence yourself unless it is about to be destroyed; gathering evidence must consider legal procedures for it to be useful. Your LCFS can investigate in accordance with legislation. **Be Afraid of Raising Your Concerns.** The Public Interest Disclosure Act 1998 protects employees who have reasonable concerns. You will not suffer discrimination or victimisation by following the correct procedures.
If you suspect that fraud against the NHS has taken place, you must report it immediately. You can do so in a number of ways: Contact your Local Counter Fraud Specialist (LCFS) / Counter Fraud Team, namely: Benjamin Rees – Head of Local Counter Fraud Services. Email: Benjamin.Rees2@wales.nhs.uk Telephone: 01267 283025 Or Terry Slater – Local Counter Fraud Specialist. Email: Terry.Slater@wales.nhs.uk	

Telephone: 01267283025 / 07980919347

Further team details / updated information can be found on the UHB Counter Fraud intranet site, which can be found by clicking here. You can also email the UHB counter fraud team on HDUHB.CounterFraudTeam.HDD@wales.nhs.uk

Alternatively, you can report fraud against the NHS in England and Wales by using our online reporting form, which can be accessed via Report NHS Fraud | Home | NHSCFA or calling our freephone line 0800 028 4060 (available 24/7).

Both of these options allow you to make an anonymous report should you wish.

Equality Impact Assessment (EqIA) Screening Template

When to complete an EqIA Screening

An EqIA Screening Template must be completed when reviewing, changing and developing procedures/ proposals/ projects/ policies. This is a first step and is used to consider whether there are any negative impacts that may arise.

Purpose of an EqIA Screening Template

The purpose of this short exercise is to ensure that you have shown appropriate due regard when considering the impact for people with protected characteristics in your decision making. The screening process is designed to help you consider the circumstances and to inform evidence-based decisions.

If the proposal is of a significant nature and it is apparent from the outset that a full EqIA will be required, then it is not necessary to complete this Screening Template, you can proceed to complete the full EqIA.

If no negative impacts are identified following completion of the EqIA screening then it is not necessary to undertake a full EqIA however, the decision and justification must be clearly recorded in this document.

On completion of the Screening Template:

- Ensure that all the white boxes within the screening are completed.
- Ensure that the Procedure/ Project/ Proposal/ Policy owner has signed and dated the Screening Template.
- Send a copy of the completed template along with the related policy or project proposal to Inclusion.hdd@wales.nhs.uk for the Diversity & Inclusion Team to review.
- Each Screening Template will be reviewed by the Diversity & Inclusion Team and feedback will be provided to the Procedure/ Project/ Proposal/ Policy owner. This may include recommendations for further action to inform robust decision-making.

Support

For further support please visit the EqIA Sharepoint or contact:
Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Director and Directorate	Huw Thomas – Director of Finance
Service Area	Finance

Title of Procedure, Project, Proposal, Policy being screened:	815 - Counter Fraud, Bribery and Corruption Policy

Description of the Procedure/ Project/ Proposal/ Policy being screened (including key aims and objectives)

This policy document aims to:

- Improve the knowledge and understanding of everyone in the UHB, irrespective of their position and role, about the risk of fraud, bribery, and corruption within the UHB and its unacceptability.
- Assist in promoting an open, honest, and well-intended atmosphere within the UHB with a culture and environment where staff feel able to raise concerns sensibly and responsibly.
- Set out the duty of each member of staff in terms of their responsibility to prevent fraud, bribery, and corruption and how to report it, to allow rigorous investigation of any suspicions of economic crime against the UHB.
- Ensure the appropriate sanctions are considered following an investigation, which may include any or all of the following: criminal prosecution, civil proceedings or internal and/or external disciplinary action.

Evidence considered (including staff and population data, relevant research, expert and community knowledge etc.)

The Health Board has a range of staff across all protected groups at all levels across the three counties.

The protected characteristics of individuals do not factor into any of the procedures associated with the policy, other than where assistance may be needed to help individuals understand the policy, processes and the consequences of their actions.

The policy was assessed as having a low relevance to the equality duties. It is a prescriptive process of how to address incidences of fraud, bribery and corruption that may arise across the Health Board. It will however be important to ensure that any staff against whom the policy is invoked clearly understand what this entails. It is the responsibility of managers who implement the policy to ensure that it is implemented fairly. Staff are required to undertake training in the policy and this could be conducted face to face or electronically and could be arranged to suit individual needs e.g. to work round caring responsibilities, shift work, literacy levels etc.

This policy has been assessed as having a neutral impact in relation to protected groups.

A search of similar policies elsewhere indicated similar result. counter fraud bribery and corruption policy nhs equality impact assessment - Search

A review of the Health Board's Counter Fraud, Bribery and Corruption Policy (815) has been undertaken and amendments have been made, these include amendments to the structure, contents and the inclusion of new legislation under the Economic Crime and Corporate Transparency Act 2023.

All staff must adhere to the guidance set out within this document, like they would with regard to any criminal legislation covering everyday life.

This policy does not apply to service users, however the issue of law would.

Assess which protected characteristics will potentially be affected by the proposal in the table below (please ✓ the relevant box to confirm positive, negative or no impact)**.**

If at any point a negative impact has been identified (actual or potential), you do not need to proceed with the completion of this form, as a full EqIA must be undertaken: Equality Impact Assessments (EqIAs) (sharepoint.com)

Age Is it likely to affect older and younger people in different ways or affect one age group and not another?					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: The Policy does not differentiate between people's age. Individuals are treated equal and fairly regardless of their protected characteristic.					
Disability Is it likely to affect those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes?					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: The Policy does not differentiate between people's disability. Individuals are treated equal and fairly regardless of their protected characteristic.					
Gender Reassignment Is it likely to affect those who either: • Have undergone, intend to undergo or are currently undergoing gender reassignment. • Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: The Policy does not differentiate between people's gender. Individuals are treated equal and fairly regardless of their protected characteristic.					
Marriage / Civil Partnership					

Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment.
Is it likely to affect those who are married or in a Civil Partnership? This means someone who is legally married or in a civil partnership.

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The Policy does not differentiate between people's marital status. Individuals are treated equal and fairly regardless of their protected characteristic.

Pregnancy and Maternity
Is it likely to affect those who are pregnant or have recently had a baby? Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The Policy does not differentiate between pregnancy and maternity status. Individuals are treated equal and fairly regardless of their protected characteristic.

Race / Ethnicity
Is it likely to affect people of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers?

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The Policy does not differentiate between race, ethnicity or nationality. However, the Health Board has an approved translation service that can be utilised as soon as deemed necessary via the Business, Partnership and Inclusion Team SharePoint page or via policies.
Individuals are treated equal and fairly regardless of their protected characteristic.

Religion or Belief
Is it likely to affect people who have a religion or belief? The term 'religion' includes a religious or philosophical belief.

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The Policy does not differentiate between individual's religions or beliefs. Individuals are treated equal and fairly regardless of their protected characteristic.

Sex
Is it likely to affect people who are mostly male or female. Where it applies to both equally does it affect one differently to the other?

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The Policy does not differentiate between a person's sex. Individuals are treated equal and fairly regardless of their protected characteristic.

Sexual Orientation
Whether a person's sexual attraction is towards their own sex, the opposite sex or either.

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The Policy does not differentiate between a person's sexual orientation. Individuals are treated equal and fairly regardless of their protected characteristic.

Armed Forces Community

Consider whether this impacts on members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'

For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see:
Armed-Forces-Covenant-duty-statutory-guidance

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The Policy does not differentiate between a person's previous occupation or association with the armed forces community.

Socio Economic Duty
Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered.

For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resources please see:
more-equal-wales-socio-economic-duty

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The Policy does not differentiate between different level of individual's socio-economic deprivation.

Welsh Language
Is it likely to impact on opportunities for people to use the Welsh language? The Welsh language should be treated no less favourably than the English language.

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
If requested, this Policy can be translated and provided in Welsh If face-to-face meetings are requested through the medium of Welsh, and staff are not Welsh speakers the Health Board's approved translation service would be utilised. The Health Board has an approved translation service that can be utilised as soon as deemed necessary via the Business, Partnership and Inclusion Team SharePoint page or via policies.

If a negative impact has been identified, you are not required to complete this form as a full EqIA must be undertaken. A full EqIA template and guidance can be found on the following link: Equality Impact Assessments (EqIAs) (sharepoint.com)

Screening Completed by:	Name	Benjamin Rees
	Title	Head of Local Counter Fraud Services
	Contact details	Benjamin.Rees2@wales.nhs.uk
	Date	08/07/2025
Screening Authorised by:	Name	Rhian Davies

(Directorate level owner of the procedures/ proposals/ projects/ policy)	Title	Assistant Director of Finance
	Contact details	Rhian.Davies10@wales.nhs.uk
	Date	08/07/2025
Guidance has been provided by Diversity & Inclusion Team:	Name	Alan Winter
	Title	Senior Diversity & Inclusion Officer
	Contact details	Alan.winter@wales.nhs.uk
	Date	9/7/2025
Diversity and Inclusion Team additional Comments:		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.

7

12:40, 0 Mins

7 - Assurance and Risk

7.1

12:40, 5 Mins

7.1 - Risk Assurance Report

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

For assurance

Attachments

7.1 SBAR Risk Assurance Report ARAC August 2025.pdf

7.1 Risk Assurance Report August 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:	12 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Risk Assurance Report
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

The purpose of this report is to provide assurance to the Audit and Risk Assurance Committee (ARAC) on the effectiveness of the Risk Management Framework, and the implementation of the Risk Management Strategy.

Cefndir / Background

ARAC's terms of reference state that one of its principal duties is to 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.

Asesiad / Assessment

The attached report aims to provide assurance by outlining the risk management activity that has taken place since the previous report presented to ARAC in April 2025 on the effectiveness of the Risk Management Framework, and the implementation of the Risk Management Strategy.

The Risk Management Framework, approved by the Board in July 2022, sets out the components that provide the foundation and organisational arrangements for supporting risk management processes in Hywel Dda UHB.

The Risk Management Strategy, approved by the Board in March 2024, provides a supportive framework that ensures the integration of risk management into policy making, planning and decision-making processes.

The revised Risk Management Framework and Strategy are being presented for approval at this Committee meeting, under the next agenda item.

This report provides ARAC with a high-level summary of each Clinical Care Group and Executive Function's internal escalation status in relation to their risk management processes.
Argymhelliad / Recommendation The Audit and Risk Assurance Committee is asked to **TAKE ASSURANCE** on risk management arrangements and processes 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:	2.4 The Committee's principal duties encompass the following: 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. 2.4.3 Work with the Quality, Safety and Experience Committee, the People Organisational Development and Culture Committee, Strategic Development and Operational Delivery Committee and Sustainable Resources Committee to ensure that governance and risks are part of an embedded assurance framework that is 'fit for purpose'.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Included within the report
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:	Datix Risk Module Performance Dashboard
Rhestr Termau: Glossary of Terms:	Included within the report
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 / 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-reporting of risks 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-reporting of risks 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-reporting of risks could mean that the UHB is not addressing any gaps in control in relation to workforce issues and risks.
Risg: Risk:	Risk implications are inherent within the report.
Cyfreithiol: Legal:	No direct impacts from this report; however, late or non-reporting of risks 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:	No direct impacts from this report; however, late or non-reporting of risks 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.
Gyfrinachedd: Privacy:	No direct impacts from this report.
Cydraddoldeb: Equality:	No direct impacts from this report.

Purpose of the report

The purpose of the report is to provide assurance to the Audit and Risk Assurance Committee (ARAC) on the effectiveness of the Risk Management Framework (the Framework), approved by Board in July 2022, and the implementation of the Risk Management Strategy (the Strategy), approved by Board in March 2024.

The Framework and Strategy are currently under review and being consulted upon, ahead of being presented to Board for approval at its meeting in September 2025.

The overall aim of risk management is to:

- Ensure conformity with applicable rules, regulation and mandatory obligations;
- Provide assurance to the Board and the Audit and Risk Assurance Committee (ARAC) that risk management and internal control activities are proportionate, aligned, comprehensive, embedded and dynamic;
- Support decision-making through risk based information; and
- Provide effective and efficient strategy, operations and compliance activities.

Risk Management Framework

The risk management framework is made up of the **risk architecture**, **strategy** and **protocols** (RASP), which wraps round the Health Board's risk management process.

In order to provide the Committee with assurance that the goals are being met and that the risk management framework is effective, this report will outline the risk management activity that has taken place since the previous report as presented to ARAC in April 2025.

The report will also aim to provide assurance to ARAC on the effectiveness of the internal escalation framework in respect to risk management and will include detail on the escalation status of Clinical Care Groups (CCGs) and Executive Functions (hereafter referred to collectively as Functions) in line with the 3As assessment approach, complementing the Audit Tracker paper. Data will be assessed as at the most recent month-end position to align with the escalation framework (June 2025).

Risk Management Strategy

The Health Board's Risk Management Strategy provides a supportive framework that ensures the integration of risk management into policy-making, planning and decision-making processes, and specifically:

- To improve the quality of service and protect patients, carers, staff and others who come in to contact with the Health Board;
- To create awareness through the Health Board about the importance of recognising and managing risk in a timely manner and providing staff with the appropriate knowledge, skills and support;
- To promote positive risk taking in the context of clinical care and in controlled circumstances;
- To provide a robust basis for strategic and operational planning through structured consideration of key risk elements;
- To enhance partnership working with stakeholders in the delivery of services;
- To improve compliance with relevant legislation and national best practice standards; and
- To enhance openness and transparency in decision-making and management.

Risk Management Process

The Health Board's risk management process is recorded via the Datix Risk Register Module (Datix) and reported via risk register reports to both assurance and management meetings. Datix enables risks to be recorded at one of three risk levels:

- **Principal** – Risks that affect the organisation's ability to achieve its strategic objectives in the long-term
- **Corporate** – Significant risks that affect the organisation's ability to achieve its planning objectives and to deliver healthcare services in the 'here and now'
- **Operational** – Risks that affect the objectives of a Function (replaces the previous "service" and "directorate" level risks)

This ensures that risks are reported to, and scrutinised at, the most suitable forums. Following the recent operational Organisation Change Process (OCP), risk management processes have been reviewed and updated to:

- Ensure ownership by appropriate service leads in line with revised management hierarchies; and
- Support effective oversight and escalation through updated operational and executive governance arrangements within the Functions.

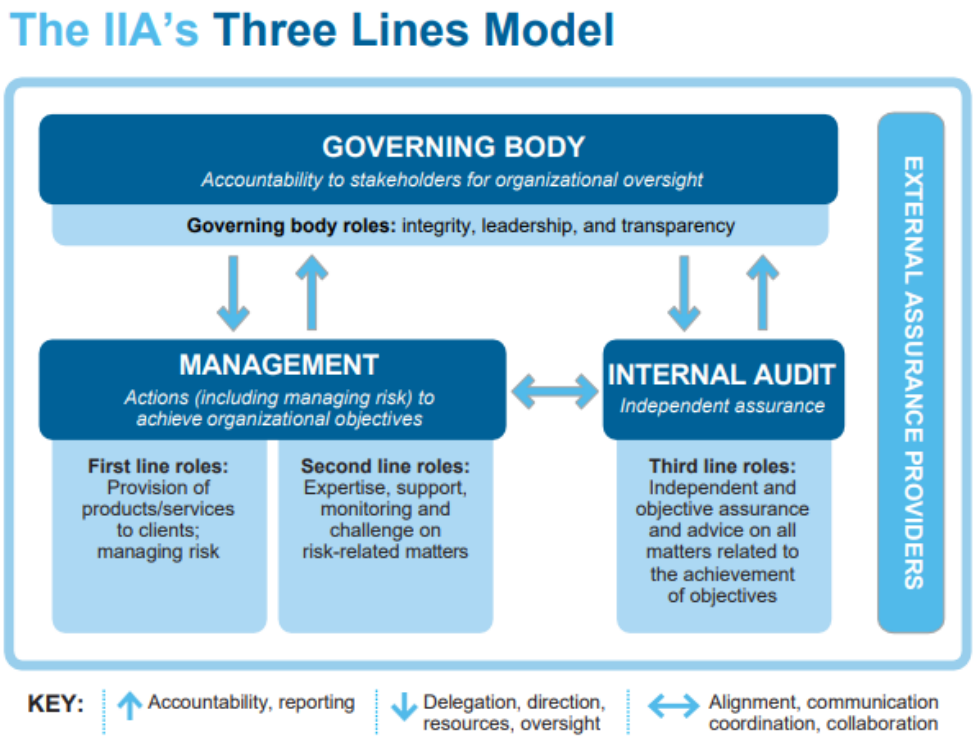
Following Board approval in March 2025, a revised approach to risk tolerance is being embedded across the organisation. This replaces the previous model, which applied fixed tolerance levels across risk impact domains. The new approach is outlined in the Risk Treatment section of this report.

Risk Architecture

Risk architecture is the organisational arrangements for risk management which details the roles, responsibilities and the lines of communication for reporting on risk management and have recently been updated in light of the change to the Clinical Care Group operational structure to reflect revised management hierarchies and governance arrangements.

Three Lines of Defence for Risk Management

The Health Board operates within the widely accepted "Three Lines of Defence Model" which provides a simple and effective way to delegate and coordinate risk management roles and responsibilities within an organisation, to ensure the appropriate responsibility is allocated for the management, reporting and escalation of risk.



Risk Management (1st line)

The Health Board has 579 open risks on the Datix Risk Module as of 30 June 2025 (February 2025: 583), split as follows:

Risks per Risk Level

Risk Level	April 2025	May 2025	June 2025
Principal Risks	15	15	15
Corporate Risks	21	21	21
Operational Risks	550	556	543

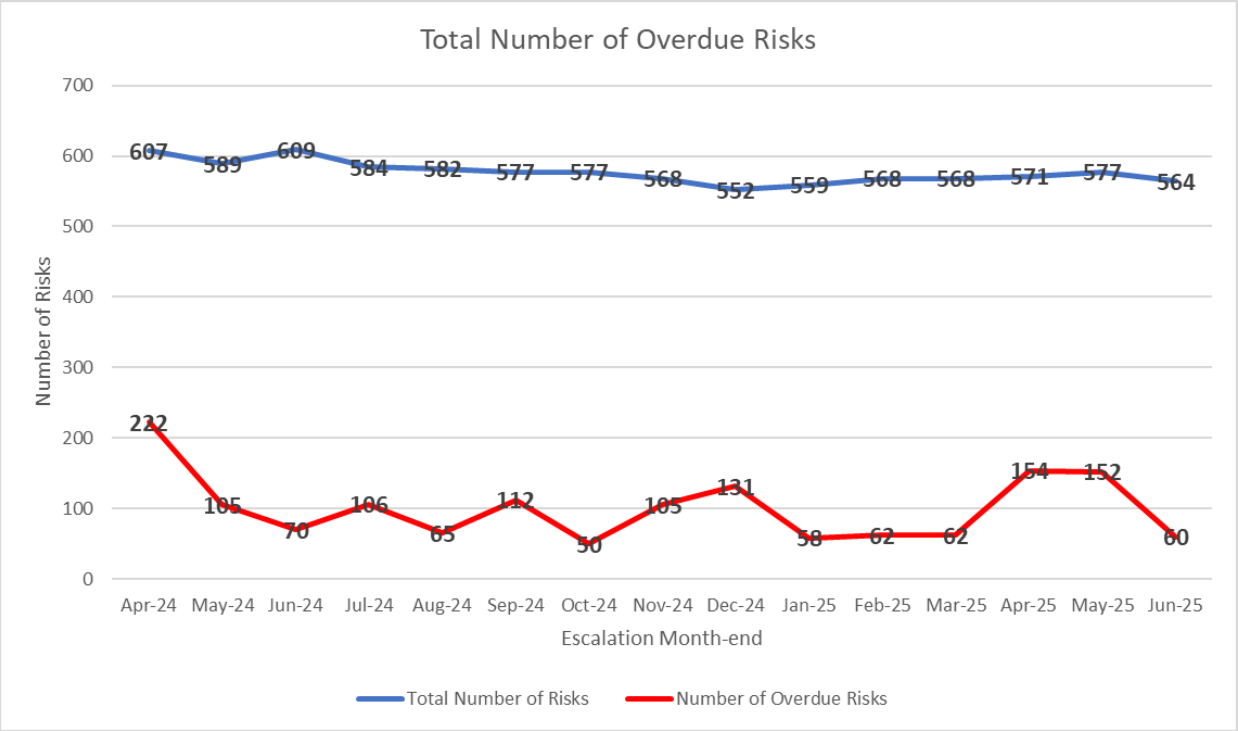
As Principal Risks are reviewed and updated by the Executive Team in line with the Board Assurance Framework, the focus of this paper and the Improving Together metrics are on Corporate and Operational Risks.

The table below provides a summary of open risks per Function in line with the internal escalation framework:

Clinical Care Group / Executive Function	Total number of risks as at 30 Jun 2025	%age of all Health Board risks as at 30 Jun 2025	Number of Overdue risks as at 30 Jun 2025	Total number of overdue risk actions as at 30 Jun 2025	%age of overdue risk actions as at 30 Jun 2025
Chief Operating Officer Management	9	2%	2	1	8%
Community & Integrated Medicine	93	16%	6	25	15%
Director of Allied Health Professions and Health Science	5	1%	0	6	29%
Estates & Facilities	130	23%	0	7	4%
Director of Finance	25	4%	2	7	22%
Director of Nursing	16	3%	2	5	21%
Director of Public Health	14	2%	0	0	0%
Director of Strategy and Planning	4	1%	0	0	0%
Director of Workforce	2	<1%	0	5	36%
Medical Director	5	1%	1	1	20%
Mental Health and Learning Disabilities	29	5%	0	6	9%
Operational Allied Health Professions and Health Sciences	84	15%	19	30	19%
Planned and Specialist Care	110	20%	26	64	38%
Primary Care, Community Strategy & Long Term Care	38	7%	2	12	17%
Corporate Services	0	0%	0	0	0%
Chief Executive	0	0%	0	0	0%
Total:	**564**		**60**	**169**	

Timeliness of Risk Reviews

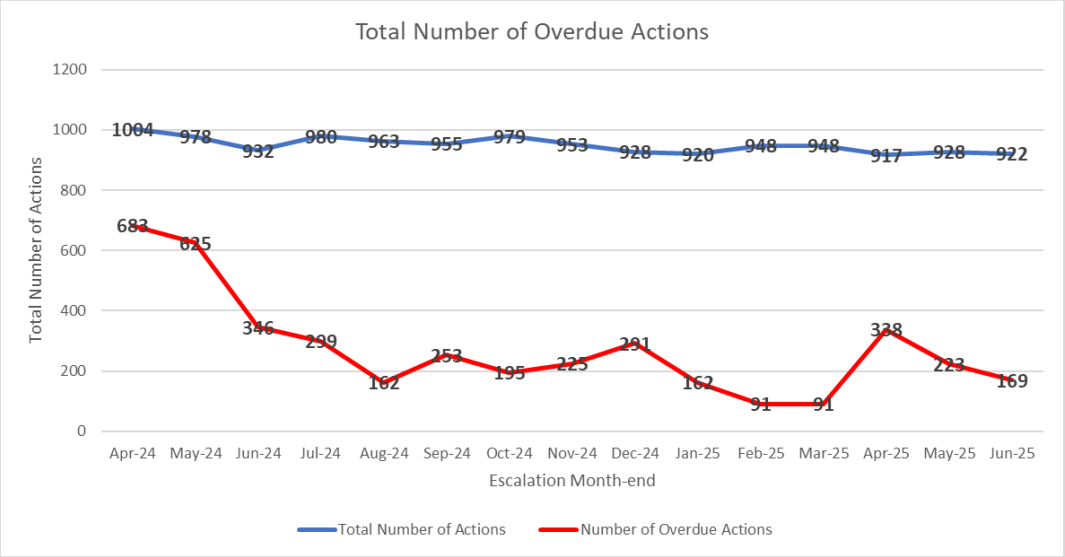
Since the introduction of the internal escalation framework in April 2024, there has been an overall improvement in the timeliness of risk reviews, with 11% overdue for review as at 30 June 2025. The timeliness of risk reviews, however, has been inconsistent, with fluctuations in the number of overdue risks throughout the year which may reflect the impact of operational demands across the Health Board.



Of the 60 risks noted as overdue at June 2025, 54 have recently lapsed, i.e., not overdue by more than one month (April 2025: 55), with 6 risks becoming overdue as at May 2025, 2 of which are noted as being overdue by 3 months. The data demonstrates an overall improvement in the timeliness of risk reviews since the implementation of the internal escalation process, with the majority of risks now being reviewed within expected timeframes (April 2024: 222); however recognising there continue to be inconsistencies across the year. Due to Datix system maintenance being undertaken during March 2025, risk leads were unable to access the risk register at this time, leading to an increase in overdue risks during April and May 2025.

