Date	**2026-08-13**
Time	**09:30 - 12:00**
Location	**Microsoft Teams Meeting; HDD Picton - Dolau Cothi**

Audit & Risk Assurance Committee Meeting

HDD_Audit and Risk Committee

NHS Wales

Agenda - 13 August 2026

1 1 Introductions

09:30, 0 min

1.1 Apologies

09:30, 0 min
Rhodri Evans (Hywel Dda UHB - Independent Member)

1.2 Declaration of Interests

09:30, 0 min
All

2 Governance

09:30, 0 min

2.1 Minutes of the Meetings held on 7 May and 23 June 2026

09:30, 0 min
Rhodri Evans (Hywel Dda UHB - Independent Member)

2.2 Table of Actions

09:30, 5 min
Rhodri Evans (Hywel Dda UHB - Independent Member)

2.3 Matters Arising not on Agenda

09:35, 0 min
Rhodri Evans (Hywel Dda UHB - Independent Member)

2.4 Escalation Status Update Report

09:35, 15 min
Philip Kloer (Hywel Dda UHB - Chief Executive), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Shaun Ayres (Hywel Dda UHB - Director of Delivery)

3 Audit Wales

09:50, 0 min

3.1 Audit Wales Update Report

09:50, 5 min
Anne Beegan, Urvisha Perez

3.2 Review of Cancer Services

09:55, 0 min
Anne Beegan, Urvisha Perez

3.3 Deep Dive Review of the Arrangements to Manage Estates

09:55, 0 min
Anne Beegan, Urvisha Perez

4 Financial Focus

09:55, 0 min

4.1 Financial Assurance Report

09:55, 5 min
Huw Thomas (Hywel Dda UHB - Director of Finance)

4.2 Counter Fraud Update

10:00, 5 min
Benjamin Rees (Hywel Dda UHB - Local Counter Fraud Specialist)

5 NWSSP – Audit and Assurance Services - Internal Audit

10:05, 0 min

5.1 Internal Audit Plan Progress Report

10:05, 10 min
James Johns (NWSSP - Internal Audit)

5.2 Correspondence Regarding Audit Participation and Implementation of Recommendations

10:15, 10 min
Rhodri Evans (Hywel Dda UHB - Independent Member), Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair), Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

5.3 Capital Equipping (Limited Assurance)

10:25, 20 min
James Johns (NWSSP - Internal Audit), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning)

5.4 **Progress Update on Major Infrastructure Investment Programme Internal Audit**

10:45, 15 min
Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Rob Elliott (Hywel Dda UHB - Programme Director Major Infrastructure Projects)

5.5 **BREAK**

11:00, 10 min

5.6 **Progress Update on Human Tissue Authority Internal Audit**

11:10, 15 min
James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science), Jonathan Arthur (Hywel Dda UHB - Deputy Director of Health Sciences), Craig Baker (Hywel Dda UHB - Cellular Pathology Service Manager)

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6 **Assurance and Risk**

11:25, 0 min

6.1 **Scrutiny of Outstanding Improvement Plans - Update on Status of Risks and Audits: Community and Integrated Medicine**

11:25, 20 min
Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Peter Skitt (Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine), Anna Chiffi (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality)

6.2 **Risk Assurance Report**

11:45, 10 min
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

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7 **For Information**

11:55, 0 min

7.1 **ARAC Workplan 2026/27**

11:55, 0 min

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8 **Any Other Business**

11:55, 5 min

9 Review of Meeting

12:00, 0 min

9.1 Matters and Risks for Escalation to the Board

12:00, 0 min

10 Date and Time of Next Meeting

12:00, 0 min

In-Committee Session

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09:30, 0 Mins

1 - 1 Introductions

1.1

09:30, 0 Mins

1.1 - Apologies

Rhodri Evans (Hywel Dda UHB - Independent Member)

For information

1.2 **09:30, 0 Mins**

1.2 - Declaration of Interests ***All***

HDdUHB Register of Board Members Interests 2026-27

For information

2

09:30, 0 Mins

2 - Governance

2.1

09:30, 0 Mins

2.1 - Minutes of the Meetings held on 7 May and 23 June 2026

Rhodri Evans (Hywel Dda UHB - Independent Member)

For approval

Attachments

2.1 Unapproved ARAC Minutes 7 May 2026.pdf

2.1 Unapproved ARAC Minutes 23 June 2026.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, Thursday 07 May 2026**
Venue: **Virtual, via Microsoft Teams and Picton Terrace**

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, Hywel Dda UHB (VC)

In Attendance:
Ms Urvisha Perez, Audit Wales (VC)
Mr David Williams, Audit Wales (VC)
Mr James Johns, Head of Internal Audit, NWSSP (VC)
Mr Murray Gard, Audit Manager, Specialist Services Unit, NWSSP (VC) (part)
Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary
Mr Huw Thomas, Executive Director of Finance (VC)
Professor Philip Kloer, Chief Executive (VC)
Mrs Lisa Gostling, Director of Workforce and OD/Deputy Chief Executive (part)
Mr Lee Davies, Executive Director of Strategy and Planning (part)
Ms Alwena Hughes Moakes, Communications and Engagement Director (VC) (part)
Mr Anthony Tracey, Digital Director (VC) (part)
Ms Janice Cole-Williams, Assistant Director of Nursing (VC) (part)
Mr Rob Elliott, Programme Director Major Infrastructure Projects (VC) (part)
Ms Fiona Hancock, Senior Communications Officer (VC) (part)
Ms Rhian Davies, Assistant Director of Finance (VC) (part)
Mr Timothy John, Head of Accounting and Statutory Reporting (VC) (part)
Ms Clare Moorcroft, Committee Services Officer (minutes)

Minutes Ref.	Item	Action
AC(26)73	**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 Sophie Corbett, Deputy Head of Internal Audit, NWSSP • Miss Charlotte Wilmshurst, Assistant Director of Assurance and Risk • Ms Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience • Ms Heather Hinkin, Assistant Director, People Management	
AC(26)74	**Declaration of Interests** Mr Maynard Davies declared an interest in relation to item AC(26)76, noting that he participated in the procurement process by which CGI were appointed as the Health Board's digital partner.	

AC(26)75 Audit Wales Update Report

Ms Urvisha Perez introduced the Audit Wales Update Report, noting that the Digital Transformation review is complete and is included on today's agenda. The remainder of performance audit work is at fieldwork or planning stage. Members were advised that the update report now reflects this year's Audit Plan, which was presented to ARAC last month. Ms Perez wished to highlight that Audit Wales is currently reviewing the Structured Assessment. Plans are still being finalised and an update will be provided in due course. Audit Wales has not published any national reports relevant to the Health Board since the last meeting; however, a link is provided in the report to its Annual Plan.

Highlighting the new 'Well-led' Framework being introduced by Welsh Government, Mrs Joanne Wilson suggested that the potential impacts and links to planned audit work will require future consideration. Cllr. Evans enquired whether a timescale has been identified for the Review of Eye Care Services. In response, Ms Perez advised that this is currently at the planning stage. Once resourcing has been confirmed, a date will be indicated in the Audit Plan. She would aim to do so by the next meeting. Cllr. Evans also requested assurance regarding whether proposed audit delivery dates were achievable and this was confirmed by Ms Perez.

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

The Committee agreed to **ASSURE** the Board in relation to the Audit Wales Update.