Risk Action Plans

While the introduction of the internal escalation framework in April 2024 has led to a notable reduction in the number of overdue risk actions, further progress is required to ensure the timely review and completion of, and improved quality of, risk actions. This is evidenced by the increase in overdue actions from 91 (10%) in the previous report to 169 (18%) as at 30 June 2025 (recognising that some of these may also be attributable to risk leads not having access to Datix whilst system maintenance was being undertaken).



Although the trend in reviewing overdue actions has significantly improved, actions remain which may have either been assigned unrealistic or unachievable timescales or are not being updated fully during risk reviews.

The number of overdue or long-standing risk actions may also reflect the difficulties currently faced by management including staff absences and workforce challenges, in addition to the number of action plans that are reliant on additional funding to progress, which results in these actions not being updated due to a lack of any notable progress to report. These limiting factors should be reflected in the rationales being provided by risk leads relating to the achievement of the Target Risk Score (TRS), and the expected date of its achievement, in line with the revised approach to risk tolerance.

Risk leads are advised to provide realistic revised action dates where original dates have lapsed, with sufficient narrative noted in the progress update noting the reasons behind any delays and justification for the new date. The timeliness of risk reviews, along with the progression of risk actions, are key components in determining the levels awarded under the governance domain of the escalation framework.

Risk leads are also advised to ensure that risk actions are aligned to the Health Board's Annual Plan. Functions have been requested by 31 July 2025 to complete a comprehensive review of their risks, quantified and linked where possible to operational, workforce, quality, financial and infrastructure domains, and the identification of any risks that cannot be mitigated within current means and resources to inform the planning process for financial year 2026/27.

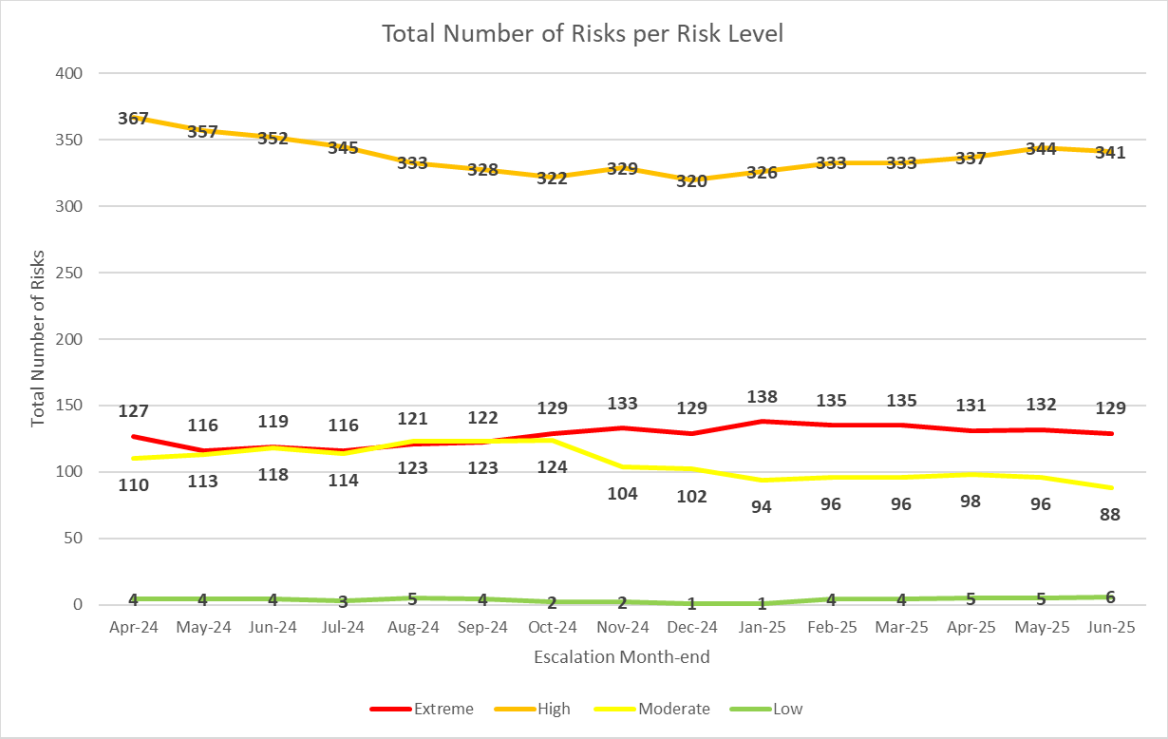
Risk Profile

As of June 2025, the average age of a risk is 3 years and 5 months, with 120 (21%) risks having been identified as a risk pre-Covid (April 2025: 129 (22%)). 57% of these risks are aligned to the Estates and Facilities Function, who are currently in the process of reviewing and cleansing their risk register. To date, the Function has removed 6 risks due to the installation of new equipment, and a review of risks being undertaken where it was identified that some were recognised as managed issues. However, as their risks primarily relate to the condition of the Health Board's ageing estate and equipment (e.g., air handling units, heating, water and electrical systems) it

is unlikely the remaining aged risks will be fully mitigated until capital funding has been agreed and obtained.

Since the mandatory requirement for a 'Rationale for Target Risk Score (TRS)' and 'expected date to achieve TRS' were introduced to risks on Datix in April 2025, many risks are citing lack of available funds as a barrier to setting and achieving low TRS. The Assurance and Risk team will be supporting services to escalate risks via the appropriate management and governance structures for discussion at Executive level for guidance and permission to 'accept' risks (i.e. the amount of risk an organisation is willing to accept once all mitigating actions have been undertaken in order to achieve its objectives).

The following graph shows the trend in the number of extreme, high, moderate and low-level risks (risk level) since the introduction of the internal escalation framework. This data demonstrates the dynamic nature of the risk register, with risks being reviewed and re-scored during this period.



The number of extreme and high risks indicates that the organisation is taking risks beyond an acceptable capacity (the maximum level of risk to which the organisation should be exposed, having regard to financial and other resources).

Risk Treatment

The strengthened approach adopted by the Health Board to risk treatment reinforces the Target Risk Score (TRS) to define the minimum residual risk the Health Board is willing to accept once all planned mitigating actions have been completed. Developments to the Datix risk register system since April 2025, where risk leads are required to note an expected date of achieving the TRS is aimed to support the process for informed decision making, and to facilitate the appropriate escalation of risks.

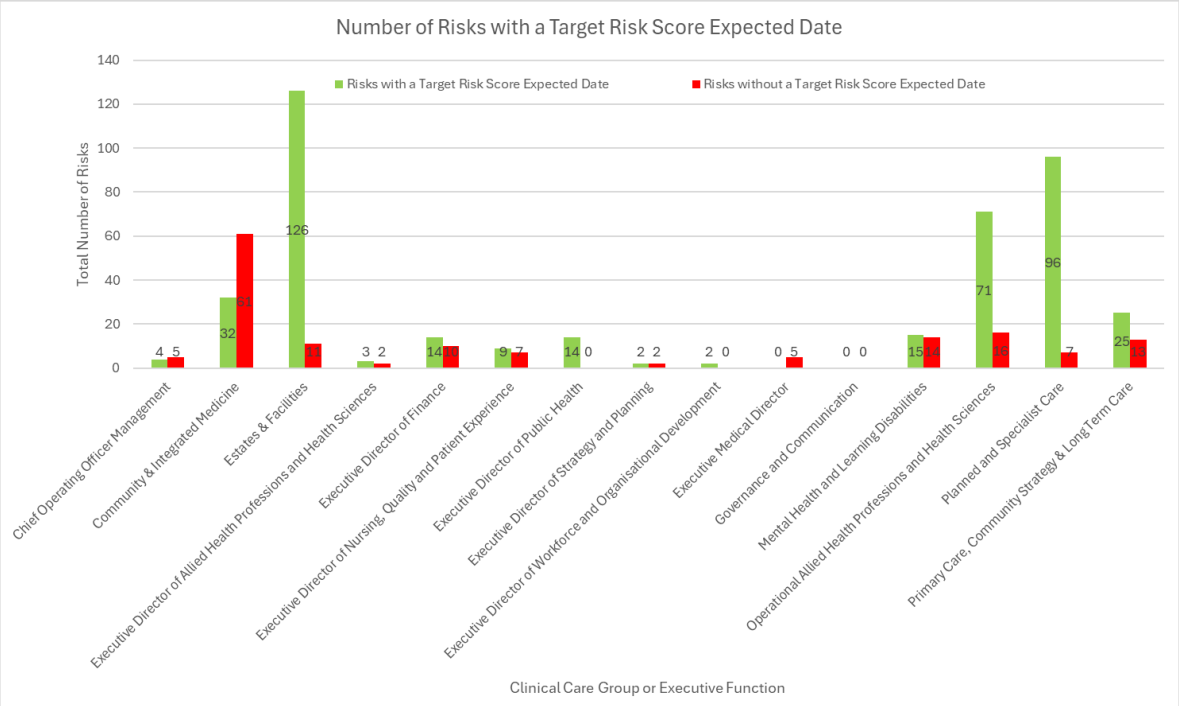
This model strengthens the link between proposed actions and their expected impact on the risk score, introduces timelines to illustrate the risk score trajectory, and supports informed decisions to tolerate risks based on measurable indicators and the organisation's capacity to further mitigate.

The TRS represents the ultimate level of risk achievable, given the available means and resource. Once the TRS is achieved, if the risk continues to exist, it should then be tolerated/accepted unless further actions are identified or made possible, such as through additional funding or capacity. If the TRS is deemed unacceptable, (i.e., too high), further discussion or escalation is required.

The TRS should be quantified and where possible aligned to performance targets, including quality metrics, with a set timescale for achieving the reduction to the target risk score. Trajectories could be used to provide assurance that the right actions are being taken to reduce the risk to its TRS. If the trajectory is not being met, this becomes a decision point for risk owners to identify further actions required to bring the risk back on trajectory.

If further action cannot be taken within available means and resource, the risk should be escalated through management structures using metrics, such as quality, to support decision-making. This approach would require risk leads to set a realistic TRS and a date by which it will be achieved.

Risks will be 'treated' until a discussion to 'accept' a risk is triggered, or when the TRS is not supported by the Executive Risk Owner for corporate risks and Executive Director/Clinical Care Group Director for operational risks.



Management teams across the Health Board are responsible for identifying risks that affect their services, with the Assurance and Risk team providing technical risk management advice to support the consistency in risk scoring across the organisation.

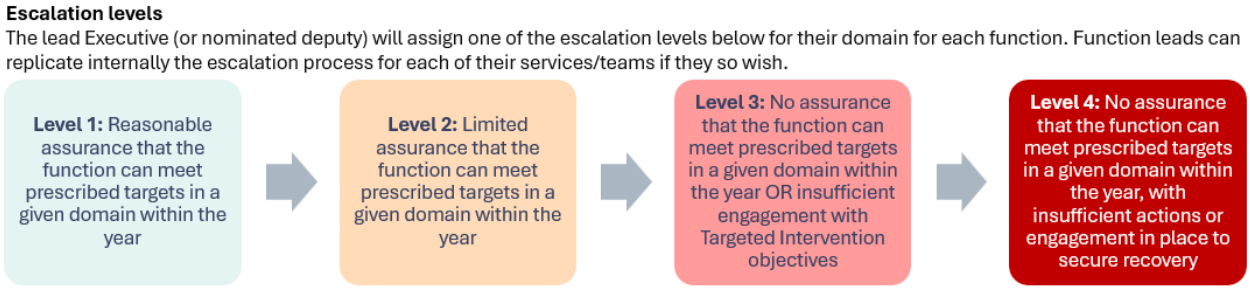
Risk management training is provided to managers and service leads to address gaps in knowledge and increase risk awareness across the organisation. Since the previous report presented to ARAC, risk management training material has been updated to reflect revised operational hierarchies as a result of the OCP, along with the new approach to risk tolerance. This information is supplemented within reports provided by the Assurance and Risk team to Function governance meetings.

Oversight of Risk (2nd Line)

Internal Escalation Framework

The Health Board has an internal escalation process, as part of the Executive Improving Together (EIT) Framework, whereby Functions are assessed monthly against the following seven domains to drive improvement in performance:

- Quality and safety;
- Governance;
- Workforce;
- Finance;
- Strategy, planning and fragile services;
- Population health; and
- Performance.



Following a review of the internal escalation process, a new Level 4 has been introduced from April 2025 for functions that are unable to provide any assurance that prescribed targets are being met within the year, are taking insufficient actions, or have unsatisfactory levels of engagement.

One key metric in the Health Board's internal escalation process under the Governance domain is **how Functions are managing risks in terms of the scale, significance, timeliness and quality**, with measures extended from April 2025 to inform levels to be awarded. Levels awarded ranging between 1-4 to highlight progress being made as outlined in the table below:

Measures to assess against the Governance Domain - Risks

Level	Criteria
Level 4 – no assurance and insufficient actions / engagement	No plan in place and no engagement, (eg no risk action plans, no expected date to achieve Target Risk Score). No evidence that risks are escalated via CCG management structures where necessary, no engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 3 – no assurance	Lack of evidence that risks are being managed and mitigated within expected timescales. Evidence where known risks are not articulated on the function's risk register. **Less than 80% compliance** of risks and risk actions being updated within required timescales Limited evidence that risks are escalated via CCG management structures where necessary, therefore not demonstrating good engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 2 – Limited assurance	Relevant risks articulated on risk registers with action plans in place, but lack of evidence that risks are being managed and mitigated within expected timescales. *(eg risk action plans not being implemented within original action dates, limited evidence of reduction in current risk score).* **Between 80% - 89% compliance** of risks and risk actions being updated within required timescales Some evidence that risks are escalated via CCG management structures where necessary, demonstrating engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 1 – Reasonable assurance	Relevant risks articulated on risk registers with action plans in place, and evidence that the function is delivering against these (eg specific and measurable risk action plans, current risk score and target risk score clearly articulated, achieving expected target risk dates) **Over 90% compliance** of risks and risk actions being updated within required timescales Evidence that risks are escalated via CCG management structures where necessary, demonstrating good engagement and the ability for leadership to make informed decisions on prioritisation of resources

For Level 4, the Executive for the escalated function alongside the triumvirate senior management for a Clinical Care Group and the Domain Lead Executives will attend a one-off **Chief Executive Officer CEO Recovery Meeting** with the Chief Executive, supported by the Director of Finance as the Executive Lead for performance to determine next steps.

The Assurance and Risk team provides focussed support for those Functions at Levels 3 and 4 to aid their de-escalation/recovery, and to prevent those awarded Level 2 status being escalated. Detail is provided within each report provided and presented at Function governance meetings the reasons behind their escalation status, and suggested actions in order to de-escalate (where appropriate).

A summary of each Function's performance for the Governance domain since April 2025 can be found in the following table:

Clinical Care Group/Executive Function	April 2025	May 2025	June 2025
Chief Operating Officer Management	2	2	1
Community & Integrated Medicine	2	2	2
Estates & Facilities	3	3	2
Executive Director of Allied Health Professions and Health Science	1	2	1
Executive Director of Finance	2	2	2
Executive Director of Nursing, Quality and Patient Experience	2	2	2
Executive Director of Public Health	2	1	1
Executive Director of Strategy and Planning	2	2	2

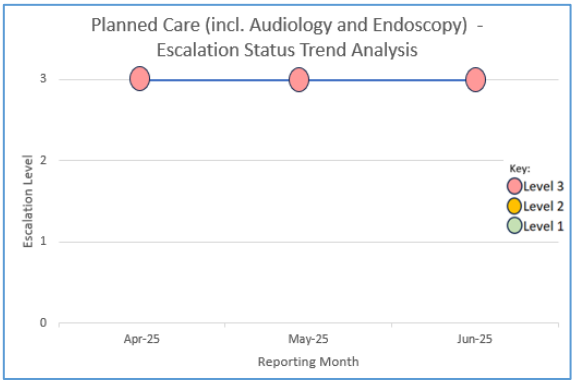
Executive Director of Workforce and Organisational Development	1	1	2
Executive Medical Director	2	2	1
Governance and Communication	1	1	1
Mental Health and Learning Disabilities	3	3	2
Operational Allied Health Professions and Health Sciences	2	2	2
Planned and Specialist Care	3	3	3*
Primary Care, Community Strategy & Long Term Care	2	2	2

**Escalated for Governance due to risk management, as well as factors outside the remit of this paper ie. implementation of external recommendations /compliance with WHCs /governance arrangements*

As at end of June 2025, one Function met the Level 3 escalation criteria for risk management under the Governance domain. A detailed analysis can be found below. Whilst nine Functions met the Level 2 escalation criteria under the Governance Domain, their escalation status was not attributable to risk management, as it was predominantly based on the management of their audit and inspection recommendations and other factors such as implementation of Welsh Health Circulars/Ministerial Directions and general governance arrangements.

Level 3 – No Assurance

Planned and Specialist Care



At June 2025, the CCG had 110 open risks, of which 26 were overdue (24%), therefore meeting the Level 3 escalation criteria for risk management (less than 80% compliance of risks and risk actions being updated within required timescales). Of the 26 overdue risks, 6 (5%) were overdue by more than one month. Additionally, the CCG had 168 open risk actions, of which 64 were noted as overdue for review (38%). Since the data was extracted, General Managers and risk leads within the CCG have held risk review sessions, supported by the Assurance and Risk team, with further scheduled for August 2025.

Risk Themes

Risk owners can assign multiple ‘themes’ to their risks on Datix, which allows the Health Board to share risk information on specific areas, such as health and safety, information governance and workforce with the relevant subject matter experts within the Health Board. They, in turn, can offer specific support and guidance to risk owners in the management of risk and identify trends and areas of concern. Each risk theme is aligned to a specific and relevant committee or sub-committee, to provide assurance that processes are in place to deliver a holistic approach to risk management. This further enables the Health Board to better identify and define its risk appetite, risk capacity and total risk exposure in relation to each risk, and to group similar risks or generic type of risk.

Each risk theme has assigned owners based on their subject matter expertise, who receive notifications when risks are added to the system and are also provided with the relevant thematic risk register on a bi-monthly basis. Upon receipt, theme risk owners are required to review themed risks to ensure that:

- they have been correctly allocated;
- the risk, controls and planned actions are reviewed from an expert perspective; and
- oversight and guidance are provided to the relevant manager of any further controls that need to be undertaken to manage the risk to an acceptable level.

Theme owners are provided with a thematic risk register on a bi-monthly basis to identify trends, or risk clusters, and to consider whether there are gaps in controls in the Health Board's control framework, and to determine whether further action is required to prevent risks from materialising.

The Assurance and Risk team is currently reviewing existing risk themes to ensure their validity and usefulness, with a view to further strengthening the approach to risk management within the Health Board.

Independent Assurance (3rd line)

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

On 11 March 2025, Welsh Government considered the Health Board's escalation status and in recognition of governance improvements, related to improved Board stability and an increased degree of confidence in the organisation's governance, the Health Board was de-escalated for Governance from level 4 (targeted intervention) to level 3 (enhanced monitoring), and remain at level 3 per the review undertaken in July 2025. Risk management is one of the criteria considered in the governance domain and therefore reflects confidence across the Health Board's governance framework, including its risk management framework.

Committee and Reporting Structures

Effective risk management requires a reporting and review structure to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place. The Health Board's risk reporting structure is outlined in Appendix 2 of the Risk Management Strategy.

1. The Board

The Board is responsible for oversight of the Health Board's principal risks, which are those that affect its ability to achieve its strategic objectives. Since the Board meeting in March 2025, the 2024/25 planning objectives, outcome measures and principal risks have been realigned to the Health Board's 4 new strategic objectives which are included within the Board Assurance Framework (BAF), namely Thriving Teams, Healthier Communities, Great Care and Positive Futures.

Principal risks are reported to the Board 3 times a year, with the last report provided in July 2025 as part of the BAF Dashboard. The Health Board will be looking to update

the planning objectives which support the four strategic objectives during 2025/26, upon which the BAF will be refreshed and the associated principal risks.

The Board is also responsible for oversight of corporate risks, which are defined as significant risks that affect the Health Board's ability to deliver the healthcare services in the 'here and now'. Corporate risks are reported to the Board 3 times a year, with the last report provided in July 2025. The Health Board has 21 corporate risks as at June 2025.

The formal Executive Team reviews the corporate risk register on a monthly basis, and the principal risk register on tri-monthly basis, ahead of Board reporting. The Executive Team is able to:

- Approve or escalate new risks for addition to corporate/principal level;
- Approve the closure or de-escalation of corporate/principal risks to operational level.

The table below summarises the changes to the Corporate Risk Register (CRR) since the previous report presented to ARAC in April 2025:

Risk Ref and Title	Risk Score Jul-25	Change in Risk	Date of change on CRR
2086 - Risk that the cash consequences of the Health Board deficit cannot be covered by WG should it exceed our Target Control Total	**20**	New risk (added June 2025), superseding closed risk 1843	04/06/25
2079 - Risk of loss of Pathology services across the Health Board due to delayed implementation of LIMS	**20**	New risk (added May 2025)	23/05/25
1032 - Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity	**20**	TRS increased from 16 to 20	21/05/25
1861 - Risk of harm to staff, patients public and critical assets due to insufficient physical security measures and systems	**16**	TRS increased from 9 to 12	10/06/25
1664 - Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	**16**	TRS increased from 9 to 10	31/05/25
2104 - Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 25/26 due to demand exceeding capacity	**12**	New risk (added June 2025), superseding closed risk 1842	01/04/25
1843 - Risk that the cash consequences of the Health Board deficit cannot be covered due to significant deficit position	**10**	Risk closed (May 2025)	16/05/25

1842 - Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 24/25 due to demand exceeding capacity	**9**	Decrease in risk score from 12 to 9 and risk closed.	21/05/25
2000 - Risk of the Health Board significantly underspending in excess of its statutory Capital Resource Limit for 2024/25	**4**	Risk score decreased from 12 to 4 and risk closed	21/05/25

All changes are included in risk reports presented to Board and Committees.

2. Board Committees and Sub-Committees

Terms of References (TORs) are in place for each committee at the Health Board, outlining their responsibility to review and to seek assurance that risks aligned to Committees are being effectively managed across the Health Board and report any areas of significant concern. Due to the change in reporting arrangements, all risks (Principal, Corporate and Operational) will be reported to each Committee meeting via the "Assurance on Governance Arrangements" paper. Risks are also reported to sub-committees, each of whom have delegated authorities from the parent committee, who received update reports at each meeting.

All open risks have been realigned to the new Board Committee governance structure implemented on 1 April 2025, as well as other system changes implemented on Datix Risk Module. Risk reporting to committees resumed in June 2025 following these updates.

3. Clinical Care Group and Executive Function Level Monitoring Arrangements

Risks are discussed at the CCG Integrated Governance Group meetings, which occur fortnightly, alternating the agendas of Quality, Health & Safety, and Business, Planning, Performance & People. The CCG's remit is to evidence to the Integrated Quality, Finance and Performance Delivery Group (IQFPDG) that these risks are being managed and monitored effectively in line with the Health Board's Risk Management Framework.

Executive Functions have local governance arrangements for risk, with the frequency of these meetings varying, dependent on the Function. Continuing local governance arrangements, including frequency of stood down meetings, are considered when awarding the escalation status for Governance.

Risk Management Strategy

The Risk Management Strategy (the Strategy), approved by Board in March 2024, sets out the Health Board's risk management policy statement and objectives in respect of strengthening risk management for the period up to September 2025. This report provides a progress update against the three objectives for this period.

The Strategy has been refreshed during Quarter 1 of 2025/26 and has been included on the agenda for ARAC at its meeting in August 2025, for endorsement ahead of formal approval by Board at its meeting in September 2025. The revised Strategy

contains three objectives to strengthen risk management within the Health Board for the next 12 months.

The Strategy aims to support a dynamic and systematic approach to risk management, and to ensure prompt and comprehensive identification, assessment and management of risks that threaten the delivery of its strategic objectives and day-to-day operations.

The Strategy, which covers the period April 2024 – September 2025 contains the following three objectives, with progress against each objective detailed below:

1. *Implement and embed the UHB's refreshed risk appetite statements Appetite and Tolerance Statement*

We will further develop the Health Board's risk appetite by:

- *Developing an implementation strategy to embed revised risk appetite statement across the UHB;*
- *Reviewing our approach to risk tolerance and how it aligns to the refreshed risk appetite statements (approved by Board in January 2025);*
- *Providing practical support to services in the utilisation of refreshed risk appetite statement; and*
- *Reviewing the risk appetite statement after 6 months with the Executive Risk Group (ERG) to ensure it remains fit for purpose and support effective decision making.*

The risk appetite statements (approved by Board in January 2024), were reviewed and refreshed by the Executive Team in December 2024 as part of the required annual review, and approved by Board at its meeting in January 2025.

Risk tolerance is the *organisation's readiness to bear the risk after risk treatment in order to achieve its objectives.*

The revised approach to risk tolerance was included in the CEO report to Board at its meeting in March 2025, and approved. The new approach to risk tolerance has been outlined earlier in this report, which links proposed actions to their anticipated impact on risk score, and shows the risk score trajectory over time.

Where barriers to the achievement of the TRS are noted, these should be escalated appropriately via management structures to support decision-making, these processes which have been further strengthened with the introduction of the CCG structures, with clear management structures in place to escalate as appropriate to IQFPD ahead of Executive Team. Risk leads will therefore be required to set realistic TRS, and an expected date for which they will achieve it.

The decision to 'accept a risk' should be informed by metrics and the ability to support further actions, and the Board will be asked to accept any risks where the Health Board is unable to treat within its available means.

Work continues to develop an integrated impact assessment (IIA) process for the Health Board. This will incorporate an assessment of risk appetite and ensure that the

Board are cognisant of making decisions that are within or even above their risk appetite.

2. *Support the strengthening of operational risk management arrangements*

We will do this by:

- *Ensuring risk management arrangements and systems are realigned to the new Operations Directorate structure (when approved), and systems used to capture this process are appropriately updated;*
- *Supporting corporate and operational directorates via quality and business meetings and Directorate Improving Together sessions to identify, assess and manage risks and improve outcomes;*
- *Reviewing current partnership risk management arrangements with key partners and to utilise learning to develop a plan for all partnerships to strengthen these arrangements which will support the UHB to achieve its objectives;*
- *Reviewing the training needs analysis and provision of risk management training to implement the operationalisation of revised risk appetite statements across the UHB;*
- *Implement the new Once for Wales Concerns Management system when it has been developed and is ready to be rolled out; and*
- *Providing practical support to services with operational risk management arrangements via business partnering arrangements to ensure risk management outcomes inform and prioritise organisational decision making.*

The Datix risk register system has been realigned to the new structures and hierarchies to support the implementation of the revised arrangements within the Operations Directorate from April 2025. Refresher training sessions were held for colleagues across the Health Board during Quarter 1 2025/26, as well as governance meeting updates to inform them of changes made, and relevant procedural documents are in the process of being updated to reflect these changes. Notable system changes include:

- Updated risk management ownership levels to reflect revised operational management structures;
- Updated naming conventions to mirror new structures; and
- Inclusion of a rationale for TRS for operational risk, and expected date of achievement of TRS.

The Assurance and Risk team operates within a business-partnering approach to support operational and corporate teams to meet their obligations in respect of risk management. Each Function is assigned a dedicated Assurance and Risk Officer (ARO), who are either fully qualified risk professionals with the Institute of Risk Management (IRM), or working towards accreditation. AROs prepare risk reports and attend relevant service governance meetings, in addition to meeting risk leads to facilitate and support discussions on risk management. Performance dashboards are also in place, which allow staff across the organisation access to a summary of all Health Board risks.

The Assurance and Risk team provides both system and technical risk training to operational managers and risk leads across the Health Board, with guidance issued

on Risk Management within the Manager's Passport Programme. Relevant materials are also available to further support colleagues via the Assurance and Risk Sharepoint site.

A desktop review of the Health Board's key partnerships has been undertaken by the Corporate Legal team. Ascertaining whether we feel appraised of relevant risks with our partnership organisation that could impact our organisation was one area of focus during the risk maturity self-assessment, which has informed the objectives included within the revised Risk Management Strategy for 2025/26. While key people are aware of areas of potential risk with partnerships, there are currently no defined approaches and processes for addressing risk with all our key partners.

The Health Board completed a Readiness Report for the new Once for Wales Concerns Management system in which it stated it would not be migrating to the new system and would continue to use the current Datix Web system which has been extended to 30 November 2027. This allows the Health Board to continue using the existing Datix Risk Module system, with meetings currently being set up with alternative providers to identify a suitable alternative from 1 December 2027.

3. *Understand how established risk management processes currently contribute to the overall health of the UHB (i.e. achievement of objectives, delivery of plans and performance), and how this can be strengthened.*

We will do this by:

- *Engaging with relevant teams across the UHB to establish how risk information is currently utilised within their areas to support the achievement of the delivery if our objectives and performance targets to inform our risk maturity assessment, and how this could be strengthened; and*
- *Engaging with service leads across the UHB to assess the risk culture within the organisation to identify areas of improvement to support individuals in undertaking risks in an informed manner to support the achievement of our objectives and performance targets.*

The previous report to ARAC provided the Committee with the outcomes of the risk maturity self-assessment undertaken during Quarter 3 of 2024/25, in accordance with the Orange Book (a recognised risk management standard for the public sector).

The outcomes and identified next steps of the assessment have been used to inform the revised Strategy, with the Head of Assurance and Risk developing an implementation plan to ensure the delivery of the refreshed objectives. Progress against these will be reported to future ARAC meetings.

Next steps

As outlined within this report, the following key actions will be undertaken, with progress provided to ARAC in the next Risk Assurance Report in December 2025:

- To identify a suitable risk management system and commence work on its implementation and roll-out ahead of 30 November 2027; and
- Complete the review of risk themes.

7.2

12:45, 5 Mins

7.2 - Risk Management Framework and Strategy

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

For approval

Attachments

7.2 SBAR Risk Management Framework.pdf

7.2 608 - Risk Management Framework August 2025.pdf

7.2 EqIA Screening form RM Framework August 2025.pdf

7.2 SBAR Risk Management Strategy.pdf

7.2 Risk Management Strategy August 2025.pdf

7.2 EqIA Screening form RM Strategy August 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:	12 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Risk Management Framework
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)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Audit and Risk Assurance Committee (ARAC) is requested to endorse the revised Risk Management Framework (the Framework) prior to its submission to the Board for approval on 25 September 2025.

Cefndir / Background

Risk Management is the process which aims to help organisations understand, evaluate and take action on all their risks with a view to increasing the probability of success and reducing the likelihood of failure (Institute of Risk Management). It forms part of the overall governance framework of the organisation.

The scope of a framework is the risk architecture, strategy and protocols. The risk architecture sets out the roles and responsibilities of the individuals and committees that support the risk management process. The risk strategy should set out the objectives that risk management activities are seeking to achieve, and the risk protocols describe the procedures by which the strategy will be implemented and risks are managed. This is built around and supports the risk management process.

This is consistent with the concept of the risk management framework described in ISO 31073 which is a generic risk management standard, provides principles, framework and a process for managing risk, and can be used by any organisation, regardless of size, activity or sector).

The Strategy needs to be read in conjunction with the Risk Management Framework, which was approved by the Board in July 2022, and due for review concurrently with the Strategy in September 2025.

The Framework will help provide the mandate for embedding risk reporting in the Health Board by clearly setting out roles and responsibilities of both individuals and committees in one document.

Asesiad / Assessment

The Framework focuses on the risk architecture, the roles, responsibilities, communication and risk reporting arrangements that support the risk management process, by clearly setting out roles and responsibilities of both individuals and committees in one document. The Framework also includes the process for escalation of risk, and acceptance of risks which exceed the Health Board's risk appetite.

Feedback has also been incorporated, where appropriate, from the recent global consultation on the Framework which ran from 22 July - 5 August 2025.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is requested to **APPROVE** the Risk Management Framework, prior to its submission to the Board for onward ratification on 25 September 2025.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1 The Committee shall review the adequacy of the UHB's strategic governance and assurance arrangements and processes for the 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) that supports the achievement of the organisation's objectives.
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:	6. All Apply

Quality and Engagement Act (sharepoint.com)	
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:	Legislation and national policy. ISO 31000, 2018 ISO Guide 73, 2009
Rhestr Termau: Glossary of Terms:	Explanation of terms is included within the body of the policies appended.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	As detailed in the assessment

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Staff accessing written control documentation which is out of date, no longer relevant or contradicts current guidance may have a negative effect on the quality, safety and experience of care. It may also lead to unwarranted variation in care delivery
Gweithlu: Workforce:	Not applicable
Risg: Risk:	The presence of written control documentation on the intranet, outside of the Policies, Procedures and other Written Control Documentation intranet webpage, may result in staff accessing documents which are out of date, no longer relevant, or contradicting current guidance.

Cyfreithiol: **Legal:**	It is essential that the HDdUHB has up to date policies and procedures in place.
Enw Da: **Reputational:**	Not applicable
Gyfrinachedd: **Privacy:**	Not applicable
Cydraddoldeb: **Equality:**	An equality impact assessment has been undertaken for the policies.

Risk Management Framework

Policy information

Policy number: 608
Classification: Corporate
Supersedes: Previous versions
Version number: *3.0*
Date of Equality Impact Assessment: 30/06/2025

Approval information

Approved by: Public Board
Date of approval: TBC
Date made active: TBC
Review date: TBC

Summary of document:
This document aims to set out the components that provide the foundation and organisational arrangements for supporting risk management processes in Hywel Dda UHB.

Scope:
This framework applies to all UHB staff, contractors and other third parties working within the UHB. Managers at all levels within the UHB must take an active lead to ensure that risks are managed effectively and that a risk aware culture across the UHB is facilitated / maintained.

To be read in conjunction with:
156 - Risk Management Strategy and Policy (opens in a new tab)
674 - Risk Assessment Procedure (opens in a new tab)

Patient information:
N/A

Owning group:
Audit and Risk Assurance Committee (ARAC)

Executive Director job title:
Chief Executive

Reviews and updates:
1.0 – New Policy
2.0 – Full Review including additional risk escalation process
3.0 – Full Review

Keywords
Risk, Risk Management, Risk Management Framework

Glossary of terms
UHB - University Health Board
RASP - Risk Architecture, Strategy and Protocols
BAF - Board Assurance Framework
CRR - Corporate Risk Register
CEO - Chief Executive Officer
ARAC - Audit and Risk Assurance Committee
RM - Risk Management
SRO - Senior Reporting Officer
QSEC - Quality, Safety and Experience Committee

Term	Definition
Risk	The effect of uncertainty on objectives. Note that an effect is a deviation from the expected. It can be positive, negative or both, and can address, create or result in opportunities and threats. (International Organisation for Standardisation (ISO) 31073, 2022)
Risk management	The process which aims to help organisations understand, evaluate and take action on all their risks with a view to increasing the probability of success and reducing the likelihood of failure. (The Institute of Risk Management)
Risk management framework	Set of components that provide the foundations and organisational arrangements for designing, implementing, monitoring, reviewing and continually improving risk management processes throughout the organisation. (ISO Guide 73, 2009)
Risk appetite	The amount and type of risk that an organisation is willing to pursue or retain (ISO 31073, 2022)
Risk tolerance	The organisation's readiness to bear the residual risk in order to achieve its objectives. (ISO 31073, 2022)
Risk acceptance	An informed decision to take a particular risk. Risk acceptance can occur without risk treatment or during the process of risk treatment. Accepted risks are subject to monitoring and review. (ISO 31073, 2022)
Risk owner	Person or entity with the accountability and authority to manage risk. (ISO 31073, 2022)
Risk exposure	The level of risk that the organisation is exposed, either in regard to an individual risk or the cumulative exposure to the risks faced by the organisation
ISO 31073, 2022	Generic risk management standard, which provides principles, definitions, framework and a process for managing risk, which can be used by any organisation, regardless of size, activity or sector

ISO Guide 73, 2009	Provides the definitions of generic terms related to risk management.
Hazard risks	“Pure” risks facing the organisation, which result in negative outcomes and disrupt normal operations / service delivery
Opportunity risks	Risk that is associated with the benefit of speculative opportunities

Contents

Introduction

The Institute of Risk Management defines risk management as 'the process which aims to help organisations understand, evaluate and take action on all their risks with a view to increasing the probability of success and reducing the likelihood of failure'. Risk management has become increasingly more important due to high profile corporate failures, increasing stakeholder expectations, and the impact of global events such as COVID-19. As well as supporting better decision making and improved efficiency, risk management can also provide greater assurance to stakeholders that concerns are being managed and mitigated as effectively as possible.

Any risk management initiative must add value to the organisation. Risk management activities should be designed to achieve the best possible outcomes and reduce the uncertainty of these outcomes. A successful risk management process (and framework) should be:

- **P**roportionate to the level of risk within the organisation;
- **A**ligned to other business activities, e.g. planning;
- **C**omprehensive, systematic and structured;
- **E**mbedded within business procedures and protocols;
- **D**ynamic, iterative and responsive to change.

Risk management should be embedded into the University Health Board's (UHB) business and strategic planning, change management processes, day to day operations, and compliance activities. If used successfully, 'risk management enhances strategic planning and prioritisation, assists in achieving objectives and strengthens the ability to be agile to respond to the challenges faced.' (The Orange Book, 2023).

Policy statement

This policy aims to set out the components that provide the foundation and organisational arrangements for supporting risk management processes in Hywel Dda UHB (the UHB).

Scope

This framework applies to all UHB staff and Independent Members, contractors, other third parties working within the UHB and those who work in partnership with the UHB. All managers, (working in both Clinical Care Groups and Executive Functions) must take an active lead to ensure that risks are managed effectively and drive the development of a risk aware culture within the UHB.

Aim

The aim of this document is to:

- set out the components that provide the foundation and organisational arrangements for supporting risk management processes in the UHB.

The overall aim of risk management is to:

- Ensure conformity with applicable rules, regulations and mandatory obligations;
- Provide assurance to the Board and the Audit and Risk Assurance Committee (ARAC) that risk management and internal control activities are proportionate, aligned, comprehensive, embedded and dynamic;
- Support decision-making through risk based information; and
- Provide effective and efficient strategy, operations and compliance activities.

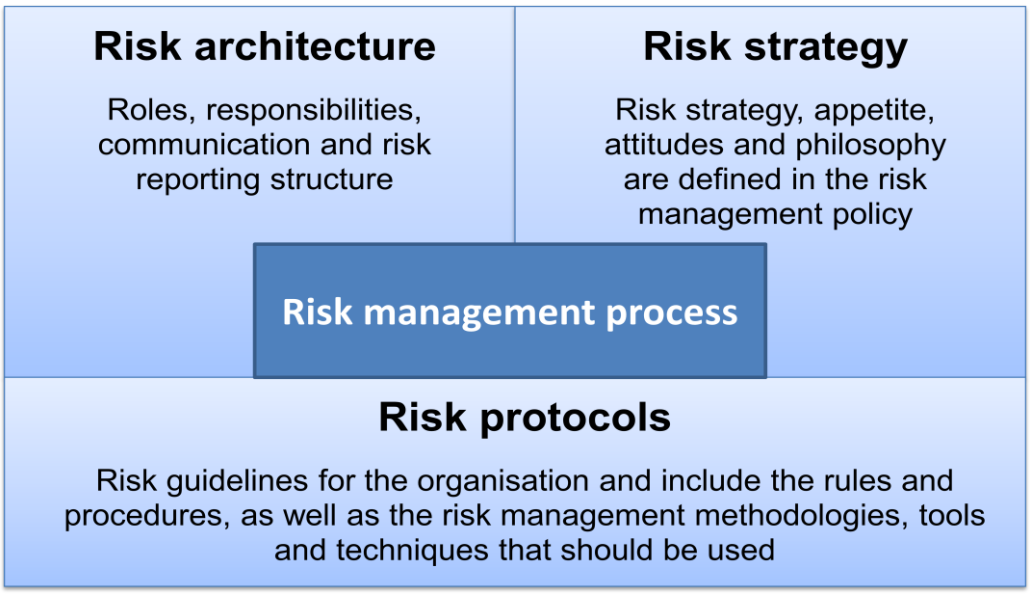
Objectives

The aim of this document will be achieved by the following objectives:

- Managers and staff to be aware of this policy and its implications and adhere to its principles in carrying out their duties.

Risk Management Framework

An organisation will describe its framework for supporting risk management by way of the risk architecture, strategy and protocols (RASP) that it is built around and supports the risk management process. It sets out the roles and responsibilities of individuals and committees that support the risk management process. The risk strategy should set out the objectives that risk management activities are seeking to achieve, and the risk protocols describe the procedures by which the strategy will be implemented, and risks are managed.

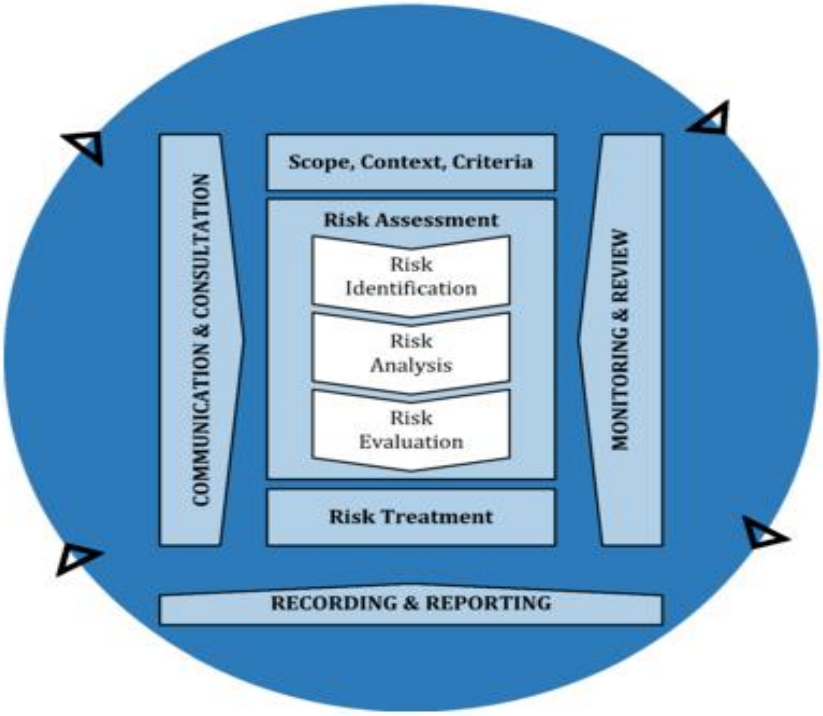


Fundamentals of Risk Management (2020)

Risk Management Process

Risk management should be a continuous process that supports the development and implementation of the strategy of the UHB. It should methodically address all the risks associated with all the activities of the UHB (including the influence of external factors (e.g. third party partnerships)), such as strategy, operational activities and compliance with legislation/standards. This will include identifying the potential for events that constitute threats to success, opportunities for benefit or an increased degree of uncertainty.

The risk management process can be presented as a list of coordinated activities as illustrated below:



(ISO 31000, 2018)

The primary reason for undertaking risk assessments is to ensure that current controls can be validated, and the need for any further actions (risk treatment) to improve control of the risk can be identified. Controls are what the organisation has in place which makes a risk less likely to occur, or able to mitigate should the risk materialise, i.e. people, processes, systems, policies, etc.

The aim of risk management is not necessarily to remove risk altogether, but to manage risk to an acceptable level, considering the cost of minimising the risk and reducing risk exposure.

Risk Registers

The risk management process is recorded via the Datix Risk Module which generates risk register reports. A risk register provides an agreed, standardised approach to recording of the significant risks that have been identified through the risk assessment process, ownership of those risks, and serves as a record of the control activities that are currently undertaken to manage or mitigate the risk. It also provides a record of the additional actions proposed to improve the 'control' of the risks (i.e., to treat the risk further), including responsibility and timescales for implementation. The Datix Risk Module generates risk registers for reporting at different levels (Principal, Corporate and Operational), as well as the reporting of similar types of risks for oversight by specialist areas and functions within the UHB via themed risk registers.

All recorded risks on Datix are exported to the UHB Risk Performance Dashboard on a fortnightly basis. The UHB Risk Performance Dashboard offers all managers a more dynamic and accessible way of reviewing risks and provides reliable performance data in an easily accessible format using Power Business Intelligence (BI). It also allows staff from across the organisation the ability to view a summary of the UHB's risk profile.

A well-constructed and dynamic risk register is at the heart of a successful risk management process. In order for risk management to be effective and make a significant contribution to the organisation, risk registers need to become a document that drives changes and improvements. Therefore, it can sometimes be better to think of the risk register as a 'risk management action plan'.

Risk registers are used to provide assurance that risks are being managed appropriately and effectively. This is undertaken through formal monitoring and scrutiny processes by the UHB's Committee structure who will seek assurance on behalf of the Board (see section 'Committee Duties and Responsibilities (2nd line of defence)'

Risks can be recorded on different levels of risk registers depending on the type and severity of risk, as per the following sections below:

- Board Assurance Framework (BAF) via the Principal Risk Register;
- Corporate Risk Register (CRR);
- Operational Risk Register (ORR); and
- Project/Programme Risk Registers

Board Assurance Framework (BAF)

The BAF enables the Board to focus on those risks (referred to as principal risks) which may compromise the achievement of strategic objectives. The BAF provides a structure and process to enable the organisation to focus on its principal risks. It will also highlight any key controls that have been put in place to manage the risk, sources of evidence or assurance, and any gaps which require further action. The BAF is more than a risk register, as it provides evidence through 'assurance' on the achievement of the UHB's strategic objectives. It should support effective decision-making and inform Board agendas, in addition to providing assurance on the system of internal control.

The Executive Team has responsibility to discuss and agree the BAF and any amendments, to ensure there is appropriate scrutiny and challenge of principal risks prior to the BAF being submitted to the Board. This will include:

- Ensuring existing principal risks have been updated by the risk owners and reflect the current position;
- Considering closure or de-escalation of any principal risks to operational risk registers; and
- Agree the submission of any new principal risks.

It is in the interests of the Executive Team to work collectively to manage these principal risks to ensure that strategic objectives are delivered within the agreed timescales, thus increasing the UHB's probability of success and reducing the likelihood of failure.

Principal risks are closely aligned to the UHB planning process to ensure the Board is aware of the risks to achieving objectives when approving its plan.

The Board has delegated some of its role of scrutiny of the assurances on the BAF to its Committees to make the most appropriate and efficient use of expertise. Therefore, Committees must ensure that assurance reports relevant to the principal risks are received and scrutinised, and an assessment made as to the level of assurance it provides, taking into account the validity and reliability (i.e. source, timeliness, methodology behind its generation and its

compatibility with other assurances). This enables the Board to place greater reliance on assurances if they are confident that they have been robustly scrutinised by one of its Committees. It also provides Board with greater confidence about the likely achievement of strategic objectives, as well as providing a sound basis for decision-making. It is the role of Committees to challenge where assurances, in respect of any component, are missing or inadequate. Any gaps are escalated to the Board.

Corporate Risk Register (CRR)

The CRR is a log of significant risks that have been identified from a top-down and bottom-up approach. These are significant risks that affects the organisation's ability to achieve its planning objectives, and significant operational risks affecting the delivery healthcare services in the 'here and now'. The Executive Team is responsible for approving the escalation of operational risks on the CRR, and subsequent de-escalation/closure of risks on the CRR (see appendix 1 and appendix 2).

Whilst each Director will be responsible for the ownership of risk(s) and identifying current controls and developing action plans, it will be the role of Executive Team at its Formal Executive Team meetings, to review controls and ensure appropriate action plans are in place, which might include the development and agreement of corporate risk management strategies to manage risk(s). It will also be the role of the Executive Team to recommend to the Board the 'acceptance' of those risks that cannot be brought within the Board's risk appetite through the CRR report and/or Committee update reports to Board. The Board must be provided with assurance that everything that can be done, has been done to reduce the risk and that there are effective plans and controls in place to manage the situation should the risk materialise. This will help limit damage, control loss and contain costs for the UHB. Whilst a risk may be accepted by the Board, the risk owner must ensure that the current control measures are regularly reviewed to ensure they remain effective. This process is outlined in appendix 4.

The Executive Team should use risk information, including discussions from Committees, to inform the prioritisation of resources and decision-making, i.e. by ensuring risk information is fed into different business processes within the UHB such as capital planning, budget planning, workforce planning etc.

Each risk on the CRR has been mapped to a Board level Committee to ensure that risks on the CRR are managed appropriately, taking account of gaps, planned actions and tolerances, and provide assurance to the Board through their update report to the Board on the management of these risks. The Executive Risk Owner is responsible for discussing acceptance of risk above UHB risk appetite with the Executive Team, before being presented to the relevant Committee for discussion and recommendation to Board for approval.

Operational Risk Registers (ORR)

The ORR should include risks associated with:

- the achievement of Clinical Care Group (CCG) or Executive Function objectives;
- the day-to-day operation of the CCG or Executive Function, i.e., delivering a safe and sustainable service for patients; and
- any legislation or standards that the CCG or Executive Function should be compliant with.