AC(26)76 Digital Transformation Review

Ms Perez presented the Digital Transformation Review report, which had considered the Health Board's approach to the digital transformation in supporting service improvement, specifically the approach to strategy, leadership and skills development. It had also evaluated how the organisation manages risks around digital infrastructure, cyber resilience and Artificial Intelligence (AI). Members were advised that the latter section has been redacted from the public domain, due to sensitivities around cyber risk. The full report will be discussed during the In-Committee session.

In terms of key messages, Ms Perez indicated that the report was generally positive. The Health Board has a clear and ambitious approach to digital transformation, supported by strong leadership and an established strategic plan. Whilst Board oversight of digital transformation is effective, assurance could be strengthened by consolidating information on digital initiatives and the outcomes and impacts of engagement across digital engagement projects. There is a commitment to investing in digital transformation, demonstrated by the 10 year strategic partnership with CGI. However, limited funding poses a risk to the delivery of the strategic priorities. The Health Board is actively progressing a

range of local and national projects, with the three year digital transformation roadmap aiming to improve outcomes and staff experience and drive financial sustainability.

There is a good approach to evaluating digital projects and tracking benefits. The Health Board is making good progress in understanding and improving digital skills through targeted training, the skills pathway and digital inclusion initiatives. However, digital confidence varies across the organisation and the absence of a standalone digital workforce plan is a noticeable gap, especially as digital transformation activities accelerate. There is a strong commitment to digital inclusion and partnership working. Engagement with staff and service users is improving through clinical informatics leads, digital champions, and design workshops. The Health Board also actively contributes to national and regional programmes, with many of the national digital peer groups chaired by the Health Board's digital leaders.

In total, Audit Wales has made five recommendations, one of which will be discussed during the In-Committee session. The Health Board's completed management response is provided. Finally, Ms Perez advised that Audit Wales will be producing a national digital report, which will consider national leadership, including Digital Health and Care Wales (DHCW) and Welsh Government.

Mr Huw Thomas thanked Ms Perez and the team for this timely review. He recalled a session provided to Executive Directors by an Organisational Development (OD) digital specialist, who had suggested that last year was the 'final year of normal', given the pace of change in digital transformation. Certainly, progress in relation to AI has been extremely rapid. The review and report have provided a number of helpful additions to the Health Board's approach. Mr Thomas suggested that the Digital, Data and Innovation Committee (DDIC) has strengthened oversight in this area. The report's findings dovetail well into the DDIC workplan and provide a useful way forward. Finally, Mr Thomas thanked Audit Wales for issuing a redacted version of the report.

Mr Anthony Tracey joined the Committee meeting.

Cllr. Evans suggested that the report should be considered by DDIC. Agreeing, Mr Maynard Davies, Chair of that committee, welcomed the useful report. He felt that its findings both reflect reality and his assessment, and provide the Health Board with appropriate challenge where further work is required. The latter includes workforce and minimising duplication. Above all, the themes within the report are recognisable. Mr Maynard Davies noted that the report does not seem to include a conclusion on the Health Board's position with regard to digital transformation. Ms Perez committed to feed this back, although Mr Thomas suggested that a comparison between organisations may form part of the planned national report. To provide further assurance around the review findings, Mrs Wilson advised that similar

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themes had emerged from the recent DDIC self-assessment exercise.

Mr Winston Weir thanked Audit Wales for their report, and agreed with the views of colleagues. He would also welcome, as part of the national report, an assessment of how HDdUHB compares with other health boards in terms of digital transformation. In regard to the recommendation around a standalone digital workforce plan, Mr Weir noted that the Health Board's workforce comprises a high proportion of older staff. He enquired whether the recommendation is aimed at providing these staff with the requisite skills and equipment, and raising the profile of digital. Secondly, what Audit Wales sees as the key elements of a good digital workforce plan.

In clarifying the reason for this recommendation, Ms Perez suggested that, whilst there is a great deal of activity to upskill staff, there is no link back to the Health Board digital strategic plan. There is a need to map ambitions in the strategic plan with the skills required to achieve them. It is recognised that different skillsets will be required for different staff groups, and that individual staff have different baselines in terms of digital skills. In response to a further query around whether other health boards have digital committees, Members heard that this varies, with one having recently disbanded its digital committee. Mr Thomas welcomed Mr Weir's comments, indicating that these also highlight a broader cultural issue which the Health Board needs to address. Digital adoption is a challenge, demonstrated by the rollout of electronic patient flow systems, where engagement has been variable. Adoption and use of the systems has reflected this pattern. Addressing this issue will be key. Returning to the recommendation around a standalone digital workforce plan, Mr Maynard Davies queried whether this should indeed be separate, or whether it would be more appropriate to enhance the existing workforce plan with greater digital input and leadership. The management response focuses on the former; however, he emphasised that digital input needs to be all-encompassing.

Mr Thomas agreed with this helpful feedback, indicating that he had reflected on the matter further since the management response was prepared. One of the themes which had emerged from the OD session mentioned earlier was whether the focus should be on digital leadership, or leadership in a digital age. He felt that it was the latter, and assured Members that there is a commitment to one workforce plan, with digital enhancement. Mrs Eleanor Marks agreed that leadership in a digital age is the more relevant. She also welcomed the report, suggesting that there should be consideration of next steps and skills and resourcing implications. Whilst technical ability is required, there also needs to be leadership to ensure digital is prioritised.

Commending the report, Professor Philip Kloer emphasised the importance of leadership from a Board perspective also. He is aware that consideration is being given to Board and Executive

Team OD; specialist OD advice and support will be required. Mrs Wilson explained that the OD input mentioned by Mr Thomas has been provided to Independent Board Members as well as Executive Directors. She recognised, however, that further OD provision will be required. Cllr. Evans agreed with colleagues that there should not be a standalone digital workforce plan; rather, that digital should be enhanced in the organisational workforce plan. He further enquired whether this is sufficiently embedded in the Health Board's Annual Plan, to ensure clarity around direction. Whilst suggesting that the review's recommendations probably require further reflection, Mr Thomas assured Members that this is an area in which work is being prioritised. Anything not sufficiently emphasised in the Annual Plan can be addressed.

With regard to OD, Mr Anthony Tracey acknowledged that actions to address this aspect could have been made more explicit in the management response. He indicated that, at an operational level, various steps are being taken, including training and surveys delivered by the Digital Inclusion team, and development of a digital inclusion delivery framework. A Digital OD post within the Workforce and OD team has also just been approved and should be advertised shortly. There will be a strong link between this post and the Digital team. In terms of the workforce plan, whilst there is a comprehensive workforce plan for the digital technical side, Mr Tracey recognised the need to expand this further, with input around digital inclusion. He is undertaking work around the concept of a digital adoption team, to ensure that when new systems are introduced, there is an adoption approach which will consider digital inclusion, individuals' capabilities and skills. It is hoped that this will remove some of the barriers to digital adoption.

Mr Maynard Davies emphasised the valuable work which has been and is being undertaken by the Digital Inclusion team. He suggested that the planned relaunch of the digital strategic plan should include consideration of the workforce aspect. Agreeing, Mr Thomas highlighted that the regional perspective also requires consideration; however, this can be undertaken once the national report has been issued. In response to a query around whether the stated completion dates are achievable, Mr Tracey confirmed that they are. With regard to potential challenges, however, it was noted that management capacity may be an issue, given the significant workload around digital programmes, particularly the rollout of Electronic Staff Record (ESR) 2. Returning to an earlier query, Professor Kloer highlighted that Goal 5 in the Health Board's Annual Plan, around Great Care, covers digital in detail. Whilst he did feel that digital is sufficiently embedded in this document, he agreed that it should be tested against the review's recommendations. This provides a useful check and challenge.

Decision: The Committee **NOTED** the Audit Wales Digital Transformation Review.

The Committee agreed to **ASSURE** the Board in relation to the Audit Wales Digital Transformation Review.

Mr Anthony Tracey left the Committee meeting.

AC(26)77 Internal Audit Plan Progress Report

Mr James Johns introduced the Internal Audit Plan Progress Report, which provides the usual update on progress in delivering the Internal Audit Plan. Section 2 of the report details those audits finalised since the previous meeting, with two having been awarded Reasonable Assurance ratings. Several audits due to be presented at today's meeting have been deferred to June 2026. Members were assured that all audit work will be finalised by then, to facilitate production of the final Head of Internal Audit Opinion and the conclusion of the Annual Report. Referencing discussion at the previous meeting around the Opinion, it has been decided at this stage to postpone confirming this until other work is completed. Internal Audit will look to issue an Opinion as soon as it is felt that all contributory elements have concluded.

Cllr. Evans noted that a lack of a draft Head of Internal Audit Opinion at this point represents an unusual and position for the Health Board. In addition, the number of deferred reports will make the next meeting extremely challenging. He was also concerned to note the statement that the GP Out of Hours audit is still at the planning stage. With regard to the latter, Mr Johns explained that a discussion had taken place around the brief and scope for this audit, which has delayed commencement. He assured Members that it will be possible to now progress this at pace. Mrs Wilson agreed that the position is not as would be wished, emphasising that this matter has been discussed at length with the Internal Audit team. She suggested that a meeting be scheduled between Cllr. Evans, Mr Thomas, Mr Johns and herself, to discuss this further and ensure that lessons are learned for future years. This should include particularly the need to forward plan sufficient time for scoping audits, dealing with queries and escalating issues. **JW**

Mrs Marks recognised that both parties involved with audits will be susceptible to issues which may contribute to delays. It is, however, unfortunate that the Opinion is not yet available, as this is a key piece of information for the Health Board. High numbers of deferred audits also have resourcing implications, in terms of Committee time and capability to apply due diligence. She had a number of queries and comments: firstly, whether the number and focus of internal audits is correct. Secondly, whilst the organisation has made progress in implementing audit recommendations, there is further room for improvement. Mrs Marks' third query was more specific, relating to the Sickness Management audit. All recommendations are marked as high priority; however most are implemented or partially implemented. She enquired why these are still rated as Red and Amber.

In response to the final query, Mr Johns explained that the Red and Amber classifications are the priority ratings from the original report, not new ratings. Mrs Wilson addressed the issue of

whether the number and topic of internal audits is correct. She felt that it is, given that it reflects a risk-based approach and recognising that this can negatively impact on audit outcomes. It is imperative, however, that there is clarity around which audits are being undertaken and when, and that this is adhered to. Mrs Wilson agreed that improvements are required in terms of both implementing recommendations and in making these more robust. Agreeing, Mr Thomas noted that the Performance Dashboard evidences that the organisation is not sufficiently adept at closing down audit recommendations. Members heard that this is due to be addressed via the new ways of working being introduced at an operational level.

Cllr. Evans requested assurance that all outstanding audit reports will be presented to the June 2026 meeting. Mr Johns confirmed that all audit fieldwork is either complete or well underway, with the exception of the GP Out of Hours audit already mentioned. In response to a query around the anticipated timescale for confirming the Head of Internal Audit Opinion, Mr Johns reminded Members that at the previous meeting he had indicated this may be one of Limited Assurance. He had also described the additional narrative being drafted to accompany the Opinion. Mr Johns is keen to close off a number of outstanding audits before confirming the position; particularly one audit, which has involved additional evidence and clarification. He emphasised the importance of considering every element of information available to inform the overall Opinion; for this reason, it is challenging to give a definite date at this stage. Mrs Wilson indicated that she will be meeting with Mr Johns next week and committed to provide an update to the ARAC Chair following their discussion. **JW**

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

The Committee agreed to **ASSURE** the Board in relation to the Internal Audit Plan Progress Report.

AC(26)78 Sickness Management Follow-up (Review)

Mrs Lisa Gostling and Ms Janice Cole-Williams joined the Committee meeting.

Mr Johns introduced the Sickness Management Internal Audit report, which outlined the follow-up to an earlier audit, together with sickness management elements of the previous Nursing Management audit. It had been identified that there were a number of common issues and related actions from both of these audits. Of the three key areas from the previous report being followed-up, one has been fully implemented and two partially implemented. The findings confirm that work has been undertaken to address outstanding issues. This included the development of template documents for service areas to utilise, although these are at different stages of implementation. It is felt that further work could be undertaken to adopt a more consistent approach. There

are, however, a number of other areas which still require focus, to improve sickness management at the operational level across the whole organisation.

Welcoming the report, Mrs Lisa Gostling noted that the area found to be partially implemented is around managers undertaking audits of their sickness absence. She further noted the comment that the Workforce and OD team have not audited these audits. In response, she would wish to highlight that this team has three members dealing with sickness absence for 13,000 Health Board staff. It was suggested that the focus should be on responsibility and accountability, with all managers having a responsibility for their staff and all the associated processes and policies. The audit requirement for an audit checklist to be produced has been implemented. However, it is for directorates, Clinical Care Groups (CCGs) and their managers to complete. In addition, when staff are absent due to sickness, it is the managers' responsibility to ensure this is reported in a timely way, recorded on ESR, and that Return to Work (RTW) discussions and any reviews required are undertaken. Additional support is being offered to CCGs, with Mrs Gostling and her team reviewing every member of staff on long-term sickness absence to ensure the correct process is being followed. However, this arrangement cannot be sustained; there needs to be instilled in managers the concept that sickness management is part of their routine activity in managing staff.

Mr Maynard Davies agreed that this is a managerial responsibility, whilst querying how this can best be reinforced and enforced. It is vital for sickness absence to be managed correctly and consistently, not least because it can cause discontent among staff if it is not. He enquired as to the level of confidence around effective operation of the system, which already exists, and queried whether the timescales for the original recommendations had been overly optimistic. With regard to the latter, Mrs Gostling noted that the date of September 2025 to implement the process had been met. The issue is application of and compliance with the process on an ongoing basis, as this is not occurring consistently. These gaps are recognised; it is hoped that implementation of the new ESR system will assist. Whilst the current ESR does issue auto-reminders, this will be via a different portal and mechanism under the new ESR, which may have benefits. With regard to actions from the original audits, Ms Janice Cole-Williams wished to emphasise that the development of a good practice guide has taken place. This has been developed based on good practice identified at Prince Philip Hospital and has been circulated to all roster managers in nursing. It is suggested that consideration be given to whether other staff groups might find it useful. The cultural aspect of this topic is recognised; however, an improved staffing position in nursing should afford greater capacity to manage sickness more effectively. Whilst good progress has been made, more work is required.