Operational risks are mostly identified from a bottom-up approach. The Executive Risk Owner is responsible for presenting any operational risks to the Executive Team for approval for inclusion on to the CRR (see appendix 1). Additionally, the Executive Risk Owner is responsible for agreeing in principle, the acceptance of any operational risks above the UHB risk appetite, where the risk treatment is proposed to be amended to "Tolerate" from "Treat". The Executive Team is responsible for endorsing this, prior to presentation to the relevant Committee for recommendation to the Board.

Risks identified within operational risk registers are aligned by the management leads to a formal Committee or Sub-Committee, which will provide assurance through the parent Committee (e.g., QSEC) to the Board that operational risks are being identified, assessed and managed effectively. Further details can be found in the section on 'Board Committees' and 'Sub-Committees' below.

Project/Programme Risk Registers

Every project or programme should maintain a risk register. Those projects or programmes managed through the organisational project and programme management tool have risk registers included by default, on which risks to that project or programme can be reported before being transferred or managed. Project risk management is concerned with the risks embedded within delivery of the project or programme (i.e. delivering the project or programme on time, within budget and within specification), and aims to reduce the variance between anticipated outcomes and actual results.

A project risk register should be populated and updated regularly throughout the duration of the project and should help prioritise risk management activity. Project/programme risks are managed/reviewed outside of the Datix system by the relevant Senior Responsible Officer (SRO). Risks are reported through project group risk registers, and other groups with responsibility for project oversight (e.g. Capital Sub Committee), to provide assurance on the management of the risks and the delivery of relevant capital and digital projects funded by discretionary and all Wales capital. Where a project/programme has the ability to impact on operational activity i.e. business continuity, these should be reported within the project risk register for the SRO and transferred to Datix before being recorded as closed, to ensure that all risks are captured and managed appropriately.

Risk Escalation

Risks should be managed by the risk owner, or the person appointed by the risk owner. However, there may be circumstances where the ability to manage a risk may exceed the authority of the risk owner. Circumstances which may lead to risks being escalated may include:

- Risks that exceed the organisation's risk appetite, and there is nothing further that the risk owner can do to reduce it to within accepted levels (risk tolerance). This is based on the target risk score to demonstrate the lowest level of risk exposure that the UHB is prepared to accept following the completion of all planned actions aligned to a risk;
- Risk treatments are outside of the delegation of the risk owner; or
- A risk shared by other areas of the organisation where risk treatment cannot be agreed.

Where significant risks have been identified which are deemed challenging to manage, consideration should be given for the escalation of these risks to the next level of responsibility

for additional risk action. A risk may be considered for escalation to corporate level if it has the potential to significantly impact on:

- the delivery of safe services;
- the UHB's ability to deliver short to medium term objectives (in-year delivery);
- the UHBs ability to remain within its financial allocation;
- the reputation of the UHB, particularly in relation to stakeholder and public trust; or
- the operational areas' ability to delegate authority or resources to manage the risk effectively.

The above can often be identified when a risk has either an extreme or high target risk score (TRS), which is used to demonstrate the lowest level of risk exposure that the UHB is prepared to accept following the completion of all planned actions, or where progress in managing the risk has been limited or unsuccessful, or may be reliant on external factors in order to further progress. In essence, escalation should be considered when the risk is too significant, complex or impactful for the Clinical Care Group / Executive Function to address appropriately and within its means.

Any risk which requires escalation to corporate level requires the endorsement in the first instance of the Clinical Care Group Director / Executive Function lead via local governance arrangements ahead of approval by the relevant Lead Executive and the wider Executive Team.

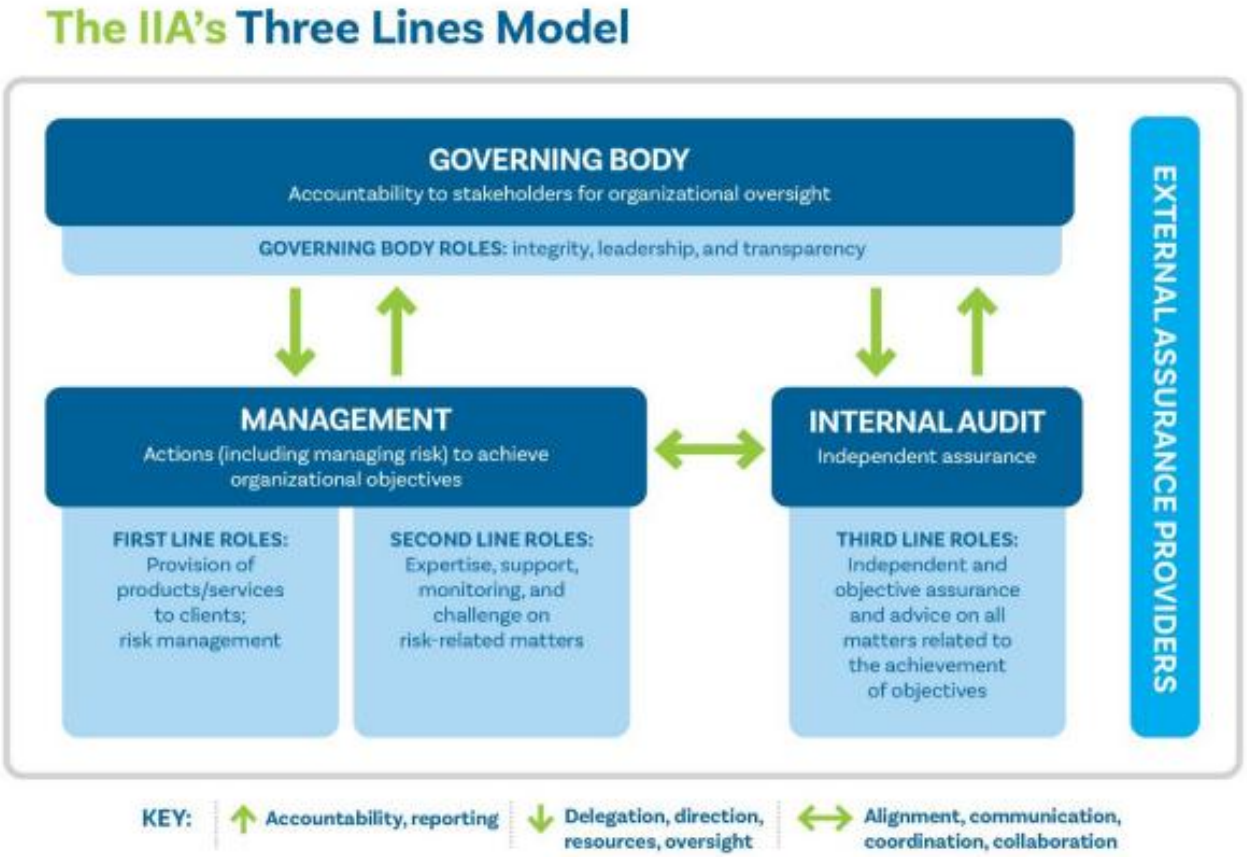
- Further guidance on risk escalation, which has been approved by the Executive Team, is outlined in appendix 1 and appendix 2.

Risk Architecture

Risk architecture is the organisational arrangements for risk management detailing the roles, responsibilities and the lines of communication for reporting on risk management.

The Three Lines of Defence Model

The UHB operates a 'Three Lines' model, with the diagram below outlining the principles for the roles, responsibilities and accountabilities for risk management:



(IIA, 2024)

In the 'Three Lines of Defence' model, management control is the first line of defence in risk management. The various risk control and compliance oversight functions established by management are the second line of defence, and independent assurance is the third. Each of these three "lines" plays a distinct role within the UHB's wider governance framework. All three lines need to work interdependently to be effective.

The Board has responsibility and accountability for setting the organisation's objectives, defining strategies to achieve those objectives, and establishing governance structures and processes to best manage the risks in accomplishing those objectives.

These roles and responsibilities are further outlined in section 'Individual Responsibilities (1st line of defence)' to section 'Internal Audit (3rd line of defence)' below.

Responsibilities

Individual Responsibilities

Risk management is the responsibility of all staff. The following sections define the expectations of particular roles.

Chief Executive Officer

The Chief Executive Officer (CEO), as Accountable Officer, is responsible for systems of internal control and implementing the policies set by the Board. The CEO also has overall accountability for risk management within the UHB and as such is responsible for the annual signing of the Accountability Report including the Governance Statement, as well as devolving

responsibility for the management of risk to relevant Executive Directors in accordance with the scheme of delegation.

Director of Corporate Governance / Board Secretary

The Director of Corporate Governance / Board Secretary is the delegated lead for ensuring that the UHB has an effective risk management framework in place to inform planning and decision-making within the UHB.

Assistant Director of Assurance and Risk

The Assistant Director of Assurance and Risk will support the Director of Corporate Governance / Board Secretary to ensure that the UHB has an effective risk management framework in place and is responsible for:

- Developing and maintaining the BAF and the CRR for the Board;
- Facilitating a risk-aware culture within Hywel Dda UHB;
- Developing the risk management framework and strategy;
- Developing the risk appetite statement and acceptable risk tolerance levels;
- Undertaking an annual assessment of the UHB's risk maturity; and
- Ensuring risks are reported, monitored and scrutinised by the Board and its Committee structure.

Head of Assurance and Risk

The Head of Assurance and Risk is responsible for the development of an effective risk management process and framework. The Head of Assurance and Risk will support the Assistant Director of Assurance and Risk with the responsibilities listed in section 'Assistant Director of Assurance and Risk' above, as well as:

- Implementing the risk management framework and strategy, including the risk appetite and tolerance levels across the organisation;
- Establishing and implementing internal risk procedures and guidelines;
- Co-ordinating risk management activities;
- Strengthening operational risk management arrangements; and
- Providing training, information and support to staff and managers.

Executive Directors

Executive Directors have responsibility for the ownership and management of principal (strategic) risks and operational risks within their portfolios. These responsibilities include:

- Promoting a risk-aware culture within their directorate;
- Identifying strategic (principal) risks associated with the delivery of strategic objectives;
- Identifying new and escalating risks for inclusion on the corporate risk register;
- Ensuring there are processes in place within their Directorate to
  - Approve risks emerging from CCGs and Executive Functions to be included on the relevant risk register(s);
  - Oversee the co-ordination, updating and validation of risk registers from CCGs and Executive Functions within their areas of responsibility;
  - Communicate and monitor risks within their directorates; and
  - Ensure that risk management processes are managed in accordance with the UHB Framework

Lead Executive Directors, as risk owners, are responsible for managing risks to an acceptable level and if this is not possible, to report the acceptance of risk above the UHBs risk appetite to the Board, or appropriate Board level Committee, depending on the level of the risk (See appendix 1).

Managers

Managers, working within both CCGs and Executive Functions, are to take the lead on risk management and set an example through visible leadership of their staff. These responsibilities include:

- Taking responsibility for managing risk;
- Ensuring that risks are assessed that are:
  - Identified within the working activities carried out within their management control;
  - Identified within the environment within their control; and
  - Reported from the staff within their management control.
- Identifying and managing risks that cut across delivery areas;
- Discussing risks on a regular basis with staff and through discussions at meetings and via local governance arrangements to help improve knowledge about the risk faced, increasing the visibility of risk management and moving towards an action focussed approach;
- Ensuring risks are entered promptly on the UHB's risk management system, and updated regularly, to a high standard and appropriately acted upon;
- Communicating downwards what the top risks are;
- Reporting and escalating risks from the front line;
- Linking risk to discussions on finance, and stopping or slowing down non-priority areas or projects to reduce risk as well as staying within budget, demonstrating a real appetite for setting priorities;
- Ensuring staff are suitably trained in risk management and are clear on their responsibilities;
- Monitoring mitigating actions and ensuring action owners are clear about their roles and what they need to achieve;
- Ensuring that people are not blamed for identifying and escalating risks, and fostering a culture, which encourages them to take responsibility in helping to manage them;
- Ensuring that risk management is included in appraisals and development plans where appropriate; and
- Ensuring the adoption, implementation and operation of the risk management framework across their work area.

Staff

All staff are responsible for:

- Identifying and reporting hazards, risks and opportunities they may encounter within the working activities and environment:
  - To their manager if the hazard, risk or opportunity is within their department;
  - To another manager if outside their department.
- Reporting incidents and near misses;
- Ensuring visitors and contractors comply with procedures; and
- Contributing to the management of risks and opportunities within the scope of their activities and environment.

Specialist Risk Management Functions

These functions provide part of the second line of defence in respect of managing risks. The second line of defence consists of activities covered by several components of internal governance and relate to a number of functions within the UHB such as health and safety, workforce, finance, risk management, quality and digital services. These are the subject matter experts who provide the tools, information, knowledge and support to assist the first line of defence (operational management) to manage risks.

This line of defence monitors and facilitates the implementation of effective risk management practices by operational management and assists risk owners in reporting adequate risk related information up and down the organisation. These are usually management functions that may have some degree of objectivity, however, are not entirely independent from the first line.

Independent Members

Independent Members have an important role in risk management within the UHB. This role is restricted to seeking assurance on the robustness of processes and the effectiveness of controls through constructive, robust and effective challenge to Executive Directors and senior management. It is not appropriate for Independent Members to be involved in the management of individual risks, but to understand and question risk on an informed and ongoing basis.

Additionally, Independent Members chair Board level committees, and in line with the relevant committee Terms of Reference, which provide assurance to the Board that risks within its remit are being managed effectively by the risk owners, and report any areas of concern, to the Board.

Committee Duties & Responsibilities

Effective risk management requires a reporting and review structure to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place. Appendix 3 sets out process for monitoring risks through Board & Committee Structure.

The Board

The Board maintains overall accountability for effective risk management, and has responsibility for the following key duties:

- Approving the UHB's framework and strategy for risk and assurance;
- Proactively determining and refreshing its risk appetite to underpin strategy, decision making and the allocation of resources, and ensure the right focus on risk management and reporting within the organisation;
- Setting the UHB's tolerance for risk and deciding what level of risk is acceptable;
- Agreeing strategic objectives and seeking assurance on the management of associated risks included in the BAF, reviewing its achievement against these objectives, and using this Framework as a dynamic tool to drive the board agenda;
- Reviewing the principal risks set out in the BAF, and those risks above tolerance in the risk categories for which the Board has agreed the lowest risk tolerance; and
- Regularly receive assurance that principal and corporate risks are effectively managed.

The behaviour and culture of the Board are key determinants of the Board's performance. Independent Members and Executive Directors must constructively challenge each other in respect of risk to enable the UHB to maximise its opportunities and manage any threats to the achievement of its purpose, aims and objectives. The Board should have it in mind that it is

the first line regulator on behalf of the public, and should be confident at all times that they understand and are alerted to any significant failures in controls or gaps in assurance (NHS Confederation, 2009).

The Board's assesses its risk management maturity, and how to strengthen it, as part of the Board's annual maturity assessment.

The Audit and Risk Assurance Committee

The Audit and Risk Assurance Committee (ARAC) is responsible for overseeing risk management processes across the organisation, and seeks assurance that:

- Effective systems are in place to manage risk;
- An effective framework of internal controls is in place to address risks; and
- The effectiveness of the framework is regularly reviewed.

The Committee is responsible for monitoring the assurance environment and challenging the build-up of assurance on the management of key risks across the year, to ensure that the Internal Audit Plan is based on providing assurance that controls are in place, and can be relied on and reviewing the internal audit plan in year as the risk profiles change. The Committee will also take on responsibility for considering and recommending to the Board approval of the Risk Management Framework.

The Board receives annual reports on Committee's activities to provide assurance that Committees have reviewed risks that are aligned to them to ensure that they are being managed appropriately and that the risk management framework and process is effective.

Board Committees

Board Committees are responsible for:

- Seeking assurance on the management of corporate risks, and providing assurance to the Board that risks are being managed effectively, and to report any areas of significant concern, e.g., limited assurance, where risk appetite is being exceeded, lack of action etc;
- Review corporate and operational risks over tolerance and where appropriate, recommend the acceptance of risks that cannot be brought within the UHB's risk appetite;
- Identify through discussions any new or emerging risks, ensuring these are assessed by management;
- Signpost any risks out of its remit to the appropriate Committee;
- Utilise risk registers to inform meeting agendas to seek assurance on management of risks and the systems in place to provide assurance;
- Receive assurance through Sub-Committee Update Reports and other management group reports that risks relating to their areas are being effectively managed; and
- Provide annual reports to ARAC on the effectiveness of management of risks within its remit.

Sub-Committees

Sub-Committees are responsible for:

- Scrutinising appropriate operational risks over tolerance within their remit either tvia standard operational risk reports, through reports from services, or assurance reports requested by the Sub-Committee;
- Gaining assurance that the risks are being appropriately managed, effective controls are in place and planned additional controls are being implemented;

- Identifying, through discussions, new risks emerging risks and ensure these are assessed by management;
- Providing assurance to the parent committee that risks are being managed effectively and report risks which have exceeded tolerance through Sub-Committee Update Reports;
- Signposting any risks out of its remit to the appropriate UHB Committee or Sub-Committee; and
- Using risk registers to inform meeting agendas;

Executive Team

The Executive Team collectively share responsibility for agreeing the risks on the CRR and the BAF prior to submission to the Board, to ensure there is appropriate scrutiny and challenge of principal risks, the current controls and assurances and the actions to address any gaps in these. The Executive Team have a pivotal role as a second line of defence, to determine risk management strategies for the more challenging risks that threaten the UHB's operations.

It is also the role of the Executive Team to agree that risks are being managed to an acceptable level, balancing priorities, resources and the risk to the UHB, and recommend this course of action to the Board. The Board must be provided with assurance that everything that can be done, is being done, to reduce the risk, and that there are effective plans and controls in place to manage the situation should the risk materialise. This will help limit damage, control loss and contain costs for the UHB.

Whilst a risk may be accepted by the Board, the risk owner must ensure that the current control measures are regularly reviewed to ensure they remain effective and efficient. This process is outlined in Appendix 4.

The Executive Team will use risk information to inform prioritisation of resources, improve the decision-making process and feed into different business processes, i.e. IMTP/annual planning, budget planning, capital planning, etc.

Operational Risk Management Arrangements

All CCGs and Executive Functions must have the necessary arrangements in place to ensure good governance, quality, safety and risk management. This includes the:

- Identification, assessment and control of risks;
- Preparation and maintenance of an up-to-date operational risk register;
- Monitoring and review of operational risks, including the controls, management actions and linked risks, in line with guidance, and the appropriate escalation of risks via local governance arrangements where risks are unable to be managed and mitigated within the UHBs risk appetite;
- Communication of risk information to relevant parties, e.g. those who are impacted or those responsible for using the controls; and
- Use of operational risk registers to inform decision-making and allocation of resources.

Internal Audit

The relationship between risk management and Internal Audit is critically important. Risk management is concerned with the assessment of risk and the identification of existing and additional controls whereas it is Internal Audit's role to evaluate these controls and test their efficiency and effectiveness. Internal Audit are the 3rd line of defence and should maintain

independence from the management of risks. Evaluation of controls is undertaken through the Internal Audit programme of work. The Head of Internal Audit will:

- Provide an overall opinion each year to the Accountable Officer of the organisation's risk management, control and governance, to support the preparation of the Governance Statement;
- Focus the internal audit work on the significant risks, as identified by management, and auditing the risk management processes across the organisation;
- Audit of the organisation's risk management, control and governance through operational audit plans in a way which affords suitable priority to the organisation's objectives and risks; and
- Provide assurance on the management of risk and improvement of the organisation's risk management, control and governance by providing line management with recommendations arising from audit work.

Risk Strategy

The UHB has a Risk Management Strategy in place that sets out its risk management policy statement, its current risk appetite and objectives in respect of risk management.

The Board is responsible for approving the Risk Management strategy and is available on the UHB website and staff intranet site via the following link:

https://hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/policies/risk-management-strategy-and-policy/ (opens in a new tab)

Risk Protocols

Risk protocols are the means by which the risk management strategy and architecture are delivered in practice and are the operational procedures and practices to put into effect the full range of activities within the risk management framework.

There is an information portal on the staff intranet https://nhswales365.sharepoint.com/sites/HDD_Corporate_Governance/SitePages/Risk.aspx (opens in new tab) where the following procedures, guidance, tools and templates can be accessed:

- Risk Strategy and Policy
- Risk Management Process
- Risk Assessment Procedure and flowchart
- Risk Scoring Matrix
- Risk Assessment Form

Training

Knowledge of how to identify, assess and manage risk is essential to the successful embedding and maintenance of effective risk management.

Specific training is provided to the Board and included as part of the Board's development programme.

Risk management training is provided to staff who are responsible for entering and managing risks on the Datix Risk Module by the Assurance and Risk Team.

Managers are required to assess the training needs of their staff regularly and specify the level of training staff require. This can be:

- Basic risk management awareness including risk assessment and the use of Datix; and
- Management of risk for risk owners and/or risk management leads.

A copy of the Risk Management Training Needs Analysis is included in Appendix 5.

Review of the effectiveness of the Risk Management Framework

The UHB's risk management arrangements are reviewed annually as part of Audit Wales's Structured Assessment process.

The UHB also undertakes an assessment of its risk maturity, the outcomes of which are reported to ARAC via the Risk Assurance Report.

References

AcademiWales (2017) The Good Governance Pocket Guide for NHS Wales Boards. Available at: http://www.primarycareone.wales.nhs.uk/sitesplus/documents/1191/Pocket%20Guide%20for%20NHS%20Wales%20Boards%20English.pdf (opens in a new tab)

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Hopkin & Thompson (2021) Fundamentals of Risk Management: Understanding, Evaluating and Implementing Effective Enterprise Risk Management. 6th Ed. London: Kogan Page Ltd.

IIA (2013) The Three Lines of Defence in Effective Risk Management and Control. Altamonte Springs: The Institute of Internal Auditors Inc. Available at: https://na.theiia.org/standards-guidance/Public%20Documents/PP%20The%20Three%20Lines%20of%20Defense%20in%20Effective%20Risk%20Management%20and%20Control.pdf (opens in a new tab)

ISO 31000:2018(en) Risk management. Available at: https://www.iso.org/iso-31000-risk-management.html/ (opens in a new tab)

Welsh NHS Confederation (2009) The Pocket Guide to Governance in NHS Wales. Good Governance Institute. Available at: http://www.wales.nhs.uk/sitesplus/documents/1064/NHS%20Wales%20Confed%20-%20Governance%20Pocket%20Book%20FINAL%5B1%5D.pdf. (opens in a new tab)

Appendix 1 – Escalation and Acceptance of Risk above UHB Tolerance

Escalating a risk

Risks should be managed by a specified risk owner, or a person appointed by the risk owner. There may be circumstances where the ability to manage a risk exceeds the authority of the risk owner/operational team/CCG/Executive Function, or is unable to be fully managed or mitigated within their scheme of delegation. The risk management framework utilised by the UHB allows the opportunity to escalate risks from operational to corporate level.

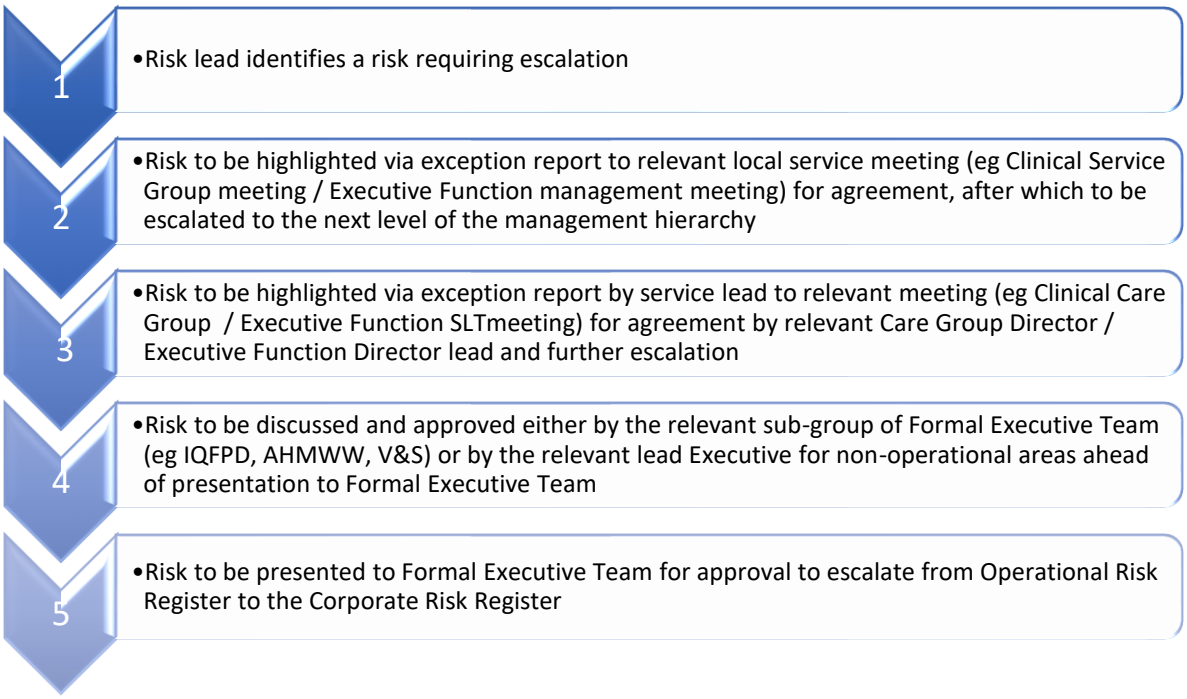
Where significant risks have been identified which are deemed challenging to manage at CCG/Executive function level, consideration should be given for the escalation of these risks to corporate level.

A risk may be considered for escalation to corporate level if it has the potential to **significantly** impact on:

- the UHB's ability to deliver safe services;
- the UHB's ability to deliver short to medium term objectives (in-year delivery);
- the UHBs ability to remain within its financial allocation;
- the reputation of the UHB, particularly in relation to stakeholder and public trust;
- the operational areas' ability to delegate authority or resources to manage the risk effectively;

Significant risks can often be identified when it has either an extreme or high target risk score (TRS), which is used to demonstrate the lowest level of risk exposure that the UHB is prepared to accept following the completion of all planned actions, or where progress in managing the risk has been limited or unsuccessful, or may be reliant on external factors in order to further progress. In essence, escalation should be considered when the risk is too significant, complex or impactful for the Clinical Care Group / Executive Function to address appropriately and within its means.

In such instances, it is the responsibility of the risk owner to escalate a risk via appropriate management structures and local governance arrangements. It will then be the responsibility of the next level of management to decide if further risk treatments can be implemented within their scheme of delegation. If this is not possible, further escalation will be required to inform decision-making on the management of the risk.



Any risk which requires escalation to corporate level requires the endorsement in the first instance of the Clinical Care Group Director / Executive Function lead via operational governance arrangements ahead of approval by the relevant Lead Executive and the wider Executive Team.

Risks that are escalated to from operational risk to corporate level) should remain within the risk profile of the relevant Clinical Care Group (CCG) / Executive Function that is responsible for the management of the risk. For example, a CCG / Executive Function may have a risk profile/register that includes risks at both corporate and operational levels.

Risks can be de-escalated when the management of the corporate risk has brought the risk within risk appetite, e.g. the risk has been reduced, the risk has been accepted above the UHB's risk appetite and there is no further benefit of higher-level oversight (see table below).

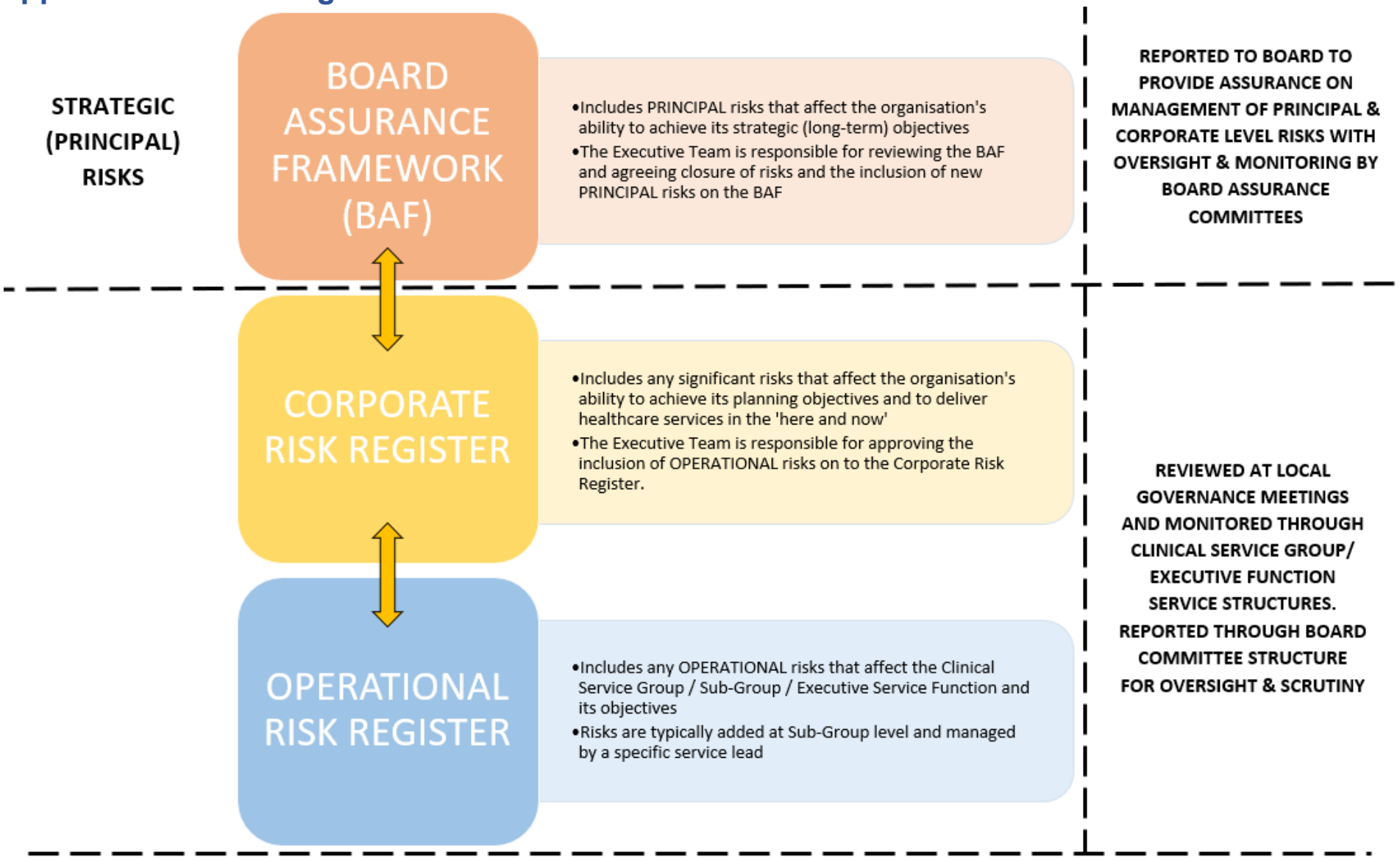
Accepting a risk

There may be circumstances where there is no alternative other than to accept a risk above the UHB's risk appetite, (for example no further actions can be taken by the UHB to reduce the risk, or it is not proportionate to reduce the risk taking into account current capacity/resources available). It is the responsibility of risk owners to highlight such risks via their local governance structures to determine if it should be considered to be formally accepted by the Board, (see appendix 4 and diagram below).

The Executive Risk Owner will recommend the acceptance of the risk to the Executive Team for specified timeframe (eg, to review the risk treatment ahead of the next round of planning), ahead of reporting to the appropriate Committee through the relevant assurance and risk report for consideration and to agree to make a recommendation to the Board to accept the risk. Once the Board agrees to accept a risk above the UHBs risk appetite, the risk decision on Datix will be changed from 'Treat' to 'Tolerate'*. The rationale and timeframe for accepting the risk will be added, as well as noting the 'Date of Decision' on Datix. Risks will remain noted as 'Tolerate' on Datix will still need to be included on risk registers and be reviewed regularly by risk owners, who will need to establish if risk treatment can be made ahead of acceptance timeframe expiring, or any further escalation required.

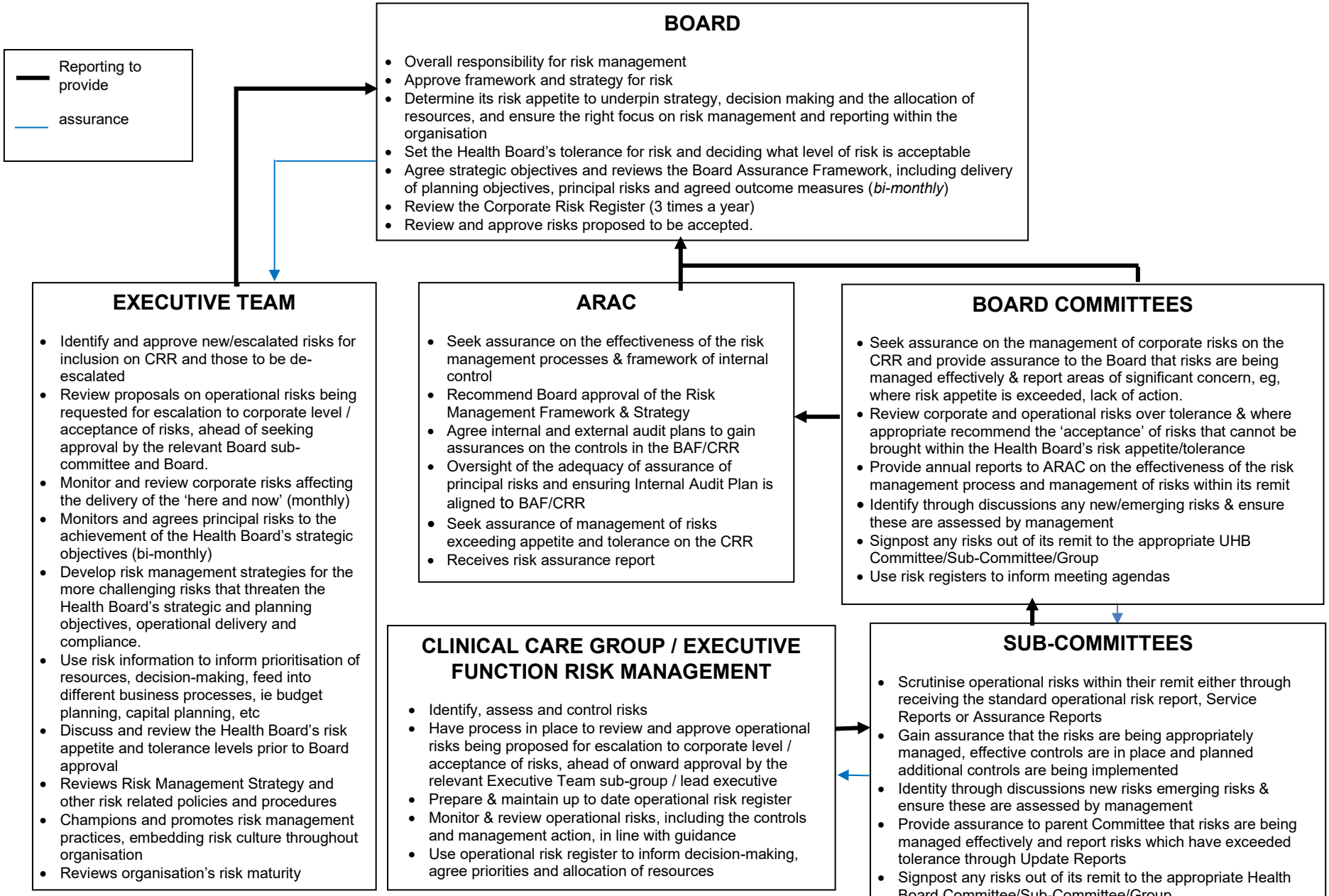
**The Datix Risk Module uses the 4Ts of risk treatment – Terminate, Treat, Tolerate, Transfer. Tolerate is a risk profession term for accepting a risk.*

Appendix 2 – Risk Registers

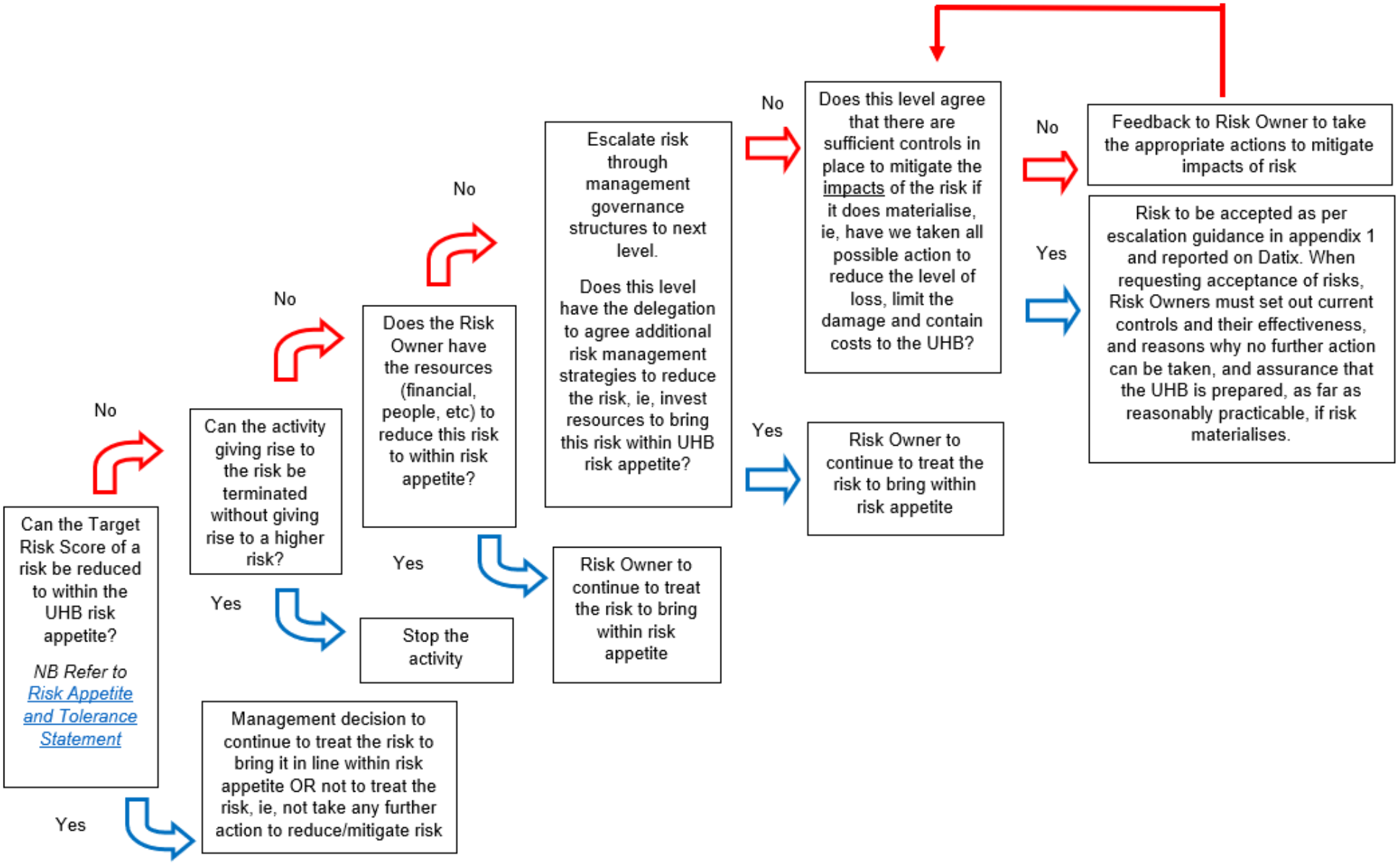


Please note: Project/programme risks are managed/reviewed outside of the Datix system by the relevant Senior Responsible Office (SRO) and are reported through project group risk registers and other groups with responsibility for oversight e.g. Capital, Estates, IM&T Sub Committee to provide assurance on capital projects.

Appendix 3 – Committee Reporting Structure



Appendix 4 – Risk Evaluation (accepting a risk)



Appendix 5 – Training Needs Analysis

Risk Management Training Needs Analysis

Name:

Date TNA Completed:

The purpose of this assessment is to help identify the appropriate level of risk management training you may require in your role within the organisation.

The levels of training that the organisation can provide is outlined below:

Risk Management Awareness	
Target Audience:	All Staff
When:	On Welcome Day or as part of local induction
Duration:	N/A
Frequency:	On commencement in organisation or new role
Format:	Checklist
Intended Outcome:	To have an understanding of: • What is risk? • What is risk management? • How to report a risk • Risk culture
If you are involved in managing a service/function, or if you are a designated risk owner, please discuss with your line manager or contact the Assurance and Risk Team for risk management training or advice at AssuranceandRisk.HDd@wales.nhs.uk.	

Risk Management Strategy & Practice	
Target Audience:	Any employees with the responsibility for undertaking risk management as part of their role. This could include, but is not limited to • Team Leaders • Service Managers • Heads of Service • General Managers • Clinical Care Group / Executive Function
When:	Prior to obtaining access to Datix Risk Module, or on commencement of an applicable new role
Duration:	90min Part 1 – 60 minutes Risk Management Strategy & Practice Part 2 – 30 minutes RL Datix Risk Module
Frequency:	One off session
Format:	Teams
Intended Outcome:	To leave the session with understanding of: Part 1 – Risk Management Strategy, Board Assurance Framework, Risk Appetite, Risk Description, Cause and Effect, Risk Grading, Hierarchy of Controls, Action Planning, Assurance, Risk Management Culture, Roles and Responsibilities Part 2 – RL Datix Risk Module

Level 3 - Board Level Risk Management Session	
Target Audience:	Board Members / Board Directors
When:	On Commencement with organisation / Refresh as part of Risk Appetite Review / Through IM Lunch and Learn Sessions as requested
Duration:	1 hour
Frequency:	At least annually to align with the review of the organisational Risk Appetite Statement
Format:	Face to Face or Teams
Intended Outcome:	To leave the session with an understanding of: • The Risk Management Strategy – what are we trying to achieve? • Board Assurance Framework/ Organisational Risk Register – purpose, approach and rationale, etc. • The risk management framework including an overview of the operational risk management approach within the organisation including escalation from service to Board • The level of assurance gained from the BAF and other risk management activity shared with the Board • Setting the tone/Risk Culture/Role of Board • Risk Appetite and Risk Tolerance levels

Now you have considered the levels of risk management training please indicate by placing a tick in the box below which session(s) would apply to you:

Level 1	
Level 2	
Board Level	

Next Steps:

Please return this form to your Line Manager and where applicable please ensure that you are booked on the relevant session within 4 weeks of completing this TNA via the following link: Assurance and Risk Training

Thank You!

Equality Impact Assessment (EqIA) Screening Template

When to complete an EqIA Screening

An EqIA Screening Template must be completed when reviewing, changing and developing procedures/ proposals/ projects/ policies. This is a first step and is used to consider whether there are any negative impacts that may arise.

Purpose of an EqIA Screening Template

The purpose of this short exercise is to ensure that you have shown appropriate due regard when considering the impact for people with protected characteristics in your decision making. The screening process is designed to help you consider the circumstances and to inform evidence-based decisions.

If the proposal is of a significant nature and it is apparent from the outset that a full EqIA will be required, then it is not necessary to complete this Screening Template, you can proceed to complete the full EqIA.

If no negative impacts are identified following completion of the EqIA screening then it is not necessary to undertake a full EqIA however, the decision and justification must be clearly recorded in this document.

On completion of the Screening Template:

- Ensure that all the white boxes within the screening are completed.
- Ensure that the Procedure/ Project/ Proposal/ Policy owner has signed and dated the Screening Template.
- Send a copy of the completed template along with the related policy or project proposal to Inclusion.hdd@wales.nhs.uk for the Diversity & Inclusion Team to review.
- Each Screening Template will be reviewed by the Diversity & Inclusion Team and feedback will be provided to the Procedure/ Project/ Proposal/ Policy owner. This may include recommendations for further action to inform robust decision-making.

Support

For further support please visit the EqIA Sharepoint or contact:
Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Director and Directorate	Director of Corporate Governance / Board Secretary Corporate Governance (CEO Office)
Service Area	Assurance and Risk

Title of Procedure, Project, Proposal, Policy being screened:	Risk Management Framework

Description of the Procedure/ Project/ Proposal/ Policy being screened (including key aims and objectives)

This document aims to set out the components that provide the foundation and organisational arrangements for supporting risk management processes in Hywel Dda.

This framework applies to all UHB staff, contractors and other third parties working within the UHB. Managers at all levels within the UHB must take an active lead to ensure that risks are managed effectively and the development of a risk aware culture within the UHB.

Evidence considered (including staff and population data, relevant research, expert and community knowledge etc.)

Those affected by the policy will include the Health Bard and its Committees, Staff (including secondees, locum and agency staff), volunteers and contractors. Health Board Partners (as defined in the Strategy & Policy) will also be affected, along with in-patients, out-patients and community service users, their families and carers. In reviewing the previously approved Risk Management Strategy, reference has been made to recognised good practice, and guidance via publicly available documentation from the Institute of Risk Management.

Assess which protected characteristics will potentially be affected by the proposal in the table below (please ✓ the relevant box to confirm positive, negative or no impact)**.**

If at any point a negative impact has been identified (actual or potential), you do not need to proceed with the completion of this form, as a full EqIA must be undertaken: Equality Impact Assessments (EqIAs) (sharepoint.com)

Age Is it likely to affect older and younger people in different ways or affect one age group and not another?					
Positive Impact	√	Negative Impact		No Impact	
Justification of impact identified: The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.					
Disability Is it likely to affect those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes?					
Positive Impact	√	Negative Impact		No Impact	

Justification of impact identified:
The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.

Gender Reassignment
Is it likely to affect those who either:

- Have undergone, intend to undergo or are currently undergoing gender reassignment.
- Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth

Positive Impact	√	Negative Impact		No Impact	

Justification of impact identified:
The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.

Marriage / Civil Partnership
Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment.
Is it likely to affect those who are married or in a Civil Partnership? This means someone who is legally married or in a civil partnership.

Positive Impact	√	Negative Impact		No Impact	

Justification of impact identified:
The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.

Pregnancy and Maternity
Is it likely to affect those who are pregnant or have recently had a baby? Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.

Positive Impact	√	Negative Impact		No Impact	

Justification of impact identified:
The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.

Race / Ethnicity
Is it likely to affect people of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers?

Positive Impact	√	Negative Impact		No Impact	

Justification of impact identified:
The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.

Religion or Belief
Is it likely to affect people who have a religion or belief? The term ‘religion’ includes a religious or philosophical belief.

Positive Impact	√	Negative Impact		No Impact	

Justification of impact identified:
The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.

Sex
Is it likely to affect people who are mostly male or female. Where it applies to both equally does it affect one differently to the other?

Positive Impact	√	Negative Impact		No Impact	

Justification of impact identified:
The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.

Sexual Orientation
Whether a person's sexual attraction is towards their own sex, the opposite sex or either.

Positive Impact	√	Negative Impact		No Impact	

Justification of impact identified:
The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.

Armed Forces Community
Consider whether this impacts on members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'

For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see:
Armed-Forces-Covenant-duty-statutory-guidance

Positive Impact	√	Negative Impact		No Impact	

Justification of impact identified:
The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.

Socio Economic Duty
Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered.

For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resources please see:
more-equal-wales-socio-economic-duty

Positive Impact	√	Negative Impact		No Impact	

Justification of impact identified:
The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery.

Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.

Welsh Language Is it likely to impact on opportunities for people to use the Welsh language? The Welsh language should be treated no less favourably than the English language.					
Positive Impact	√	Negative Impact		No Impact	
Justification of impact identified: The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.					

If a negative impact has been identified, you are not required to complete this form as a full EqIA must be undertaken. A full EqIA template and guidance can be found on the following link: Equality Impact Assessments (EqIAs) (sharepoint.com)

Screening Completed by:	Name	Rachel Williams
	Title	Head of Assurance and Risk
	Contact details	Rachel.williams61@wales.nhs.uk
	Date	05/08/2025
Screening Authorised by: (Directorate level owner of the procedures/ proposals/ projects/ policy)	Name	Charlotte Wilmshurst
	Title	Assistant Director of Assurance and Risk
	Contact details	Charlotte.Wilmshurst@wales.nhs.uk
	Date	05/08/2025
Guidance has been provided by Diversity & Inclusion Team:	Name	
	Title	
	Contact details	
	Date	
Diversity and Inclusion Team additional Comments:		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	12 August 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Risk Management Strategy
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)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Audit and Risk Assurance Committee (ARAC) is requested to endorse the revised Risk Management Strategy (the Strategy) prior to its submission to the Board for approval on 25 September 2025.

Cefndir / Background

Risk Management is the process that aims to help organisations management understand, evaluate and take action on all their risks with a view to increasing the probability of success and reducing the likelihood of failure (Institute of Risk Management). It forms part of the overall governance framework of the organisation.