Mrs Marks shared the view that it is the job of managers to manage, adding that sickness management also involves staff

wellbeing. It concerns how the organisation lives its values, and enables managers to check whether staff are being impacted by factors other than illness. She suggested that it be 'reframed' in these terms. It was also noted that RTW discussions, for example, are sometimes undertaken in an informal way; however, they need to be formally recorded. Mrs Marks agreed that there is a cultural aspect and whilst there are examples of good practice, there are also instances of poor practice. Ultimately, it is not acceptable for Executive Directors to be undertaking tasks which are the responsibility of managers.

In response to a request for assurance that the approach will be consistent, Mrs Gostling expected that every manager is provided with information around the required process. As mentioned, the Workforce and OD team has three sickness management coordinators, who will support and educate as necessary; however, the new ESR system will also reinforce messages and assist. Cllr. Evans suggested that this area clearly needs further work and queried how best to maintain scrutiny. He felt that any future review should focus on management compliance, rather than outcomes. Mrs Gostling felt that there is scope to link this with the Grip and Control work outlined in a later agenda item. Agreeing, Mr Thomas stated that the organisation is aware of challenges in relation to annual leave management and roster management. Robust processes are in place for these and sickness absence management; however, they are not being complied with.

Responding specifically to Cllr. Evans' concerns, Mrs Wilson suggested that oversight by other committees might be more appropriate. From an ARAC perspective, whilst it was felt that assurance can be taken around implementation of actions, ongoing compliance needs to be the focus. Building on these comments, Mr Thomas was of the opinion that there should be more audits centred on compliance with processes, rather than of the processes themselves. The latter tends to lead to repeated design and re-design of processes, which does not always address the issue. Mr Weir highlighted that, whilst assurances have been received, the report does not actually confirm that the recommendations have been implemented. In response, Mrs Gostling explained that the partially implemented status recognises that, whilst the audit criteria have been defined and shared with directorates, the evidence that they are taking place is not yet available. Hence the concerns around compliance.

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

Whilst assured regarding implementation of the actions outlined within the audit recommendations, the Committee agreed to **ADVISE** the Board regarding the Sickness Management Follow-up (Review) Internal Audit report, given concerns around compliance with sickness management processes.

Mrs Lisa Gostling and Ms Janice Cole-Williams left the Committee meeting.

AC(26)79 Major Infrastructure Investment Programme (Reasonable Assurance)

Mr Lee Davies and Mr Rob Elliott joined the Committee meeting.

Mr Murray Gard introduced the Major Infrastructure Investment Programme Internal Audit report. The programme aims to address the estate's infrastructure risks across the Health Board's acute sites. The audit had concluded an overall opinion of Reasonable Assurance. This reflected findings that the programme is well-founded, risk-based and supported by a strategic rationale, whilst recognising that certain areas do need strengthening as the programme progresses. The programme's prioritisation was robust, well-documented and underpinned by the strategic estates development plan. One high priority issue around advisors' contracts not having been executed at the time of audit had been identified; however, this has now been fully resolved and all contracts are now in place, significantly strengthening the programme's contractual position. Of the remaining actions, several have already been completed.

Mr Lee Davies thanked the team for the helpful and positive report. In terms of prioritisation, the Health Board faces a number of significant risks and needs a robust prioritisation approach, especially given limited capital availability. The issue in relation to advisors contracts had been an oversight in the process, which has now been addressed. Adding his thanks, Mr Rob Elliott emphasised the journey undertaken by the organisation in terms of infrastructure investment, which had included various exercises in response to Welsh Government requests. He felt that the culture has changed, with more joint working with both Welsh Government and the NHS Wales Shared Services Partnership (NWSSP). This has helped to change views and create a more positive and supportive working relationship.

Whilst acknowledging the positive assurance rating, Cllr. Evans felt that there are a number of themes in the report which are of concern, particularly around procurement. Mr Maynard Davies agreed, noting that it was pleasing to see a number of actions already implemented. However, he highlighted in particular the high priority recommendation and queried the appointment of an external project manager via a consultant contract. Such contracts usually require Board approval and assurance was requested around the processes followed in this case. In response, Mr Elliott explained that the Project Manager had been appointed late in the process, due to challenges in securing funding. The contract was based on the contract element of the framework structure used for this particular procurement exercise. Whilst their status is the same as the other consultants, who were appointed via a more traditional Joint Contracts Tribunal (JCT) approach; a different, shortened, contract version had been used. He assured Members

that it is a legitimate contract, and is the same as that used for other consultants such as architects and engineers.

Mr Maynard Davies emphasised that this is the heart of his query, as such consultant contracts, if in excess of £25k, should be reported to and approved by ARAC and the Board. Cllr. Evans shared this concern and had others regarding procurement in general, and requested assurance that the correct processes are being adhered to. He also noted that the contract cost which was originally £1.07m had increased to £1.7m and enquired whether checks are in place to ensure value for money. Whilst recognising that there is greater grip and control on expenditure, Mrs Marks echoed her colleagues' concerns and queried whether potential issues around procurement might have resulted in this project costing more and taking longer than it should. Mr Lee Davies confirmed that the award of the contracts in question had been considered by the Board.

To clarify the change in project value, Mr Elliott explained that when the consultant appointments were first put out to tender, the project cost was based on priorities at that point in time. Subsequent to this, the Health Board was able to secure a substantial sum from the Targeted Estates Fund (TEF), which enabled it to fast track certain elements. This meant they could be removed from the major infrastructure plan. At the same time, the Health Board was beginning the engagement with the NWSSP technical team to jointly develop and agree on priorities. This piece of work identified far greater risks and additional areas not included in the original plan. As a result, the workload and scope changed, meaning that these additional costs were appropriate. The costs were fully validated and taken through the appropriate forum (Financial Control Group at that time). The Procurement team was also fully involved in this process. To address Mrs Marks query, scrutiny and evaluation, in conjunction with Procurement, suggests that the project has not cost any more than it should have. It has not taken any longer, because until the money from Welsh Government came online in December 2025, the Health Board was not able to progress the project.

Mr Thomas wished to preface his comment by recognising that leadership arrangements in this area have changed only recently. However, this is not the first time that procurement or contract management within Estates has been discussed at ARAC, suggesting a need for further reflection. He highlighted that Estates is the only function in the Health Board which manages its own procurement. Within every other function, the Procurement team provides a more direct approach, which serves to ensure compliance with procurement processes. He felt that the concerns raised need to be addressed and taken seriously in advance of any future discussion of major estates projects. Particularly as contract management is an area which tends to attract challenge within new infrastructure development.

Mr Thomas suggested that he work with Mr Lee Davies, Mrs Wilson and Mr Elliott, in dialogue with the Procurement team, to establish how greater assurance can be provided. Mrs Marks welcomed this suggestion. Whilst accepting the explanation provided by Mr Elliott, she felt that, had the project been subject to the processes and checks other functions are, it may have been managed differently. Mr Elliott also welcomed Mr Thomas' suggestion for moving forward, agreeing that consideration should be given to how the role of Procurement in estates projects can be strengthened. Returning to the issue of whether the consultant appointment was approved, Mr Maynard Davies noted that, whilst there had been Board approval of the project, the consultant element was not explicitly identified. He felt that this issue needs to be drawn out, reviewed and clarified, particularly as the Health Board is required to report consultancy expenditure as part of its Annual Report. **HT/LD/ JW/ REII**

Mr Thomas emphasised the importance of adhering to definitions and terminology. The discussion today involves professional services, not management consultants. It is contracts in excess of £25k for the latter which require Board approval. However, using consultancy contracts for professional services blurs the definitions, potentially causing confusion. Hence the importance of working with Procurement, and not procuring outside recognised processes or frameworks, ensuring clarity around approval routes. The challenge is that Estates procure their own services, which is quite different to the way in which the rest of the organisation operates. This can be considered during the discussion proposed above. Mr Lee Davies wished to clarify that Estates in this context refers to estate capital projects, not Estates and Facilities.

Drawing discussions to a close, Cllr. Evans enquired whether auditors were content that the core controls they had identified as being absent are now in place. In response, Mr Gard highlighted that NWSSP attend and observe the Programme Group, and see the information which is presented on a monthly basis. He was able to assure Members that controls are in place and operating appropriately. Mr Gard also wished to comment on discussions around contracts, acknowledging that there is scope for greater clarity in report wording. He confirmed that these individuals were not consultants, but professional advisors, using consultant contracts. He would feed back this information to ensure future reports reflect this more clearly. Members discussed the various concerns raised by this report, agreeing that it should be revisited at a future meeting, following the discussion proposed above. **MG** **LD**

Decision: The Committee **NOTED** the Major Infrastructure Investment Programme (Reasonable Assurance) Internal Audit report.

Whilst assured regarding implementation of the actions outlined within the audit recommendations, the Committee agreed to **ADVISE** the Board regarding the Major Infrastructure Investment Programme (Reasonable Assurance) Internal Audit report. This

was due to concerns around cost controls, clarity regarding use of consultancy and professional services contracts and adherence to procurement processes within capital estates projects. Further, that this issue would be revisited at a future meeting.

AC(26)80 Withybush General Hospital – Fire Precautions Works Phase 2 (Reasonable Assurance)

Mr Gard introduced the Withybush General Hospital – Fire Precautions Works Phase 2 Internal Audit report, which had also concluded an overall opinion of Reasonable Assurance. The audit identified that the project was progressing within its approved cost envelope, with positive governance and financial management. A phased 'mini' accounts approach across the work zones represents good practice and supports strong financial discipline within the project. The project has clear leadership and effective oversight through the Project Group. The level of stakeholder engagement in place was also of particular note, with constructive collaboration between the Project Group, hospital teams and importantly, the Mid and West Wales Fire and Rescue Service (MWWFRS). This represents positive progress based on lessons learned from previous phases.

Certain areas where controls can be strengthened have been highlighted within the report. There was one high priority issue identified, in relation to fire training compliance, which has not consistently met the 85% threshold. Similar to the previous agenda item, a number of actions within the report have been completed already. Finally, Mr Gard wished to highlight and apologise for a minor error on the penultimate page of the report. The final statement should read 'A long-term plan may also be required to ensure where staff fire training is due for renewal; sufficient time is given to plan for attending the necessary training on a timely basis'.

Welcoming the report, Mr Lee Davies wished to recognise the efforts made and progress achieved by Mr Elliott in developing the working relationship with MWWFRS, which has led to significant improvements. It is also important to note that negotiation of a lower specification on Fire Precautions works was based on a commitment to higher levels of fire training compliance. Whilst the Health Board is currently at the required level, this needs to be monitored on an ongoing basis. It would have a significant impact if MWWFRS were to change their view in this regard. Mrs Wilson assured Members that this matter is scrutinised and monitored at the Health and Safety Committee, and was discussed in detail at its most recent meeting. Given the importance of fire training compliance, Cllr. Evans enquired regarding accountability for this. Mr Lee Davies responded that this lies with Health Board staff and managers. He explained that there are three levels of fire training, with requirements and accountability dependent on staff group.

Referencing the management response of '(Future action)' to Key Finding 6, Cllr. Evans queried the lack of completion or implementation date, highlighting the challenges this causes in

tracking progress. Mr Elliott explained that the specific issue outlined in this finding has elapsed due to the NEC Supervisor having been appointed for this project; however, it is intended to address this recommendation for future projects. Following discussion, it was agreed that a management response would be developed to enable tracking that these areas had progressed. **LD**

Decision: The Committee **NOTED** the Withybush General Hospital – Fire Precautions Works Phase 2 (Reasonable Assurance) Internal Audit report.

The Committee agreed to **ASSURE** the Board in relation to the Withybush General Hospital – Fire Precautions Works Phase 2 (Reasonable Assurance) Internal Audit report.

Mr Lee Davies and Mr Rob Elliott left the Committee meeting.

AC(26)81 Infection Prevention & Control

DEFERRED to 23 June 2026 meeting

AC(26)82 Commissioning Third Sector

DEFERRED to 23 June 2026 meeting

AC(26)83 Wellsky System

DEFERRED to 23 June 2026 meeting

AC(26)84 Decision Making for High Cost Drugs

DEFERRED to 23 June 2026 meeting

AC(26)85 GP Out of Hours

DEFERRED to 23 June 2026 meeting

AC(26)86 Report on the Adequacy of Arrangements for Declaring, Registering and Handling of Interests, Gifts, Hospitality, Honoraria and Sponsorship

Mrs Wilson presented the report, which describes the annual review process undertaken. Specific actions include review and enaction of the policy, increased promotion of the policy. There has been regular messaging in this regard, in addition to tailored training, particularly coming up to the Senedd election. There has also been work undertaken with the high risk groups, which has increased compliance from 25% to 63%. It is recognised, however, that further work is required.

Decision: The Committee:

- **TOOK ASSURANCE** from the adequacy of the arrangements in place for declaring, registering and handling interests, gifts, hospitality, sponsorship and honoraria during 2025-26, for onward assurance to the Board.
- **NOTED** the improved Declaration of Interests compliance rate among staff in ‘high risk’ groups, as compared with the previous year.

- **NOTED** the consultation undertaken to inform the scheduled review of the Standards of Behaviour Policy.

The Committee agreed to **ASSURE** the Board in relation to the Report on the Adequacy of Arrangements for Declaring, Registering and Handling of Interests, Gifts, Hospitality, Honoraria and Sponsorship.

AC(26)87 **Draft Audit and Risk Assurance Committee Annual Report 2025/26**

Introducing the Draft ARAC Annual Report 2025/26, Cllr. Evans wished to record his thanks to Mrs Wilson, Mr Thomas and all the teams involved in contributing to this document. He highlighted in particular the approach to Internal Audit which, whilst it can create challenging audit outcomes, focuses for good reason on those areas where it is recognised that there are issues. This is an important principle and is the correct approach. Mrs Wilson felt that the report served as an accurate reflection of the work undertaken during the year, with the breadth of topics covered reflected in detail. She recognised that the demands place on committee Members, particularly at this time of year, were particularly significant and thanked them for both their support and challenge. Adding his thanks to fellow ARAC Members, Cllr. Evans also wished to thank Executive Directors and Lead Officers for their contributions to meetings during the year.