The current Strategy was approved by Board at its meeting in March 2024, covering a period of 18 months.

The Strategy needs to be read in conjunction with the Risk Management Framework, which was approved by the Board in July 2022, and due for review concurrently with the Strategy in September 2025.

Asesiad / Assessment

The Strategy aims to improve the use of risk management as a tool for better decision-making, driving continuous improvements and linking these to organisational planning and performance reporting including learning and fostering a blame-free and open culture. It also supports a dynamic and systematic approach to risk management, and to ensure prompt and comprehensive identification, assessment and management of risks that threaten the delivery of its strategic objectives and day-to-day operations.

The Strategy outlines the broad aims and principles of risk management across the Health Board, and sets out the objectives the Health Board wants to achieve in respect of risk management over the next 12 months.

The objectives for 2025/26 have been informed by the outcomes of a risk maturity assessment undertaken in December 2024 in line with the Orange Book, which is a recognised risk management standard for the public sector. Progress against the objectives will be report to the Audit and Risk Assurance Committee on a six-monthly basis via the Risk Assurance Report.

Feedback has also been incorporated, where appropriate, from the recent global consultation on the Strategy which ran from 22 July - 5 August 2025.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is requested to **APPROVE** the Risk Management Strategy, prior to their submission to the Board for onward ratification on 25 September 2025.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1 The Committee shall review the adequacy of the UHB's strategic governance and assurance arrangements and processes for the 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) that supports the achievement of the organisation's objectives.
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:	Legislation and national policy. ISO 31000, 2018 ISO Guide 73, 2009
Rhestr Termau: Glossary of Terms:	Explanation of terms is included within the body of the policies appended.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	As detailed in the assessment

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Staff accessing written control documentation which is out of date, no longer relevant or contradicts current guidance may have a negative effect on the quality, safety and experience of care. It may also lead to unwarranted variation in care delivery
Gweithlu: Workforce:	Not applicable
Risg: Risk:	The presence of written control documentation on the intranet, outside of the Policies, Procedures and other Written Control Documentation intranet webpage, may result in staff accessing documents which are out of date, no longer relevant, or contradicting current guidance.
Cyfreithiol: Legal:	It is essential that the HDdUHB has up to date policies and procedures in place.
Enw Da: Reputational:	Not applicable
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	An equality impact assessment has been undertaken for the policies.

Risk Management Strategy

Policy information

Policy number: 156
Classification: Corporate
Supersedes: Previous Versions
Version number: 6
Date of Equality Impact Assessment: 01/07/2025

Approval information

Approved by:
Date of approval: Click or tap to enter a date.
Date made active: Click or tap to enter a date.
Review date: Click or tap to enter a date.

Summary of document:
The aim of this document is to set out the broad aims and principles of risk management across the UHB, and sets key targets and milestones for the next 12 months, at which point it will be refreshed.

Scope:
This strategy applies to all UHB staff, contractors and other third parties working within the UHB. Managers at all levels within the UHB must take an active lead to ensure that risks are managed effectively and that a risk aware culture across the UHB is facilitated / maintained.

To be read in conjunction with:
608 - Risk Management Framework (opens in new tab)
674 - Risk Assessment Procedure (opens in new tab)

Patient information:
Include links to Patient Information Library

Owning group:
Audit and Risk Assurance Committee (ARAC)

Executive Director job title:
Professor Philip Kloer –Chief Executive

Reviews and updates:
1.0 – New Policy
2.0 – Revised
3.0 – Full Review
4.0 - Full review

5.0 Version 5 – review
6.0 Review

Keywords
Risk, Risk Management,, Risk Management Strategy

Glossary of terms
UHB – University Health Board
BAF – Board Assurance Framework
RM – Risk Management
ARAC – Audit and Risk Assurance Committee
QSEC – Quality, Safety and Experience Committee
CEO – Chief Executive Officer
OD – Organisational Development

Term	Definition
Risk	The effect of uncertainty on objectives. Note that an effect is a deviation from the expected. It can be positive, negative or both, and can address, create or result in opportunities and threats. (International Organisation for Standardisation (ISO) 31073, 2022)
Risk management	The process which aims to help organisations understand, evaluate and take action on all their risks with a view to increasing the probability of success and reducing the likelihood of failure. (The Institute of Risk Management)
Risk management framework	Set of components that provide the foundations and organisational arrangements for designing, implementing, monitoring, reviewing and continually improving risk management processes throughout the organisation. (ISO Guide 73, 2009)
Risk appetite	The amount and type of risk that an organisation is willing to pursue or retain (ISO 31073, 2022)
Risk tolerance	The organisation's readiness to bear the residual risk in order to achieve its objectives. (ISO 31073, 2022)
Risk acceptance	An informed decision to take a particular risk. Risk acceptance can occur without risk treatment or during the process of risk treatment. Accepted risks are subject to monitoring and review. (ISO 31073, 2022)
Risk owner	Person or entity with the accountability and authority to manage risk. (ISO 31073, 2022)
Risk exposure	The level of risk that the organisation is exposed, either in regard to an individual risk or the cumulative exposure to the risks faced by the organisation

Risk culture	Risk culture is a term describing the values, beliefs, knowledge, attitudes and understanding about risk shared by a group of people with a common purpose (The Institute of Risk Management)
Risk maturity model	Structure for determining the level to which risk management is embedded within an organisation (Fundamentals of Risk Management, 2022 Hopkins)
ISO 31073, 2022	Generic risk management standard, which provides principles, framework and a process for managing risk, which can be used by any organisation, regardless of size, activity or sector
ISO Guide 73, 2009	Provides the definitions of generic terms related to risk management.
Hazard risks	“Pure” risks facing the organisation, which result in negative outcomes and disrupt normal operations / service delivery
Opportunity risks	Risk that is associated with the benefit of speculative opportunities
Assurance	Process to provide evidence that controls in place to manage and mitigate a risk are effective
Issue	An event which has already occurred, or is currently occurring
Risk Controls	Measures in place which reduce the likelihood and/or impact of a risk
Risk Assessment	Means by which risks are evaluated and prioritized (Fundamentals of Risk Management, 2022 Hopkins). Overall process of risk identification, analysis and evaluation. (ISO 31073, 2022)

Contents

Introduction

Hywel Dda University Health Board (the UHB) is committed to developing and implementing a risk management strategy that enables a dynamic and systematic approach to risk management, and which ensures the prompt and comprehensive identification, assessment and management of risks that threaten the delivery of its strategic objectives and day-to-day operations. Risk management is central to the effective running of any organisation. At its simplest, risk management is good management practice. It should not be seen as an end in itself, but as part of an overall management approach.

The Risk Management Strategy aims to improve the use of risk management as a tool for better decision-making, driving continuous improvements and linking these to organisational plans and performance reporting including learning and fostering a blame-free and open culture. The mission of risk management in Hywel Dda is that operational and corporate management proactively and promptly identify, assess and manage risks that affect the achievement of our strategic, operational and financial objectives, whilst mitigating instances of unsafe practice, in order to enable the Board to focus on what really matters.

The Risk Management Strategy sets out the UHB's risk management policy statement, and the objectives it wants to achieve in respect of risk management over the next 12 months.

Policy statement

Risks will inevitably occur in the course of providing care and treatment to patients, employing staff, owning, leasing and maintaining premises and equipment, and managing finances. The UHB recognises that principles of good governance must be supported by an effective risk management framework that is designed to deliver improvements in patient safety and care, as well as the safety of its staff, whilst striving to achieve its organisational objectives. The UHB has a Risk Management Framework (opens in new tab) in place, underpinned by a Risk Management Strategy, processes and procedures. This enables and supports a dynamic and systematic approach to risk management, to ensure the prompt and comprehensive identification, assessment and management of risks that threaten the delivery of its strategic objectives and day-to-day operations.

Risk Management is not about being 'risk averse' – it is about being 'risk aware'. All activities contain inherent risks and the UHB will need to take informed risks to achieve its objectives. Risk management is about making the most of opportunities and achieving objectives once those decisions have been made.

The UHB will achieve effective risk management through:

- Implementing a strategy, framework and process that is fit for purpose and compliments the other governance and quality processes within the organisation;
- Reviewing the UHB's risk appetite and tolerance as part of the process to develop the UHB's Integrated Plan;
- Ensuring a consistent understanding and application of the organisation's risk appetite and tolerance;
- Equipping managers with the skills required to identify and assess risk and communicate this appropriately and effectively;
- Acknowledging that the UHB's increasing reliance on its partners to help it achieve its objectives and deliver services. Risks are shared across partner organisations, which can increase the

complexity of analysis and reporting, and also that assurances regarding the level of risk may need to be sought from third parties as well as internal sources;
- Annually reviewing the effectiveness of risk management and reporting the UHB's capacity to manage risk as part of the annual Governance Statement; and
- Considering on an on-going basis that the UHB's approach remains in line with good practice, whilst reviewing and approving the Strategy and Framework formally every three years, with a review every 12 months following an annual review of risk management (see previous bullet point).

The Board is responsible for the effective management of the organisation's risks in pursuance of its aims and objectives. The Board collectively has responsibility and accountability for setting the organisation's objectives, defining strategies to achieve those objectives, defining the UHBs risk appetite, and establishing governance structures and processes to best manage the risks in accomplishing those objectives.

Clinical Care Groups and Executive Directorates (hereto collectively referred to as Functions), are responsible for ensuring risks to achieving their objectives, delivering a safe and effective service, and compliance with legislation and standards, are identified, assessed and managed within the Board's agreed risk appetite. Risks are reported through the Board and Committee structure to provide assurance that they are being managed effectively and efficiently.

Scope

This strategy applies to all UHB staff and Independent Members, contractors, other third parties working within the UHB and those who work in partnership with the UHB. All managers across the UHB must take an active lead to ensure that risks are managed effectively, and drive the development of a risk aware culture..

Aim

The aim of this document is to:
- Set out the broad aims and principles of risk management across the UHB; and
- Set key targets and milestones for the next 12 months at which point it will be refreshed.

Objectives

The Risk Management Strategy will provide a supportive framework that ensures integration of risk management into the delivery of safe services, policy making, planning and decision-making processes, and specifically:
- To protect patients, carers, staff and others who come into contact with the UHB;
- To promote positive risk taking in the context of clinical care and in controlled circumstances;
- To create awareness through the UHB about the importance of recognising and managing risk in a timely manner, and providing staff with the appropriate knowledge, skills and support;
- To provide a robust basis for strategic and operational planning through structured consideration of key risk elements;
- To enhance partnership working with stakeholders in the delivery of services;
- To improve compliance with relevant legislation and national best practice standards; and
- To enhance openness and transparency in decision-making and management.

Risk Management Principles

The following principles underpin the Risk Management Strategy:

- Risk management will be embedded in the core processes and systems of the UHB, including service delivery, policies, procedures, business planning, business case development, performance management and corporate governance;
- Core processes and systems will be reflected in risk management arrangements across all Functions of the UHB;
- Risks will be actively managed and positive assurance sought;
- The risk register will be a live, up-to-date, actively managed and reviewed document and not simply a passive repository of risks;
- Risk management is the responsibility of all staff within their own sphere of work, so that the person best placed to manage each identified risk is the one that does so;
- High-risk areas and activities will attract greatest focus and attention; and
- There will be learning from analysis of incidents, complaints and claims and explicit roll-out of identified improvements.

The Risk Management Strategy stretches the ambition of the UHB in its management of risk via the following objectives:

Risk Management Objectives

Risk Management Objective 1: Support operational risk management arrangements to ensure consistent approach to the ownership and oversight of risks

We will do this by:

- Supporting Functions via local quality and business performance governance meetings and Executive Improving Together sessions to identify, assess and manage risks and improve outcomes;
- Providing practical support to services with operational risk management arrangements via business partnering arrangements to ensure risk management outcomes inform and prioritise organisational decision making
- Develop a checklist to support operational management to improve local induction processes relating to risk management, highlighting local and organisational objectives, processes in place to report a risk, and priorities and support the identification of any training needs for new starters within their team;
- Further developing risk management training materials to ensure alignment with the UHBs objectives following the Strategy Refresh;
- Developing a communications plan in order to further promote awareness of risk management arrangements; and
- Developing a detailed scope and procure a new risk register system.

Risk Management Objective 2: Ensure Board is sighted on key risks and areas of concern on a regular basis (links to Targeted Intervention objective TI44)

We will do this by:

- Continuing to implement the current risk appetite across the UHB, ensuring that risks are aligned with the UHB's risk appetite;
- Reviewing the risk appetite following the Strategy Refresh; and
- Reviewing and updating strategic risks and Board Assurance Framework as part of Strategy Refresh.

Risk Management Objective 3: Improving the risk maturity of the UHB

We will do this by:

- Continued engagement with relevant teams across the UHB to establish how risk information is currently utilised within their areas to support the achievement of the delivery of our objectives and performance targets to inform our annual risk maturity assessment;
- Further development of risk management training material, with more focus on the identification of opportunities;
- Engaging with service leads across the UHB to assess the risk culture and the interdependencies of risks within the organisation to identify areas of improvement to support individuals in undertaking risks in an informed manner to support the achievement of our objectives and performance targets.
- Develop guidance for appropriate risk management arrangements with key partners of the UHB to support its ability to achieve organisational objectives;

Activities to deliver this strategy will include:

- Collaborative working with Functions to develop their risk management capability and ensure risk management is dynamic and part of the everyday;
- Embedding risk management in quality and governance processes at all levels of the UHB;
- Using data in a risk-focused way (what does this tell us about the service and where there are risks and vulnerabilities);
- Ensuring risk registers interact appropriately at different levels of the UHB to ensure risks are appropriately escalated, with appropriate oversight of risks at senior levels of the organisation; and
- Ensuring staff are aware of the options for managing a risk – whether to tolerate (accept), treat (reduce or remove), transfer (responsibility), terminate (suspend the risk situation/activity) or take the opportunity.

Responsibilities

Please refer to the Risk Management Framework (https://hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/policies/risk-management-framework/) (opens in a new tab) which outlines the roles and responsibilities with regards to risk management at the UHB.

References

- North West Ambulance Service NHS Trust

Equality Impact Assessment (EqIA) Screening Template

When to complete an EqIA Screening

An EqIA Screening Template must be completed when reviewing, changing and developing procedures/ proposals/ projects/ policies. This is a first step and is used to consider whether there are any negative impacts that may arise.

Purpose of an EqIA Screening Template

The purpose of this short exercise is to ensure that you have shown appropriate due regard when considering the impact for people with protected characteristics in your decision making. The screening process is designed to help you consider the circumstances and to inform evidence-based decisions.

If the proposal is of a significant nature and it is apparent from the outset that a full EqIA will be required, then it is not necessary to complete this Screening Template, you can proceed to complete the full EqIA.

If no negative impacts are identified following completion of the EqIA screening then it is not necessary to undertake a full EqIA however, the decision and justification must be clearly recorded in this document.

On completion of the Screening Template:

- Ensure that all the white boxes within the screening are completed.
- Ensure that the Procedure/ Project/ Proposal/ Policy owner has signed and dated the Screening Template.
- Send a copy of the completed template along with the related policy or project proposal to Inclusion.hdd@wales.nhs.uk for the Diversity & Inclusion Team to review.
- Each Screening Template will be reviewed by the Diversity & Inclusion Team and feedback will be provided to the Procedure/ Project/ Proposal/ Policy owner. This may include recommendations for further action to inform robust decision-making.

Support

For further support please visit the EqIA Sharepoint or contact:
Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Director and Directorate	Director of Corporate Governance / Board Secretary Corporate Governance (CEO Office)
Service Area	Assurance and Risk

Title of Procedure, Project, Proposal, Policy being screened:	Risk Management Strategy

Description of the Procedure/ Project/ Proposal/ Policy being screened (including key aims and objectives)

The aim of this document is to:

- Set out the broad aims and principles of risk management across the UHB, and sets key targets and milestones for the next 12 months at which point it will be refreshed.

This strategy applies to all UHB staff, contractors and other third parties working within the UHB. Managers at all levels within the UHB must take an active lead to ensure that risks are managed effectively that a risk aware culture across the UHB is facilitated / maintained.

Evidence considered (including staff and population data, relevant research, expert and community knowledge etc.)

Those affected by the policy will include the Health Bard and its Committees, Staff (including secondees, locum and agency staff), volunteers and contractors. Health Board Partners (as defined in the Strategy & Policy) will also be affected, along with in-patients, out-patients and community service users, their families and carers. In reviewing the previously approved Risk Management Strategy, reference has been made to recognised good practice, and guidance via publicly available documentation from the Institute of Risk Management.

Assess which protected characteristics will potentially be affected by the proposal in the table below (please ✓ the relevant box to confirm positive, negative or no impact)**.**

If at any point a negative impact has been identified (actual or potential), you do not need to proceed with the completion of this form, as a full EqIA must be undertaken: Equality Impact Assessments (EqIAs) (sharepoint.com)

Age Is it likely to affect older and younger people in different ways or affect one age group and not another?					
Positive Impact	√	Negative Impact		No Impact	
Justification of impact identified: The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery.					

Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.

Disability
Is it likely to affect those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes?

Positive Impact	√	Negative Impact		No Impact	

Justification of impact identified:
The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.

Gender Reassignment
Is it likely to affect those who either:

- Have undergone, intend to undergo or are currently undergoing gender reassignment.
- Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth

Positive Impact	√	Negative Impact		No Impact	

Justification of impact identified:
The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.

Marriage / Civil Partnership
Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment.
Is it likely to affect those who are married or in a Civil Partnership? This means someone who is legally married or in a civil partnership.

Positive Impact	√	Negative Impact		No Impact	

Justification of impact identified:
The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.

Pregnancy and Maternity
Is it likely to affect those who are pregnant or have recently had a baby? Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.

Positive Impact	√	Negative Impact		No Impact	

Justification of impact identified:
The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.

Race / Ethnicity
Is it likely to affect people of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers?

Positive Impact	√	Negative Impact		No Impact	

Justification of impact identified:
The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery.

Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.

Religion or Belief
Is it likely to affect people who have a religion or belief? The term 'religion' includes a religious or philosophical belief.

Positive Impact	√	Negative Impact		No Impact	

Justification of impact identified:
The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.

Sex
Is it likely to affect people who are mostly male or female. Where it applies to both equally does it affect one differently to the other?

Positive Impact	√	Negative Impact		No Impact	

Justification of impact identified:
The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.

Sexual Orientation
Whether a person's sexual attraction is towards their own sex, the opposite sex or either.

Positive Impact	√	Negative Impact		No Impact	

Justification of impact identified:
The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.

Armed Forces Community
Consider whether this impacts on members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'

For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see:
Armed-Forces-Covenant-duty-statutory-guidance

Positive Impact	√	Negative Impact		No Impact	

Justification of impact identified:
The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.

Socio Economic Duty
Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered.

For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resources please see: more-equal-wales-socio-economic-duty					
Positive Impact	√	Negative Impact		No Impact	
Justification of impact identified: The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.					
Welsh Language Is it likely to impact on opportunities for people to use the Welsh language? The Welsh language should be treated no less favourably than the English language.					
Positive Impact	√	Negative Impact		No Impact	
Justification of impact identified: The policy will impact on the above listed group and individuals as it is a factor within decision making and policy and service planning, development and delivery. Identified risks will generate an action plan in order to manage and/or mitigate the risk, and therefore result in improvement for those at risk.					

If a negative impact has been identified, you are not required to complete this form as a full EqIA must be undertaken. A full EqIA template and guidance can be found on the following link: Equality Impact Assessments (EqIAs) (sharepoint.com)

Screening Completed by:	Name	Rachel Williams
	Title	Head of Assurance and Risk
	Contact details	Rachel.williams61@wales.nhs.uk
	Date	05/08/2025
Screening Authorised by: (Directorate level owner of the procedures/ proposals/ projects/ policy)	Name	Charlotte Wilmshurst
	Title	Assistant Director of Assurance and Risk
	Contact details	Charlotte.Wilmshurst@wales.nhs.uk
	Date	05/08/2025
Guidance has been provided by Diversity & Inclusion Team:	Name	
	Title	
	Contact details	
	Date	
Diversity and Inclusion Team additional Comments:		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.

8

12:50, 0 Mins

8 - Post Payment Verification

8.1

12:50, 5 Mins

8.1 - Post Payment Verification (PPV) Annual Report

Huw Thomas (Hywel Dda UHB - Director of Finance), Amanda Legge (NWSSP - PCS), Sue Tillman (NWSSP - PCS)

For assurance

Attachments

8.1 SBAR PPV End of Year Report 2024-25 ARAC August 2025.pdf

8.1 HDdUHB End of Year PPV Report 2024-25.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:**	12 August 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Post Payment Verification End of Year Report 1 April 2024 – 31 March 2025
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Amanda Legge, All Wales Post Payment Verification Manager

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 is asked to take assurance from the contents of this report. It highlights Post Payment Verification (PPV) progress and how practices have been performing over the current cycle. It compares the overall performance of the Health Board (HB) against the national PPV visits. PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

There are no options included in this report. The report is for assurance and will only detail specific risks if any, and provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving.

Cefndir / Background

At mid-year and end of financial year, the PPV Manager will prepare a report for Health Board audit committees to outline how practices have been performing and highlighting PPV progress. The report is being produced for the Committee to review and seek assurance that the Post Payment Verification cycle is being managed appropriately.

The purpose of the PPV process is to provide assurance to Health Boards that the claims for payment made by primary care contractors are appropriate and that the delivery of the service is as defined by NHS service specification and relevant legislation.

Asesiad / Assessment

The following key points should be noted:

General Medical Services (GMS): in 2024-2025 the PPV team had 55 visits planned for Hywel Dda University Health Board consisting of 28 routine and 27 revisits. By 31 March 2025, we had 20 routine visits with 12 revisits in progress. The incompletion of routine/revisits was a national issue and is not specific to any individual Health Board. When undertaking revisits, a 100% check of the service(s) that were triggered are verified, which takes a significant amount

of time to finalise. This year, we are experiencing unexpected absence in the team in a disproportionate number.

In the first three months of the new financial year, the team has been completing all outstanding visits that are overdue before we begin the new visit plan for 2025/2026.

We have also been requested by Welsh Government to undertake the additional verification of Covid and RSV vaccines and will begin these checks for the visits due in 2025/2026.

General Ophthalmic Services (GOS): The visit plans for GOS 2024-2025 progressed better than the last few years, based on the team having the ability to carry out remote access on more contractors who have transferred to electronic patient records. We do have to carry out elements of physical visits too, as not all contractors are electronic.

For the financial year of 2024-2025 the team completed 20 visits out of 21 visits planned for Hywel Dda University Health Board and have 1 to complete and carry over into the new financial year of 2025/2026.

Moving forward into 2025/2026, we will also be verifying claims for an additional 2 services, which are the WGOS 4 (Glaucoma and Medical Retina) and Independent Prescribing Optometry Service 5 urgent claims (IPOS5).

General Pharmacy Services (GPS): In 2024/2025, PPV introduced a new service check following a successful pilot, which was the Collaborative Working Scheme. The team now verifies this service, along with the Quality and Safety Scheme remotely. We completed 32 visits in progress out of 32 visits planned for Hywel Dda University Health Board.

Additional Services: The team progressed well with its quarterly dispensing data checks and has introduced a robust service moving forward into the new financial year, which may result in future financial recoveries. The results will be added to PPV reports once finalised. Clinical Waste Self Assessments for GMS are going well and as planned to ensure compliance with legislation. We are hoping to incorporate these into our GOS visits this new year financial to align to the WGOS reform and the managing of clinical waste.

The PPV team also manages the Waste Management Audit programme on behalf of the Health Boards, offering advice and support to General Practitioners and Community Pharmacies in respect of Waste Management.

Quarterly meetings are scheduled with all Health Boards and Counter Fraud teams to regularly review the progress report and to discuss themes, recommendations, and any risks. The team is also continuing to investigate other avenues for savings from the provision of Clinical Waste services.

There are bi-monthly National GMS, GOS Working Group and Clinical Waste meetings with Primary Care Managers and PPV, to discuss and agree any issues regarding the national application of the programme. These are beneficial to all parties who attend.

PPV training events continue to be delivered to Health Boards and contractors, and we facilitate one-on-one training requirements when required, particularly for new practice staff within the Primary Care setting.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to **NOTE** and **TAKE ASSURANCE** from the contents of this report.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.14 Receive an assurance on Post Payment Verification Audits through bi-annual reporting to the Committee.
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)	3. Data to knowledge 4. Learning, improvement and research 5. Whole systems persepctive
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Striving teams
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	8. Transform our communities through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Evidence in collated based on claims submitted by contractors of a specific sample period.
Rhestr Termau: Glossary of Terms:	Included in 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:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	To promote value for money by deterring and preventing fraud and loss.
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

Audit Report - 1st April to 31st March 2025 = Hywel Dda University Health Board

To Note
Above planned numbers were sent to HB for 2024/2025 Visit Plan. Numbers may change due to ad hoc visits or closures/mergers
Health Board and Counter Fraud receive copies of each visit report to act upon PPV recommendations
PPV work collaboratively with Health Board managers and Local Counter Fraud to assist with any concerns that may arise
Training/support is provided to practices after visit and throughout the year, whenever requested

Summary of themes/findings/issues
Revisits are taking longer that expected due to 100% check of claims
Revisits are normally expected to have higher claim error rates

HDduHB 2023/2024 = 27 visits were completed with a total of recovery of £30,429.26	ALL WALES 2023/2024 = 205 visits were completed with a recovery of £216,810.03

GMS	Visit Type	HB Annual Visits Due	No. In progress	No. Recoveries	Value of recoveries	All Wales Visits Due	All Wales No. in progress	All Wales Value of Recoveries
	Routine	28	20	866	£21,651.84	152	107	£87,881.10
	Revisit	27	12	290	£20,729.79	241	88	£111,273.26
	TOTAL	**55**	**32**	**1156**	£42,381.63	**393**	**195**	**£199,154.36**

PRACTICE	Routine or Revisit	Claim errors	% recovery	Value of recovery
Practice 1	Revisit	178	99.44%	£15,414.70
Practice 2	Routine	9	2.21%	£377.27
Practice 2	Revisit	6	0.61%	£56.70
Practice 3	Routine	12	7.02%	£173.38
Practice 3	Revisit	3	1.84%	£64.52
Practice 4	Revisit	25	2.63%	£2,214.75
Practice 5	Routine	245	7.83%	£4,319.20
Practice 6	Routine	48	14.37%	£816.44
Practice 6	Revisit	21	2.89%	£519.10
Practice 7	Routine	19	5.85%	£1,064.12
Practice 7	Revisit	28	3.35%	£454.16
Practice 8	Routine	45	9.85%	£1,249.11
Practice 8	Revisit	0	0.00%	£0.00
Practice 9	Routine	17	2.44%	£492.95
Practice 9	Revisit	1	7.14%	£118.17
Practice 10	Routine	69	16.24%	£1,469.19
Practice 10	Revisit	20	37.74%	£1,103.47
Practice 11	Routine	27	7.52%	£373.06
Practice 11	Revisit	0	0.00%	£0.00
Practice 12	Routine	24	6.06%	£526.73
Practice 12	Revisit	8	17.39%	£784.22
Practice 13	Routine	20	6.76%	£223.81
Practice 13	Revisit	0	0.00%	£0.00
Practice 14	Routine	12	5.53%	£235.84
Practice 15	Routine	43	6.99%	£786.88
Practice 16	Routine	243	62.95%	£8,510.66
Practice 17	Routine	31	7.56%	£905.78
Practice 18	Routine	2	0.54%	£127.42
Practice 19	Routine	In Progress		
Practice 20	Routine	In Progress		
Practice 21	Routine	In Progress		
Practice 22	Routine	In Progress		

GOS	Visit Type	Annual Visits Planned	No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	All Wales Value of Recoveries
	Routine	20	19	81	£3,676.08	126	99	£16,247.97
	Revisit	1	1	3	68.7	5	1	£68.70
	TOTAL	**21**	**20**	**84**	**£3,744.78**	**131**	**100**	**£16,316.67**

Summary of themes/findings/issues

As contractors are transistioning to electronic records, remote access and physical visits are progressing well

PRACTICE	Routine or Revisit	Claim errors	% recovery	Value of recovery
Practice 1	Routine	2	1.94%	£337.00
Practice 2	Routine	2	1.94%	£86.46
Practice 3	Routine	2	1.94%	£24.80
Practice 4	Routine	0	0.00%	£0.00
Practice 5	Routine	3	2.91%	£111.14
Practice 6	Routine	2	1.94%	£89.68
Practice 7	Routine	10	9.71%	£368.12
Practice 8	Routine	13	12.62%	£578.74
Practice 9	Routine	18	17.48%	£774.58
Practice 10	Routine	2	1.94%	£42.44
Practice 11	Routine	5	4.85%	£169.46
Practice 12	Routine	3	2.91%	£112.46
Practice 13	Routine	0	0.00%	£0.00
Practice 14	Routine	7	13.46%	£457.08
Practice 15	Routine	5	9.80%	£248.55
Practice 16	Routine	4	7.69%	£185.57
Practice 17	Routine	0	0.00%	£0.00
Practice 18	Routine	0	0.00%	£0.00
Practice 19	Revisit	3	5.00%	£68.70
Practice 20	Routine	3	2.91%	£90.00

Summary of themes/findings/issues

Nothing to report at this stage

GPS	Visit Type	Annual Visits Planned	No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	No. Recoveries	All Wales Value of Recoveries
Q&S Scheme / Collaborative Working Scheme	Routine	32	32	0	£0.00	238	179	0	£0.00
	TOTAL	**32**							

8.2

12:55, 5 Mins

8.2 - Primary Care PPV Report

Jill Paterson (Hywel Dda Health Board - Director of Primary Care, Community and Long Term Care), Rhian Bond (Hywel Dda UHB - Assistant Director of Primary Care)

For assurance

Attachments

8.2 Primary Care PPV Report ARAC August 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:**	12 August 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Primary Care Post Payment Verification Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jill Paterson, Director of Primary Care, Community and Long Term Care
SWYDDOG ADRODD: **REPORTING OFFICER:**	Amanda Whiting, Head of General Medical Services and Community Pharmacy (Contracting & Performance)

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 an updated position on Post Payment Verification (PPV) for the following areas:

- General Medical Services for the period April 2024 – March 2025
- Community Pharmacy for the period April 2024 – March 2025
- General Ophthalmic Services for the period April 2024 – March 2025

Cefndir / Background

Over the last financial year (2024/25), the PPV team was in the second year of a GMS visiting cycle. In this time, they planned to take 28 routine visits and 27 revisits. For Practices who had been identified as requiring both routine and revisit, both of these visits were undertaken at the same time and were referred to as an “extended” visit. During an extended visit, 100% of claims were revisited on services triggered at the previous visit alongside the normal routine visit consisting of 22 or 10% of claims, whichever is the greatest for all other services.

Reports received from PPV outlined both sets of results when an extended visit was undertaken.

32 Collaborative Working Scheme & Quality and Safety Scheme Community Pharmacy remote visits were undertaken in 2024/25.

The PPV team planned to undertake 20 routine General Ophthalmic Services PPV visits and 1 revisit. A sample of 103 records were reviewed, either remotely or physically.

Asesiad / Assessment

PPV Visits for GMS

Summary of all GMS PPV visits undertaken between January and June 2025

PRACTICE	Routine or Revisit	Claim errors	% recovery	Value of recovery
Practice 1	Revisit	178	99.44%	£15,414.70
Practice 2	Routine	9	2.21%	£377.27
Practice 2	Revisit	6	0.61%	£56.70
Practice 3	Routine	12	7.02%	£173.38
Practice 3	Revisit	3	1.84%	£64.52
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Practice 7	Revisit	28	3.35%	£454.16
Practice 8	Routine	45	9.85%	£1,249.11
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Practice 9	Routine	17	2.44%	£492.95
Practice 9	Revisit	1	7.14%	£118.17
Practice 10	Routine	69	16.24%	£1,469.19
Practice 10	Revisit	20	37.74%	£1,103.47
Practice 11	Routine	27	7.52%	£373.06
Practice 11	Revisit	0	0.00%	£0.00
Practice 12	Routine	24	6.06%	£526.73
Practice 12	Revisit	8	17.39%	£784.22
Practice 13	Routine	20	6.76%	£223.81
Practice 13	Revisit	0	0.00%	£0.00
Practice 14	Routine	12	5.53%	£235.84
Practice 15	Routine	43	6.99%	£786.88
Practice 16	Routine	243	62.95%	£8,510.66
Practice 17	Routine	31	7.56%	£905.78
Practice 18	Routine	2	0.54%	£127.42
Practice 19	Routine	In Progress		
Practice 20	Routine	In Progress		
Practice 21	Routine	In Progress		
Practice 22	Routine	In Progress		

Summary of Recoveries and Action Taken:

Practice 1 (178 Claim Errors) – Revisit

Total recovery of £15,414.70 which is made up as follows:

Revisit Recoveries	Number of claim Errors
Minor Surgery	178
Total	**178**

This revisit looked at 179 minor surgery claims, of which 178 claims were recovered due to insufficient evidence being available. This issue was raised with the Counter Fraud Service who have investigated with no further action. The Practice was due a routine visit within 2024/25 and it was agreed that 100% of claims would be sampled during this visit.

PPV will make a full recovery of £15,414.70.

Practice 2 (15 Claims) - Extended Visit

Total recovery of £433.97 which is made up as follows:

Extended Recoveries	Number of claim Errors
Immunisations	1
Insulin/GLP1	4
Minor Surgery	4
Near Patient Testing	6
Total	**15**

1,387 claims were analysed, of these claims 15 errors were found with a claim error rate of 2.82%.

PPV will make a full recovery of £433.97 and a revisit will be scheduled for Minor Surgery within 12 months.

Practice 3 (12 Claims) – Extended Visit

Total recovery of £237.90 which is made up as follows:

Routine Recoveries	Number of claim Errors
Denosumab	0
Flu	1
Gonadorelin	0
Immunisations	7
Minor Surgery	1
Near Patient Testing	3
Pertussis	0
Warfarin	0
Total	**12**

The sample of claims taken from the routine visit were from February 2023 to January 2024. During this period, a total of 1,648 claims were submitted with a value of £17,101.09.

171 claims were analysed across all services, of these claims 12 errors were found. The administrative error rate was 0.58% and the overall claim error rate was 7.02%.

163 claims were analysed as part of the revisit relating to Contraceptives and Treatment Room and 3 claim errors were identified.

Following the audit there were 15 claims identified where fees will be recovered due to insufficient evidence being available.

The Practice has been advised to be mindful to ensure the accurate submission of enhanced service claims as per the specification requirements and that they should continue to develop and implement robust administrative procedures to ensure the accurate submission of Enhanced Service claims.

PPV will make a full recovery of £237.90 and a revisit will be scheduled for Immunisations and Near Patient Testing within 12 months.

Practice 4 (25 Claim Errors) - Revisit

Total recovery of £2,214.75 which is made up as follows:

Re-visit Recoveries	**Number of claim Errors**
Minor Surgery	25
Treatment Room	0
Totals	**25**

The sample of claims taken from the revisit were from February 2023 to January 2024.

952 claims were analysed across Minor Surgery and Treatment claims, of these claims 25 errors were found. The administrative error rate was 0% and the overall claim error rate was 2.63%.

Following the audit there were 25 claims identified where fees will be recovered due to insufficient evidence being available.

The Practice has been advised to be mindful to ensure the accurate submission of enhanced service claims as per the specification requirements and that they should continue to develop and implement robust administrative procedures to ensure the accurate submission of Enhanced Service claims.

PPV will make a full recovery of £2,214.75 and no further revisit review will be conducted.

Practice 5 (245 Claim Errors) – Routine Visit

Total recovery of £4,319.20 which is made up as follows:

Routine Recoveries	Number of claim Errors
Care Homes	88
Contraceptives	0
Denosumab	1
Flu	4
Gonadorelin	1
Immunisations	21
Learning Disabilities	0
Minor Surgery	0
Near Patient Testing	80
NOAC/NOAR/DOAC/DOAR	16
Pertussis	0
Treatment Room	30
Warfarin	4
Total	**245**

The sample of claims taken from the routine visit were from April 2023 to March 2024. During this period, a total of 3,127 claims were submitted with a value of £52,594.69.

3,127 claims were analysed across all services, of these claims 245 errors were found. The administrative error rate was 0.29% and the overall claim error rate was 7.83%.

Following the audit there were 245 claims identified where fees will be recovered due to insufficient evidence being available.

PPV will make a full recovery of £4,319.20 and due to the contract termination, the file has been closed.

Practice 6 (69 Claim errors) – Extended Visit

Total recovery of £1,335.54 which is made up as follows:

Routine Recoveries	Number of claim Errors
Care Homes	9
Contraceptives	0
Denosumab	0
Flu	5
Gonadorelin	1
Immunisations	8
Learning Disabilities	1
Minor Surgery	2
Near Patient Testing	18
Pertussis	0
Warfarin	4
Total	**48**

Re-visit Recoveries	Number of claim Errors
NOAC/NOAR/DOAC/DOAR	5
Treatment Room	16
Total	**21**

The sample of claims taken from the routine visit were from December 2022 to November 2023. During this period, a total of 4,078 claims were submitted with a value of £61,153.54.

334 claims were analysed across all services, of these claims 48 errors were found. The administrative error rate was 4.49% and the overall claim error rate was 14.37%.

726 claims were analysed as part of the revisit relating to NOAC/NOAR/DOAC/DOAR and Treatment Room, of these claims 21 errors were found. The administrative error rate was 0% and the overall claim error rate was 2.89%.

Following the audit there were 69 claims identified where fees will be recovered due to insufficient evidence being available.

The Practice has been advised to be mindful to ensure the accurate submission of enhanced service claims as per the specification requirements and that they should continue to develop and implement robust administrative procedures to ensure the accurate submission of Enhanced Service claims.

PPV will make a full recovery of £1,335.54 and a revisit will be scheduled for Care Homes, Flu, Immunisations, Near Patient Testing and Warfarin within 12 months.

Practice 7 (47 Claim Errors) – Extended Visit

Total recovery of £1,518.28 which is made up as follows:

Routine Recoveries	Number of claim Errors
Care Homes	
Contraceptives	
Denosumab	
Flu	
Immunisations	4
Learning Disabilities	
Minor Surgery	
Near Patient Testing	7
NOAC/NOAR/DOAC/DOAR	8
Warfarin	
Total	**19**

Re-visit Recoveries	Number of claim Errors
Gonadorelin	2
Non-routine Immunisations Hepatitis B	13
Pertussis	
Treatment Room	13
Totals	**28**

The sample of claims taken from the routine visit were from July 2023 to May 2024. During this period, a total of 3,478 claims were submitted with a value of £46,856.89.

325 claims were analysed across all services, of these claims 19 errors were found. The administrative error rate was 0% and the overall claim error rate was 5.85%.

837 claims were analysed as part of the revisit, of these claims 28 errors were found. The administrative error rate was 0% and the overall claim error rate was 3.35%.

Following the audit there were 47 claims identified where fees will be recovered due to insufficient evidence being available.

The Practice has been advised to be mindful to ensure the accurate submission of enhanced service claims as per the specification requirements and that they should continue to develop and implement robust administrative procedures to ensure the accurate submission of Enhanced Service claims.

PPV will make a full recovery of £1,518.28 and a revisit will be scheduled for Near Patient Testing & NOAC Initiation claims.

Practice 8 (45 Claim Errors) – Extended Visit

Total recovery of £1,249.11 which is made up as follows:

Routine Recoveries	Number of claim Errors
Contraceptives	3
Denosumab	3
Flu	10
Gonadorelin	2
Immunisations	7
Minor Surgery	4
Near Patient Testing	4
Treatment Room	10
Warfarin	2
Total	**45**

The sample of claims taken from the routine visit were from February 2023 to January 2024. During this period, a total of 5,477 claims were submitted with a value of £77,195.57.

457 claims were analysed across all services, of these claims 45 errors were found. The administrative error rate was 0% and the overall claim error rate was 9.85%.

258 claims were analysed as part of the revisit relating to NOAC/NOAR/DOAC/DOAR and 0 claim errors were identified.

Following the audit there were 45 claims identified where fees will be recovered due to insufficient evidence being available.

The Practice has been advised to be mindful to ensure the accurate submission of enhanced service claims as per the specification requirements and that they should continue to develop and implement robust administrative procedures to ensure the accurate submission of Enhanced Service claims.

PPV will make a full recovery of £1,249.11 and a revisit will be scheduled for Contraceptives, Denosumab, Flu, Immunisations, Minor Surgery and Treatment Room Enhanced Service claims within 12 months.

Practice 9 (18 Claim Errors) – Extended Visit

Total recovery of £611.12 which is made up as follows:

Routine Recoveries	Number of claim Errors
Care Homes	8
Immunisations	1
Insulin	3
Minor Surgery	2
NOAC/NOAR/DOAC/DOAR (Reviews Only)	1
Transgender	1
Treatment Room	1
Total	**17**

Re-visit Recoveries	Number of claim Errors
NOAC/NOAR/DOAC/DOAR (Initiations only)	1
Total	**1**

The sample of claims taken from the routine visit were from October 2023 to September 2024. During this period, a total of 9,009 claims were submitted with a value of £144,187.18

696 claims were analysed across all services, of these claims 17 errors were found. The administrative error rate was 0% and the overall claim error rate was 2.44%.

14 claims were analysed as part of the revisit, of these claims 1 error was found. The administrative error rate was 0% and the overall claim error rate was 7.14%.

Following the audit there were 18 claims identified where fees will be recovered due to insufficient evidence being available.

The Practice has been advised to be mindful to ensure the accurate submission of enhanced service claims as per the specification requirements and that they should continue to develop and implement robust administrative procedures to ensure the accurate submission of Enhanced Service claims.

PPV will make a full recovery of £611.12 and an extended visit will be scheduled for Transgender claims during the next routine visit.

Practice 10 (89 Claim Errors) – Extended Visit

Total recovery of £2,572.66 which is made up as follows:

Routine Recoveries	**Number of claim Errors**
Care Homes	54
Contraceptives	1
Immunisations	1
Minor Surgery (Injections and Aspirations only)	1
Pertussis	10
Treatment Room	2
Total	**69**

Re-visit Recoveries	**Number of claim Errors**
Minor Surgery (Excisions only)	7
Substance Misuse	13
Total	**20**

The sample of claims taken from the routine visit were from June 2023 to April 2024. During this period, a total of 5,118 claims were submitted with a value of £83,308.94.

425 claims were analysed across all services, of these claims 69 errors were found. The administrative error rate was 0% and the overall claim error rate was 16.24%.

53 claims were analysed as part of the revisit, of these claims 20 errors were found. The administrative error rate was 0% and the overall claim error rate was 37.74%.

Following the audit there were 89 claims identified where fees will be recovered due to insufficient evidence being available.

The Practice has been advised to be mindful to ensure the accurate submission of enhanced service claims as per the specification requirements and that they should continue to develop and implement robust administrative procedures to ensure the accurate submission of Enhanced Service claims.

PPV will make a full recovery of £2,572.66 and an extended visit will be scheduled for Transgender claims during the next routine visit.

Practice 11 (27 Claim Errors) – Extended Visit

Total recovery of £373.06 which is made up as follows:

Routine Recoveries	Number of claim Errors
Care Homes	1
Contraceptives	1
Flu	4
Immunisations	1
Learning Disabilities	1
Near Patient Testing	17
NOAC/NOAR/DOAC/DOAR (Reviews only)	2
Total	**27**

The sample of claims taken from the routine visit were from June 2023 to May 2024. During this period, a total of 3,797 claims were submitted with a value of £47,106.64.

359 claims were analysed across all services, of these claims 27 errors were found. The administrative error rate was 0% and the overall claim error rate was 7.52%.

The focus of the revisit was NOAC/NOAR/DOAC/DOAR and Substance misuse but during the sample period no claims were submitted for either enhanced service.

Following the audit there were 27 claims identified where fees will be recovered due to insufficient evidence being available.

The Practice has been advised to be mindful to ensure the accurate submission of enhanced service claims as per the specification requirements and that they should continue to develop and implement robust administrative procedures to ensure the accurate submission of Enhanced Service claims.

PPV will make a full recovery of £373.06 and a revisit will be scheduled for Flu and Near Patient Testing within 12 months.

Practice 12 (32 Claim Errors) – Extended Visit

Total recovery of £1,310.95 which is made up as follows:

Routine Recoveries	Number of claim Errors
Care Homes	12
Flu	1
Immunisations	8
Insulin	1
Near Patient Testing	1

Treatment Room	1
Total	**24**

Revisit Recoveries	**Number of claim Errors**
NOAC/NOAR/DOAC/DOAR	8
Totals	**8**

The sample of claims taken from the routine visit were from June 2023 to May 2024. During this period, a total of 4,444 claims were submitted with a value of £62,591.50.

396 claims were analysed across all services, of these claims 24 errors were found. The administrative error rate was 4.04% and the overall claim error rate was 6.06%.

46 claims were analysed as part of the revisit, of these claims 8 errors were found. The administrative error rate was 0% and the overall claim error rate was 17.39%.

Following the audit there were 32 claims identified where fees will be recovered due to insufficient evidence being available.

The Practice has been advised to be mindful to ensure the accurate submission of enhanced service claims as per the specification requirements and that they should continue to develop and implement robust administrative procedures to ensure the accurate submission of Enhanced Service claims.

PPV will make a full recovery of £1,310.95 and a revisit will be scheduled for Care Home and Immunisation claims within the next 12 months.

Practice 13 (20 Claim Errors) – Extended Visit

Total recovery of £223.81 which is made up as follows:

Routine recoveries	**Number of claim Errors**
Flu	1
Gonadorelins	1
Immunisations	5
Near Patient Testing	12
Treatment Room	1
Total	**20**

The sample of claims taken from the routine visit were from June 2023 to May 2024. During this period, a total of 4,657 claims were submitted with a value of £48,687.53.

296 claims were analysed across all services, of these claims 20 errors were found. The administrative error rate was 1.69% and the overall claim error rate was 6.76%.

16 claims were analysed as part of the revisit relating to Denosumab and 0 claim errors were identified.

Following the audit there were 20 claims identified where fees will be recovered due to insufficient evidence being available.

The Practice has been advised to be mindful to ensure the accurate submission of enhanced service claims as per the specification requirements and that they should continue to develop and implement robust administrative procedures to ensure the accurate submission of Enhanced Service claims.

PPV will make a full recovery of £223.81 and a revisit will be scheduled for Immunisations (Shingles and Men B) and Near Patient Testing within 12 months.

Practice 14 (12 Claim Errors) – Routine Visit

Total recovery of £235.84 which is made up as follows:

Routine recoveries	Number of claim Errors
Immunisations	2
Learning Disabilities	1
Near Patient Testing	3
Pertussis	4
Treatment Room	2
Total	**12**

The sample of claims taken from this visit were from December 2023 to November 2024. During this period, a total of 1,546 claims were submitted with a value of £22,128.90.

217 claims were analysed across all services, of these claims 12 errors were found. The administrative error rate was 1.84% and the overall claim error rate was 5.53%.

Following the audit there were 12 claims identified where fees will be recovered due to insufficient evidence being available.

The Practice has been advised to be mindful to ensure the accurate submission of enhanced service claims as per the specification requirements and that they should continue to develop and implement robust administrative procedures to ensure the accurate submission of Enhanced Service claims.

PPV will make a full recovery of £235.84 and a revisit will be scheduled for Near Patient Testing and Pertussis within 12 months.

Practice 15 (43 Claim Errors) – Routine Visit

Total recovery of £786.88 which is made up as follows:

Routine recoveries	Number of claim Errors
Care Homes	2
Contraceptives	1
Gonadorelin	1
Insulin	17
Near Patient Testing	1
NOAC/NOAR/DOAC/DOAR	9
Pertussis	1
Transgender	1
Treatment Room	3
Warfarin	7
Total	**43**

The sample of claims taken from this visit were from December 2023 to November 2024. During this period, a total of 6,027 claims were submitted with a value of £99,965.19.

615 claims were analysed across all services, of these claims 43 errors were found. The administrative error rate was 0% and the overall claim error rate was 6.99%.

Following the audit there were 43 claims identified where fees will be recovered due to insufficient evidence being available.

The Practice has been advised to be mindful to ensure the accurate submission of enhanced service claims as per the specification requirements and that they should continue to develop and implement robust administrative procedures to ensure the accurate submission of Enhanced Service claims.

PPV will make a full recovery of £786.88 and a revisit will be scheduled for Warfarin, Insulin, and NOAC enhanced services within 12 months.

Practice 16 (243 Claim Errors) Routine Visit

Total recovery of £8,510.66 which is made up as follows:

Routine recoveries	Number of claim Errors
Contraceptives	16
Flu	5
Gonadorelin	6
Immunisations	11
Insulin	102
Minor Surgery	85
NOAC/NOAR/DOAC/DOAR	3
Treatment Room	13
Warfarin	2
Total	**243**

The sample of claims taken from this visit were from December 2023 to November 2024. During this period, a total of 2,534 claims were submitted with a value of £26,751.91.