Referencing section 5 on page 5, Mr Maynard Davies noted that Healthcare Inspectorate Wales (HIW) had declined a private meeting with ARAC Members once again, and requested assurance that engagement is taking place. Mrs Wilson explained that HIW employ alternative engagement processes. They are also invited to QSEC meetings, offering an opportunity for input. It was felt, however, that there should be engagement in a private forum with ARAC Members, in the same way as for other regulators. It may be that the purpose of this process requires further clarification. Mrs Wilson offered to take this forward with Ms Sharon Daniel, who is the Executive Lead with responsibility for engagement with HIW. Professor Kloer indicated that he had met with HIW recently, as part of the new arrangements. It had occurred to him that it might be appropriate to invite the Chair of QSEC to these meetings; not necessarily every meeting. Mrs Marks was happy for this suggestion to be made to Ms Daniel. Mr Maynard Davies noted that the Chair of ARAC had, during the year, issued letters reminding Health Board staff of the importance of compliance with audit deadlines and constructive engagement with auditors. It was suggested that this be reflected in the report.

JW

PK

JW

Decision: The Committee **AGREED** to provide feedback on the ARAC Annual Report within one week and **REQUESTED** Chair's Action to approve the content of the report, prior to onward submission to the Board.

The Committee agreed to **ASSURE** the Board in relation to the Draft ARAC Annual Report 2025/26.

AC(26)88 **Draft Head of Internal Audit Opinion and Annual Report 2025/26 (Verbal Update)**

Members agreed that this item had been covered during discussion of the Internal Audit Plan Progress report.

Decision: The Committee **NOTED** the Draft Head of Internal Audit Opinion and Annual Report 2025/26 Update.

The Committee agreed to **ASSURE** the Board in relation to the Draft Head of Internal Audit Opinion and Annual Report 2025/26 Update.

AC(26)89 **Assurance Report on Board Effectiveness**

Mrs Wilson introduced the report, which is provided for assurance prior to Board consideration. She reminded Members that there had been the subject of detailed discussion at the most recent Board Seminar, with changes made to the maturity level in two criteria. Members also noted that there may be changes to the framework for assessment of Board effectiveness in the future, for example in response to the new 'Well-led' Framework.

By way of a comment, Mr Maynard Davies referenced earlier discussions around 'leadership in a digital age' and the Audit Wales Digital Transformation report. He noted, however, that there is very little mention of digital in the Board Effectiveness assessment. He enquired whether, for future years, digital considerations, and how digital is being used to support the Board might be included. Mrs Wilson agreed to consider this as part of any review process.

Decision: The Committee **TOOK ASSURANCE** from the process that has been undertaken this year to review the Board's effectiveness, recognising that this has been discussed by the Board at the Board Seminar meeting held on 23 April 2026.

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

AC(26)90 **Audit Enquiries to those Charged with Governance and Management**

Presenting the report, Mr Thomas advised that preparation of a response is a standard, annual requirement. There are only fairly marginal changes to the response submitted last year, which is also included for information. As such, he had nothing further to add, explaining that the report is presented for the Committee's assessment. Mr David Williams confirmed that the letter is a standard one, and indicated that Audit Wales is content with the Health Board's response.

Decision: The Committee **REVIEWED** the response prepared and **RATIFIED** this for onward submission to Audit Wales.

The Committee agreed to **ASSURE** the Board in relation to the Health Board's response to the Audit Enquiries to those Charged with Governance and Management letter.

AC(26)91 Draft Performance Overview

Ms Alwena Hughes Moakes and Ms Fiona Hancock joined the Committee meeting.

Presenting the Draft Performance Overview section of the HDdUHB Annual Report, Mr Thomas thanked Ms Tracy Price in the Performance team, and colleagues in the Corporate Governance and Communications teams for their contributions. There had been a request to reduce the length of the Annual Report, and Mr Thomas suggested that it is a significant feat to have summarised the Health Board's achievements across the year in such a concise and readable format. Ms Alwena Hughes Moakes echoed this and added her thanks, particularly to Ms Fiona Hancock. It has been especially challenging to simplify terminology used in the Annual Report, which includes several extremely technical aspects. Members were assured that the report will be further enhanced, to make the final version even more accessible.

With regard to the process between now and the Annual General Meeting (AGM), Ms Hughes Moakes advised as follows: Assuming that ARAC is content, the draft will be submitted to Welsh Government and Audit Wales by Friday (tomorrow). It will be issued for translation next Monday, and the final Health Board Annual Report will be submitted for approval by ARAC on 23 June 2026 and at the Extraordinary Board meeting on 25 June 2026. Audit Wales and Welsh Government are then due to provide final approval at the end of June, prior to the report being presented to the AGM at the end of July. The timescale is, therefore, a challenging one.

Mrs Marks agreed that it had been a major achievement to summarise the Health Board's work during the year. She commended the report, noting that it is well-written and provides information which is accessible to both professional and public audiences. Recognising the pressured timescale, Cllr. Evans thanked all of those involved for their contributions. He queried whether the report presents a balanced view of the Health Board's achievements and unresolved issues, for example in relation to Urgent and Emergency Care. Professor Kloer added his thanks to all of the teams who have contributed. In response to Cllr. Evans' query, he highlighted that the organisation's performance against key improvement measures is set out quite starkly in the table on pages 15 and 16. He suggested that this is intended to provide transparency. The report seeks to focus on those areas where the Health Board has set out to make improvements, and on celebrating staff achievements. It does not try to conceal those issues where further improvement is required. He acknowledged the feedback, however, and suggested that it may be possible to

reflect this to a greater extent in his introductory statement as Chief Executive Officer.

Cllr. Evans observed that the level and scope of work involved in reports such as this is not always recognised. As the Health Board's Independent Board Member Champion for Welsh Language, he also wished to thank the Welsh Language team in particular for their contribution. Replying to a query around the number of responses received when the report had been circulated for comment, Ms Fiona Hancock advised that not all parties had responded. Members were assured, however, that they had all been offered the opportunity to comment.

Decision: The Committee **RECOMMENDED** the Performance Report chapter of the 2025/26 Annual Report for approval by the Board.

The Committee agreed to **ASSURE** the Board in relation to the Draft Performance Overview section of the HDdUHB Annual Report.

Ms Alwena Hughes Moakes, Ms Fiona Hancock and Mr Murray Gard left the Committee meeting.

AC(26)92 Draft Accountability Report

Mrs Wilson introduced the Draft Accountability Report, which comprises three parts and includes Board composition and oversight throughout the year, leadership information, escalation status progress. It also provides an overall opinion around internal governance. The Head of Internal Audit Opinion section is subject to change, for the reasons already discussed, which may necessitate amendment of the report's conclusion. Subject to any amendments from Members, the report will be submitted to Welsh Government and Audit Wales tomorrow. Mrs Wilson wished to record her thanks in particular to Miss Charlotte Wilmshurst for her significant work on the report. She handed over to the Chief Executive, as accountable officer, for comment.

Professor Kloer wished to record his thanks to Mrs Wilson and Miss Wilmshurst for preparing the report. He felt that it accurately reflects the organisation's position; however, would welcome feedback from others. Cllr. Evans' main concern would be that the Health Board is making insufficient progress operationally and in operational governance, given audit results this year. Agreeing that this is a reasonable challenge, Professor Kloer assured Members that the Executive Team has been reflecting on this issue. Ensuring implementation of the Organisational Change Process (OCP) is critical, and Professor Kloer is determined to see progress in this regard. He was cognisant that the People, Organisational Development and Culture Committee (PODCC) is also monitoring this area. Members heard that new ways of working are due to be introduced shortly, and were also informed that significant effort has been and is being put into management training programmes. It is anticipated that all of these different

‘strands’ will bear fruit. A framework exists; it is the embedding of this which is required.

Mr Maynard Davies felt that the report is well-written, agreed that it is reasonably balanced. He suggested that it provides the opportunity to examine topics in detail, and does not seek to conceal anything. In terms of specific feedback and amendments, he advised as follows:

Page 10 – the Board and committee structure organisational chart on is colour coded; however, there is no key for the colours
Page 64 – the Board record of attendance for Mrs Lisa Gostling does not include a figure for Board meetings attended
Page 84/85 – no Compensation for early termination figure is included for Ms Jill Paterson
Page 87 – there is mention of benefits-in-kind for Executive Directors, but not for Independent Members

With regard to the third comment, Mrs Wilson indicated that Audit Wales had been consulted on the correct approach. Detailed information regarding payments made to Ms Jill Paterson is included on Page 87. In response to the fourth comment, it was confirmed that this is covered by the following statement:

The benefits-in-kind which arose to independent members related to the taxable reimbursement of travel expenses.

Mr Maynard Davies’ only other query was in relation to whether the organisation was potentially under-reporting Consultancy expenditure, which was discussed earlier. Mr Thomas was assured that this position is adequately and accurately captured with reporting processes as they stand. As a final query, Cllr. Evans requested assurance that risks are escalated appropriately and in a timely manner by CCGs.

Mrs Lisa Gostling, Ms Rhian Davies and Mr Timothy John joined the Committee meeting.

With over 600 risks across the organisation, Professor Kloer indicated that the Health Board had taken a risk-based approach to its planning process this year. He felt that there is a very strong risk management approach, certainly at a corporate level, and increasingly throughout the organisation. During the last year, there has been more evidence of CCGs escalating matters effectively through the reporting structures and to the Board. Culminating in, at times, both clinicians and managers presenting to the Board on issues which have existed for some time. He felt that this was evidence of improved risk escalation through the structures, increasing visibility at Board, enabling more effective prioritisation of effort. There is, however, an element of ‘work in progress’; this relates to Cllr. Evans’ earlier comment around operational governance, and how this can be strengthened.

Mrs Wilson considered actions which might be taken this year to strengthen committee support and oversight. She reminded

Members that each committee meeting includes an overview of the Corporate Risks and audits which have been aligned to them. Themes and operational risks have also been introduced to the committees. There is no dearth, therefore, in transparency. It was suggested, however, that the area where the organisation needs to improve is in acknowledging its risks. To add further assurance, Mr Thomas emphasised that internal reporting is clear, both in terms of data and performance. Each of the CCGs know which risks they are managing. This provides for transparency and clarity internally and at Board level.

Decision: Subject to the above amendments, the Committee **DISCUSSED** and **SUPPORTED** the content of the Draft Accountability Report, agreeing to provide any feedback that is relevant to its objective to the Director of Corporate Governance/ Board Secretary by 22 May 2026, in order to provide assurance to the Board that a robust governance process was enacted during the year.

The Committee agreed to **ASSURE** the Board in relation to the content of the Draft Accountability Report and that a robust governance process was enacted during the year.

AC(26)93 Financial Grip and Control

Presenting the report, Mr Thomas explained that the Financial Grip and Control tool had been developed by the NHS Wales Performance and Improvement Financial Planning and Delivery Directorate. It includes a clear set of criteria which cover various areas, against which organisations are asked to assess themselves. Mr Thomas emphasised that the Health Board has taken a fairly self-critical approach, deliberating setting out to identify gaps in processes. It is now intended to put in place a workplan to address these gaps, and consideration is required regarding the most appropriate forum or committee to monitor progress. In addition, the Internal Audit team has been asked to review the self-assessment.

Mr Weir welcomed the candour and honesty with which this exercise has been approached. He hoped that any gaps in processes identified will input into the Internal Audit Plan for the coming and future years, and would encourage a focus on these areas. In order to understand the scope and consider whether other areas should have been included, Mr Maynard Davies requested clarification regarding the background to this exercise. In response, Mr Thomas indicated that it represents an amalgam of the work with which NHS Wales Performance and Improvement have been involved, and of practice and issues seen across Wales. Mr Maynard Davies was assured by this context, agreeing that an overly-critical approach had been taken whilst suggesting that this is preferable to being challenged over a lack of evidence. In terms of the most appropriate forum, he suggested PODCC or the Finance and Performance Committee (FPC).

Mrs Gostling highlighted that new delivery and performance documents are being developed for all functions. She assured Members that the gaps relating to workforce have been added into the workforce performance and delivery plan. In addition, the CCGs have plans in relation to agency usage and sickness management. These provide a natural basis for alignment. It will be important, however, to ensure that removal of the Financial Control Sub-Group (FCSG) does not impact negatively on financial grip and control, and that this is embedded and properly maintained locally. Whilst emphasising that the list is not all-encompassing, Professor Kloer noted that workforce represents the organisation's most significant spend, therefore is bound to feature highly. He agreed with Mrs Gostling's final comment, and felt that this should be used as a guide for setting financial priorities; however, it must also be balanced with all the Health Board's other data on savings opportunities.

Mr Thomas agreed and confirmed that the list is not intended to represent a savings plan. It concerns the core controls the organisation should have in place to manage the here and now. It is not related to changes to services, or addressing any of the Health Board's fundamental challenges. Mr Thomas felt that one area requiring focus is contract management. Now that FCSG has been stood down, he, Mrs Wilson and Procurement and Finance colleagues will be meeting fortnightly to discuss how to improve contract management arrangements within the Health Board. This is an area requiring support and leadership. Mr Maynard Davies welcomed this approach, highlighting that each item in the list has an associated management overhead, and need to be prioritised according to the level of financial benefit they may return.

Noting mention of groups being stood down and the new ways of working, Cllr. Evans enquired regarding likely timescales for the impact of these changes to be seen. He queried whether ARAC will see a different reporting format, for example. These queries related specifically to assurance expectations. Mr Thomas reiterated earlier comments around the need to emphasise and enforce compliance; rather than undertake repeated cycles of process redesign, in an attempt to achieve compliance. He suggested that further consideration is required as to how this is progressed. In response to a suggestion that the Internal Audit Plan might be refocused to include this, it was felt that audits of areas where there are known to be gaps in compliance would offer limited value at present. It was suggested that there should first be a focus on enforcing compliance, after which audits can be considered. Welcoming the report, and the intention to develop action plans, Mrs Marks agreed that the time has come to focus on compliance with processes. There have been a number of references in reports and discussions to staff not recording compliance with processes, not following processes and circumventing processes. **HT/JW**

Mrs Marks' other query was around CCGs and those instances where personnel have been displaced by other appointees. She

enquired how the financial consequences of this are being managed, recognising that this is not necessarily a query for ARAC. Clarifying that this is in relation to OCPs and the assertion that there is no additional cost, Mr Thomas acknowledged that assurance around this will need to be provided to the relevant committee and Board. It was agreed that this would be evaluated and a response provided via the Table of Actions. Mrs Gostling wished to highlight, however, that the OCP2 is still in progress and is therefore not yet fully costed. **HT**

Decision: The Committee is asked to **NOTE** the Financial Grip and Control report.

The Committee agreed to **ASSURE** the Board in relation to the Financial Grip and Control report.

Mrs Lisa Gostling left the Committee meeting.