386 claims were analysed across all services, of these claims 243 errors were found. The administrative error rate was 3.11% and the overall claim error rate was 62.95%.

Following the audit there were 243 claims identified where fees will be recovered due to insufficient evidence being available.

The Practice has been advised to be mindful to ensure the accurate submission of enhanced service claims as per the specification requirements and that they should continue to develop and implement robust administrative procedures to ensure the accurate submission of Enhanced Service claims. The Practice has responded to advise that following their review of the PPV report they will undertake a full and comprehensive evaluation of their search methods and the way that information is coded within patient records.

PPV will make a full recovery of £8,510.66 and a revisit will be scheduled for Contraceptive Services, Flu, Gonadorelin, Immunisations, Insulin, Minor Surgery, NOAC/NOAR/DOAC/DOAR and Treatment Room claims within six months.

Practice 17 (31 Claim Errors) – Routine Visit

Total recovery of £905.78 which is made up as follows:

Routine recoveries	Number of claim Errors
Care Homes	6
Gonadorelin	1
Immunisations	5
Insulin	3
Near Patient Testing	10
Transgender	1
Treatment Room	3
Warfarin	2
Total	**31**

The sample of claims taken from this visit were from December 2023 to November 2024. During this period, a total of 3,931 claims were submitted with a value of £84,623.63.

410 claims were analysed across all services, of these claims 31 errors were found. The administrative error rate was 0% and the overall claim error rate was 7.56%.

Following the audit there were 31 claims identified where fees will be recovered due to insufficient evidence being available.

The Practice has been advised to be mindful to ensure the accurate submission of enhanced service claims as per the specification requirements and that they should continue to develop and implement robust administrative procedures to ensure the accurate submission of Enhanced Service claims.

PPV will make a full recovery of £905.78 and a revisit will be scheduled for Care Homes, Immunisations (Pertussis) and Near Patient Testing within 12 months.

Practice 18 (2 Claim Errors) – Routine Visit

Total recovery of £127.42 which is made up as follows:

Routine recoveries	Number of claim Errors
Gonadorelin	1
NOAC/NOAR/DOAC/DOAR	1
Total	**2**

The sample of claims taken from this visit were from December 2023 to November 2024. During this period, a total of 4,100 claims were submitted with a value of £64,822.82.

371 claims were analysed across all services, of these claims 2 errors were found. The administrative error rate was 0% and the overall claim error rate was 0.54%.

Following the audit there were 2 claims identified where fees will be recovered due to insufficient evidence being available.

The Practice has been advised to be mindful to ensure the accurate submission of enhanced service claims as per the specification requirements and that they should continue to develop and implement robust administrative procedures to ensure the accurate submission of Enhanced Service claims.

PPV will make a full recovery of £127.42 and the file has been closed.

PPV Recoveries for Dispensing Practices
As part of a new process, the PPV team has recently completed the quarterly exercise for the period January to March 2025 reviewing records for patients who do not have a dispensing flag on their record but have had prescriptions dispensed to them by their Practice. Following a staged implementation process, this will lead to the first set of recoveries for Dispensing Practices in relation to this measure.

PPV For RSV & Covid Vaccinations
The PPV team has notified Health Boards of their intention to commence with post payment verification checks on both the RSV and Covid Vaccinations within the 2025/26 financial year.

VISION TO EMIS
The PPV team has notified the Health Board of an emerging issue in relation to GP Practices who have migrated from Vision to EMIS. A PPV visit was undertaken to a Practice that had migrated in 2024, the issue related to Gonadorelin claims where there was only evidence of a prescription in the patient record and no evidence the injection was given to the patient. The patient recorded entries in VISION had been made as recalls. It has become apparent that recalls do not carry over between the two systems.

Upon investigation, Digital Health and Care Wales (DHCW) has confirmed that “Diary/Recall codes” are not transferred to EMIS Web as part of the migration. Only codes to say something has been completed are transferred. The read codes are transferred over to enable searches; these will show in Care History. However, they would not show in the Diary Screen as follow-up; this happens when EMIS web is used to add the Diary Codes.

The items that move from one system to another are:

· All read codes
· All medication issued
· Documents
· Consultations

PPV are looking into this further and will update going forward.

PPV Visits for Community Pharmacies

Summary of PPV Visits for Community Pharmacies between April 2024 and March 2025

A total of 32 Community Pharmacy Visits were undertaken in the period April 2024 and March 2025. The visiting team reviewed compliance with the Quality and Safety Scheme and the Collaborative Working Scheme. There are no recoveries to be reported at this stage.

PPV Visits for General Ophthalmic Service Practices (GOS)

Summary of PPV Visits for GOS Practices between April 2024 and March 2025

During 2024/24, a total of 20 PPV visits were conducted, either remotely or physically. A summary of these visits is provided in the table below:

PRACTICE	Routine or Revisit	Claim errors	% recovery	Value of recovery
Practice 1	Routine	2	1.94%	£337.00
Practice 2	Routine	2	1.94%	£86.46
Practice 3	Routine	2	1.94%	£24.80
Practice 4	Routine	0	0.00%	£0.00
Practice 5	Routine	3	2.91%	£111.14
Practice 6	Routine	2	1.94%	£89.68
Practice 7	Routine	10	9.71%	£368.12
Practice 8	Routine	13	12.62%	£578.74
Practice 9	Routine	18	17.48%	£774.58
Practice 10	Routine	2	1.94%	£42.44
Practice 11	Routine	5	4.85%	£169.46
Practice 12	Routine	3	2.91%	£112.46
Practice 13	Routine	0	0.00%	£0.00
Practice 14	Routine	7	13.46%	£457.08
Practice 15	Routine	5	9.80%	£248.55
Practice 16	Routine	4	7.69%	£185.57
Practice 17	Routine	0	0.00%	£0.00
Practice 18	Routine	0	0.00%	£0.00
Practice 19	Revisit	3	5.00%	£68.70
Practice 20	Routine	3	2.91%	£90.00

Of these visits, 4 resulted in no recoveries and only 1 practice will require a revisit. The majority of errors identified relate to administrative errors, such as lack of supporting documentation within the record. A breakdown of each PPV outcomes can be found below:

Practice 1 – Routine visit resulted in a recovery of £337 related to duplication of a GOS3 claim and the age of a patient at time of replacement meant that they were no longer eligible. No revisit required.

Practice 2 – Routine visit resulted in a recovery of £86.46 due to the wrong banding be claimed. No revisit required.

Practice 3 – Routine visit resulted in a recovery of £24.80 due to the lack of supporting information in the records for two GOS4 claims. No revisit required.

Practice 4 – Routine visit resulted in a no recovery being made and no revisit necessary.

Practice 5 – Routine visit resulted in a recovery of £111.14. This was related to a lack of supporting evidence for EHEW Band 1 and 2 claims. No revisit required.

Practice 6 – Routine visit resulted in a recovery of £89.68 due to lack of supporting information in the records for an EHEW Band 1 and 3 claim. No revisit required.

Practice 7 – Routine visit resulted in a recovery of £368.12. There were a number of errors identified during this visit, all relating to the lack of supporting evidence or required documentation. These included claims for GOS3 and 4, as well as EHEW Bands 1, 2 and 3. As such, a revisit is required for this practice.

Practice 8 – Routine visit resulted in a recovery of £578.74. There were a number of errors identified during this visit, all relating to the lack of supporting evidence or required documentation. These included claims for GOS4, as well as EHEW Bands 1, 2 and 3. As such, a revisit is required for this practice.

Practice 9 - Routine visit resulted in a recovery of £774.58. There were a number of errors identified during this visit, mostly relating to the lack of supporting evidence or required documentation. These included claims for GOS4, as well as EHEW Bands 1, 2 and 3. In addition, there was one incidence where incorrect vouchers had been used under GOS3. As such, a revisit is required for this practice.

Practice 10 – Routine visit resulted in a recovery of £42.44 due to no evidence of letters to the GP for two EHEW Band 3 claims. No revisit required.

Practice 11 – Routine visit resulted in a recovery of £169.46. There were a number of errors identified during this visit, including duplicated claims for a GOS4 and EHEW Band 2, an incidence where the claim should have been voided, but was submitted, as well as two incidences of a lack of supporting evidence. A revisit is required for this practice.

Practice 12 - Routine visit resulted in a recovery of £112.46. This relates to the inappropriate claiming of an EHEW Band 3 following an EHEW Band, as well as two cases with lack of supporting evidence or required documentation for a GOS 3 and EHEW Band 2 claim. No revisit required.

Practice 13 - Routine visit resulted in no recovery being made and no revisit necessary.

Practice 14 - Routine visit resulted in a recovery of £457.08. There were a number of errors identified during this visit, mostly relating to the length of time between claims for GOS3 and 6. As such, a revisit is required for this practice.

Practice 15 - Routine visit resulted in a recovery of £248.55. There were a number of errors identified during this visit that related to the lack of supporting evidence for tint claims and two incidences of patients paying privately for appliances and therefore the claim was inappropriate. As such, a revisit is required for this practice.

Practice 16 - Routine visit resulted in a recovery of £185.57. Errors identified during this visit related to three duplications of claims and a lack of supporting evidence for a GOS4 claim. As such, a revisit is required for this practice.

Practice 17 - Routine visit resulted in no recovery being made and no revisit necessary.

Practice 18 - Routine visit resulted in no recovery being made and no revisit necessary.

Practice 19 - Revisit resulted in a recovery of £68.70. Errors identified during this visit related to one duplication and a lack of supporting evidence for two GOS4 claims. As such, a revisit is required for this practice. No revisit required.

Practice 20 – Routine visit resulted in a recovery of £90.00. These were related to a lack of supporting evidence for GOS4 and EHEW Band 2 claims. No revisit required.

A total of £3,744.78 in recoveries was made during 2024/25.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to:

- **NOTE** the information contained within this report
- **NOTE** that the Primary Care team continues to work with all contractors and their professional representative bodies on the quality of claiming and continues to respond to individual claiming queries from the outset. PPV is discussed at GMS Contractual Assurance visits and training is offered by the PPV Team
- **TAKE ASSURANCE** that appropriate liaison is undertaken with the Counter Fraud Team when there are any concerns, or information needs to be queried

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.14 Receive an assurance on Post Payment Verification Audits through bi-annual reporting to the committee
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 5. Equitable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	3. Data to knowledge

Amcanion Strategol y BIP: UHB Strategic Objectives:	6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	2 Financial recovery and route map
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:	N/A
Rhestr Termau: Glossary of Terms:	NOAC - New Oral Anticoagulants DOAC - Direct Oral Anticoagulants EHEW - Eye Health Examination Wales
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	PPV Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Assurance around appropriate and proper use of funding provided by GMS Enhanced Services
Ansawdd / Gofal Claf: Quality / Patient Care:	N/A
Gweithlu: Workforce:	N/A
Risg: Risk:	Assurance around appropriate and proper use of funding provided by GMS Enhanced Services
Cyfreithiol: Legal:	Application of Statement of Financial Entitlement under the terms of the General Medical Services Contract
Enw Da: Reputational:	N/A
Gyfrinachedd: Privacy:	N/A
Cydraddoldeb: Equality:	N/A

9

13:00, 0 Mins

9 - For Information

9.1

13:00, 0 Mins

9.1 - Audit Wales - Letter regarding Future Report Writing Style

For information

Attachments

9.1 AC513 - Letter on report of PA work.pdf

9.1 AC513 - Letter on report of PA work - cy.pdf

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info@audit.wales / post@archwilio.cymru
www.audit.wales / www.archwilio.cymru

Sent via email

Reference: AC513/caf
Date issued: 29 July 2025

Dear Colleague

Report of performance audit work

I am writing to let you know that we are changing how we report the findings of our performance audit work.

The modern communications landscape, driven by technology and evolving user behaviour, is creating demand for information presented in more easily absorbable ways. We have certainly seen that reflected in feedback from our stakeholders.

Consequently, our Strategy for 2022 to 2027 sets out to improve the impact of our work through the way we communicate it. We have reviewed the structure, style and language of our performance audit reports with the aim being to make our work more accessible, and easier to read and understand. Our refreshed style will use simpler language suitable for a broader audience and wherever possible remove unnecessary ambiguity and complexity. I hope that by writing our reports in this way we make them more engaging and relevant, saving time and promoting greater understanding among all our stakeholders irrespective of background or role.

From July 2025 onwards you will start to see these changes appear, depending on the timing of your audit programme.

I recognise that simpler language and clearer messaging could initially feel uncomfortable, especially to those familiar with our current reporting style. Please

rest assured that our findings will remain based on robust methodology and sound evidence, reported with a focus on providing assurance and supporting improvement in the public sector. I certainly hope that you will find the new style strikes the right balance in providing simplicity and clarity while remaining credible and authoritative.

Please do not hesitate to contact me, Ann-Marie Harkin, Executive Director of Audit Services, or your Audit Wales Engagement Director if you would like to discuss this issue further.

Yours sincerely

ADRIAN CROMPTON
Auditor General for Wales

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Wedi'i anfon trwy e-bost

Reference: AC513/caf
Date issued: 29 Gorffennaf 2025

Annwyl gydweithiwr

Adrodd ar waith archwilio perfformiad

Rwy'n ysgrifennu i roi gwybod i chi ein bod yn newid ein dull o adrodd canfyddiadau ein gwaith archwilio perfformiad.

Mae'r dirwedd gyfathrebu fodern, sy'n cael ei hysgogi gan dechnoleg ac ymddygiad defnyddwyr sy'n esblygu, yn creu galw am wybodaeth a gyflwynir mewn ffyrdd haws eu hamsugno. Rydym yn sicr wedi gweld hynny'n cael ei adlewyrchu mewn adborth gan ein rhanddeiliaid.

O ganlyniad, bwriad ein Strategaeth ar gyfer 2022 i 2027 yw gwella effaith ein gwaith trwy'r ffordd yr ydym yn ei gyfathrebu. Rydym wedi adolygu strwythur, arddull ac iaith ein hadroddiadau archwilio perfformiad gyda'r nod o wneud ein gwaith yn fwy hygyrch, ac yn haws i'w ddarllen a'i ddeall. Bydd ein harddull newydd yn defnyddio iaith symlach sy'n addas ar gyfer cynulleidfa ehangach a lle bynnag y bo modd byddwn yn dileu amwysedd a chymhlethdod. Rwy'n gobeithio, trwy ysgrifennu ein hadroddiadau yn y modd hwn, y byddwn yn eu gwneud yn fwy diddorol a pherthnasol, gan arbed amser ac annog gwell dealltwriaeth ymhlith ein holl randdeiliaid waeth beth fo'u cefndir neu eu rôl.

O fis Gorffennaf 2025 ymlaen byddwch yn dechrau gweld y newidiadau hyn yn ymddangos, yn dibynnu ar amseriad eich rhaglen archwilio.

Rwy'n cydnabod y gallai iaith symlach a negeseuon cliriach deimlo'n anghyfforddus i ddechrau, yn enwedig i'r rhai sy'n gyfarwydd â'n harddull adrodd bresennol. Gallwn

eich sicrhau y bydd ein canfyddiadau yn parhau i fod yn seiliedig ar fethodoleg gadarn a thystiolaeth gref, wedi'u hadrodd gyda phwyslais ar roi sicrwydd a chefnogi gwelliant yn y sector cyhoeddus. Rwy'n sicr yn gobeithio y byddwch chi o'r farn bod yr arddull newydd yn taro'r cydbwysedd cywir wrth ddarparu symlrwydd ac eglurder gan barhau i fod yn gredadwy ac yn awdurdodol.

Mae croeso i chi gysylltu â mi, Ann-Marie Harkin, Cyfarwyddwr Gweithredol y Gwasanaethau Archwilio, neu eich Cyfarwyddwr Ymgysylltu Archwilio Cymru os hoffech drafod y mater hwn ymhellach.

Yn gywir

ADRIAN CROMPTON
Archwilydd Cyffredinol Cymru

9.2 **13:00, 0 Mins**

9.2 - ARAC Workplan 2025/26

For information

Attachments

9.2 Audit Work Programme 2025-26.pdf

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

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

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

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

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
AUDIT WALES									
Review External Audit Plan via update reports	**Audit Wales**	✓		✓	✓	✓	✓	✓	✓
Approve External Audit Strategy & Annual Audit Plan (designed to implement the strategy) & assoc fees	**Audit Wales**	✓						✓	✓
Review of External Audit Reports including results & the adequacy of executive & mgmt responses to any issues identified and ensure that the other Cttees monitor & report back	**Audit Wales**	✓		✓	✓	✓	✓	✓	✓
Consider any Audit Wales National Value for Money Examinations & Performance Reports	**Audit Wales**	✓		✓	✓	✓	✓	✓	✓
Receive the Auditor's General report to those charged with governance (Year-end)	**Audit Wales**		✓						
Structured Assessment 2024 Management Response Update	**Audit Wales/JW**				✓			✓	
Structured Assessment 2025	**Audit Wales**						✓	✓	
Review of Urgent and Emergency Care (Part 1 and Part 2)	**Audit Wales/AC**	D		✓	D	✓			
Planned Care Review	**Audit Wales/AC**	D		✓					
Review of Capital Investment Prioritisation	**Audit Wales/LD**			✓					
Cancer Services in Wales: A review of the strategic approach to improving the timeliness of diagnosis and treatment	**Audit Wales/AC**	✓							
Deep Dive - Review of Investment in Digital Systems	**Audit Wales/HT**				D		✓		
Review of the Management of Outpatients	**Audit Wales/AC**				D	✓			

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
Review of Radiology Services	**Audit Wales/AC**							✓	
Deep Dive - Review of the Arrangements to Manage Estates	**Audit Wales/JS**								✓
Review of Cancer Services	**Audit Wales/AC**								✓
INTERNAL AUDIT									
Internal Audit: Audit Plan Progress Report	**JJ**	✓	✓	✓	✓	✓	✓	✓	✓
Review and approve Annual Internal Audit Plan	**JJ**	✓							✓
Review of Internal Audit Reports including results & the adequacy of executive & management responses to any issues identified and ensuring that they are acted upon	**JJ**	✓	✓	✓	✓	✓	✓	✓	✓
Review and approve Internal Audit terms of reference (charter) and the effectiveness of internal audit	**JJ**	✓							
Standards of Cleanliness IA Update and Action Plan	**JS**				✓				
Learning Lessons (Reasonable Assurance)	**JJ/SD**	✓							
Elective Waiting List Management (Substantial Assurance)	**JJ/AC**	✓							
Consultant Job Planning Follow-up (Reasonable Assurance)	**JJ/MH**	✓							
Financial Management (Reasonable Assurance)	**JJ/HT**	✓							
Performance Management (Substantial Assurance)	**JJ/HT**	✓							
Executive Team Governance (Substantial Assurance)	**JJ/PK/JW**	D	✓						
Annual Planning (Reasonable Assurance)	**JJ/LD**	D	✓						

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
Digital Strategic Partner (Substantial Assurance)	**JJ/HT**		✓						
Discharge Management Follow-up (Advisory Report)	**JJ/AC**			✓					
Standards of Cleanliness Follow-up (Limited Assurance)	**JJ/AC/JS**	D	D	✓					
Withybush Hospital (WGH) RAAC (Reasonable Assurance)	**JJ/AC/JS**	D	D	✓					
Continuing Healthcare – Database Maintenance and Finance Processes (Substantial Assurance)	**JJ/HT**	D	D	✓					
Contract Management (Advisory Report)	**JJ/HT**			✓					
Follow Up Review (Reasonable Assurance)	**JJ/JW**			✓					
Corporate Risk: Ophthalmology (Reasonable Assurance)	**JJ/AC**				✓				
Sickness Management (Limited Assurance)	**JJ/LG**				✓				
Nursing Management (Limited Assurance)	**JJ/SD**				✓				
Validation of Emergency Departments performance and waiting time data	**JJ/AC**					✓			
Control of Contractors	**JJ/AC**					✓			
Risk of increasing fragility in primary care contractor services due to external factors	**JJ/AC/JP**					✓			
Human Tissue Authority	**JJ/JS**					✓			
Commissioning– Long Term Agreement	**JJ/LD**					✓			
Vaccination & Immunisation	**JJ/AG**					✓			
Operational Governance Arrangements	**JJ/AC**						✓		
Level Three / Four Directorates	**JJ/AC**						✓		
Medical Devices Regulations	**JJ/AC**						✓		

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
Theatre Stock System Implementation	**JJ/AC**							✓	
Managed Practices	**JJ/AC/JP**						✓		
Cyber Security	**JJ/HT**						✓		
Health & Safety	**JJ/JS**							✓	
Escalation Governance	**JJ/PK/JW**							✓	
Decision making for high cost drugs	**JJ/HT**							✓	
Departmental / Local IT systems management	**JJ/HT**							✓	
Estates Assurance - Space Utilisation	**JJ/LD**							✓	
Joint Committee with SBUHB	**JJ/JW**								✓
Medical Workforce Stabilisation	**JJ/MH**								✓
GP Out of Hours	**JJ/AC/JP**								✓
Major Infrastructure Investment Plan (MIIP)	**JJ/LD**								✓
Complaints	**JJ/SD**								✓
Patient Experience	**JJ/SD**								✓
Infection Prevention & Control	**JJ/SD**								✓
IRMER	**JJ/JS**								✓
Estates/Facilities Directorate - Cleaning Standards	**JJ/JS**								
Commissioning – Third Sector	**JJ/AC**								
Follow up and agreed Action Implementation Tracking -	**JJ/JW**								
Integrated Audit & Assurance Plans (SSU) – Withybush General Hospital Fire – Phase 2	**EJ/LD**								
Glangwili General Hospital Fire – Phase 2	**EJ/LD**								
CLINICAL AUDIT									
Review annual forward clinical audit plan and terms of reference	**SD**	✓				✓			✓
Review the effectiveness of clinical audit – consider recs from the ECPG on suggested areas of activity for review by internal audit	**SD**	✓				✓			✓

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
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**			D	✓		✓		
Receive PPV annual report	**HT**			D	✓				
Receive Primary Care PPV report	**JP**			D	✓		✓		
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**								
COUNTER FRAUD									
Review work plan & results from Counter Fraud activities, including anti fraud policies, etc.	**CFO**	✓		✓	✓	✓	✓	✓	✓
To provide an update on the cases highlighted as part of the counter fraud update report (In-Committee)	**CFO**	✓		✓	✓	✓	✓	✓	✓
Review and approve Counter Fraud Annual Report	**CFO**	✓							✓
Review and approve annual forward work plan for Counter Fraud activities	**CFO**	✓							✓
NHS CF Authority SRT Return	**CFO**	✓							✓
Right To Work Governance and Checks (In-Committee)	**AC/RE**	✓		✓					
Annual Review of Requisitions	**CFO**						✓		

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
Counter Fraud, Bribery and Corruption Policy Review (3 yearly)	**CFO**				✓				
Review the Health Board's assessment against NHS Protect Qualitative Assessment Reviews*	**CFO**								
ASSURANCE AND RISK									
Audit Tracker	**JW/CW**			✓		✓		✓	
Risk Assurance Report	**JW/CW**	✓			✓		✓		✓
Risk Management Framework and Strategy	**JW/CW**				✓				
Scrutiny of Outstanding Impr Plans *	**JW/CW**								
DEEP DIVE									
Planned Care						✓			
FOR INFORMATION									
ARAC Work Programme 2025/26	**Chair**	✓		✓	✓	✓	✓	✓	✓
Audit Wales Letter regarding Future Report Writing Style					✓				
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	**IMs – Independent Board Members**	**LG – Lisa Gostling**
AG – Ardiana Gjini	**JJ – James Johns**	**MH – Mark Henwood**
CH – Carly Hill	**JP – Jill Paterson**	**NLl – Nicola Llewellyn**
CW – Charlotte Wilmshurst	**JS – James Severs**	**PK – Philip Kloer**
CFO – Counter Fraud Officer	**JW – Joanne Wilson**	**RE – Rob Elliott**
CSO – Committee Services Officer	**KJ – Keith Jones**	**SA – Shaun Ayres**
EDs – Executive Directors	**LC – Liz Carroll**	**SD – Sharon Daniel**
EJ – Eifion Jones	**LD – Lee Davies**	**SMJ – Sian-Marie James**
HIW – Healthcare Inspectorate Wales	**LO'C – Louise O'Connor**	**TP – Tracy Price**
HT – Huw Thomas		

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

13:00, 0 Mins

10 - Any Other Business

11

13:00, 0 Mins

11 - Review of Meeting

11.1 **13:00, 0 Mins**

11.1 - Matters and Risks for Escalation to the Board

For discussion

12

13:00, 0 Mins

12 - Date and Time of Next Meeting

9.30am, 14 October 2025