AC(26)94 Draft Annual Accounts 2025/26

Mr Thomas introduced the Draft Annual Accounts for 2025/26, thanking Ms Rhian Davies, Mr Timothy John and other members of the Finance team for their efforts in preparing these. Whilst the format of the accounts is not that which would be the preference, the Health Board is restricted to the prescribed format. The organisation is now in the process of liaising with Audit Wales regarding the financial audit. The Committee has been provided with a high-level position statement regarding the accounts, which summarises organisational performance against financial targets. This includes the following:

Revenue Resource Performance (Statutory)
The month- and year-end position is a deficit of £22.089m, just under the £22.1m Target Control Total set by Welsh Government. This contributes to a cumulative three-year deficit of £112m. The cumulative position is rarely discussed; however, it represents a stark position, driven largely by a Year 1 deficit of £65m. It is hoped that the figure will reduce over future years, although this is dependent on the position achieved in 2026/27.

Capital Resource Performance (Statutory)
The Health Board achieved this target, with an underspend against the Capital Resource Limit of £38k. This had been a significant challenge and the teams involved had worked extremely hard, particularly in the final quarter and month of the year, to reach this position.

Duty to Prepare a 3 Year Plan (Statutory)
It has not been possible to achieve this target, as the organisation does not have a balanced Integrated Medium Term Plan (IMTP).

Creditor Payment Performance
Performance against this target has been consistent, with the 96.6% this year, versus 96.7% last year. The Health Board had, therefore, achieved the 95.7% required. It had not, however, met the in-NHS payment target, with performance of around 85%.

Whilst this is not reported in the annual accounts, it is a target against which Welsh Government measure the organisation. They have expressed disappointment regarding the performance level.

The final slides in the presentation provide an analysis of the shifts between one year and the next. Mr Thomas had nothing he particularly wished to highlight, drawing Members' attention to the narrative provided. He reiterated that the Health Board is currently participating in the process of auditing the draft accounts with Audit Wales. The accounts were submitted on 1 May 2026, in line with requirements, and (subject to satisfactory conclusion of the audit) will be submitted in final form to ARAC on 23 June 2026 and to Public Board on 25 June 2026. Ms Rhian Davies added her thanks to those teams who have contributed to preparation of the annual accounts. As has been stated, these were submitted to Welsh Government yesterday and members of the Finance team had also met with Audit Wales representatives yesterday. For context in terms of the level of audit queries, Ms Davies advised that the figures this year for materiality and triviality are £14.6m and £733k respectively.

Suggesting that the effort involved in preparing accounts of this scope cannot be underestimated, Mr Weir thanked Ms Davies and Mr John for their work. He felt that this is a clear set of accounts and welcomed the high-level summary provided. On page 10 of the latter, Mr Weir noted that the Losses, special payments and irrecoverable debts figure has increased from £2.24m to £5.7m. He enquired whether there was a specific driver for this increase, or whether it was more arbitrary. In response, Members were advised that the reason for this increase related to the payments to Band 2 staff whose roles had become Band 3. Ms Davies reminded Members that provision had been made for this rebanding last year, and was included as an 'other'. This year, the Health Board had received guidance from Welsh Government that the recognition payment should be classified as a special payment. Hence the difference between this year's and last year's position in this category.

Mr Weir's second query was regarding annual leave accrual, and whether the level is similar to previous years. Ms Davis advised that the annual leave accrual is shown under note 9.1 on page 34 of the accounts. There is an increase this year of approximately £700k compared with previous years. This has been examined; however, she assured Members that all annual leave requests are appropriately approved. Thanking her for this response, Mr Weir noted that a figure of this level is not material to the accounts, given that the threshold for materiality is £14.6m.

Building on Mr Weir's first query, Cllr. Evans enquired whether there are any other material exposures of which the Committee should be aware. He noted in particular reference to clinical negligence made on pages 11 and 12 of the presentation. Mr Thomas confirmed that clinical negligence costs are a particular concern, which are not likely to diminish. It is important to recognise that provision nationally has increased by £0.25bn this

year. The Health Board's share towards this obligation will feature in future financial positions. Reasons for the increase to future provisioning arrangements include a Supreme Court judgment in March 2026 equalising the impact between genders, and a recognition of the full-life cost of lost earnings. The latter, in the case of a child, can clearly be very significant. A great deal of work is underway nationally to address this issue. Mr Thomas was content that the Committee can take assurance around the processes which have led to the figures in the accounts. The area requiring further focus is actions to prevent clinical negligence cases occurring.

In response to a query around general lessons learned, in relation to forecasting, for example; Mr Thomas indicated that this is an area of intense focus and assured Members that continuous learning is applied. The Health Board is at the forefront of work with colleagues in NHS Wales Performance and Improvement to explore the potential of machine forecasting and AI forecasting. It will be interesting to see how these tools might assist. However, the Health Board's forecasting is already relatively robust, evidenced by a forecast of £22.1m in December which has been maintained since. Adding his thanks to all involved, Mr Maynard Davies noted a correction needed on page 72, in relation to the heading for Pooled Budget contributions, which should be in thousands. Cllr. Evans enquired whether Audit Wales are content with the submission, with Mr Williams advising that it is too early to comment at this stage. He assured Members that Health Board and Audit Wales staff are meeting on a regular basis to discuss any queries. **HT**

Finally, Cllr. Evans noted that Ms Davies is due to retire this year, and wished to place on record the Committee's appreciation for her contribution over the years.

Decision: The Committee **DISCUSSED** the draft annual accounts for 2025/26.

The Committee agreed to **ASSURE** the Board in relation to the Financial Grip and Control report.

AC(26)95 Any Other Business

There was no other business reported.

AC(26)96 Date and Time of Next Meeting

9.30am, 23 June 2026

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

Date of Meeting: **09:00, Tuesday 23 June 2026**
Venue: **Dolau Cothi, Picton Terrace and Virtual, via Microsoft Teams**

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

In Attendance:
Ms Urvisha Perez, Audit Wales (VC)
Mr David Williams, Audit Wales (VC)
Mr David Murphy, Audit Wales (VC) (part)
Mr James Johns, Head of Internal Audit, NWSSP (VC)
Ms Sophie Corbett, Deputy Head of Internal Audit, NWSSP (VC)
Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary
Mr Huw Thomas, Executive Director of Finance
Mr Ben Rees, Head of Counter Fraud (VC) (part)
Ms Claire Bird, Assurance and Risk Officer (deputising for Miss Charlotte Wilmshurst, Assistant Director of Assurance and Risk)
Professor Philip Kloer, Chief Executive (part)
Mr Andrew Carruthers, Chief Operating Officer (part)
Mr Keith Jones, Director of Operational Planning and Performance (VC) (part)
Ms Angela Bell, Assistant Director of Quality, Safety and Patient Experience for Allied Health Sciences (VC) (part)
Ms Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience (VC) (part)
Ms Rebecca Richards, Head of Infection Prevention (VC) (part)
Ms Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding (VC) (part)
Mr Mark Henwood, Executive Medical Director (part)
Mr Dilesh Khandhia, Associate Clinical Director of Pharmacy and Medicines Management
Ms Carly Hill, Assistant Director (VC) (part)
Mr Lee Davies, Executive Director of Strategy and Planning (part)
Mr Shaun Ayres, Director of Delivery (VC) (part)
Ms Rhian Davies, Assistant Director of Finance, Financial Planning and Statutory Reporting (VC) (part)
Mr Timothy John, Head of Accounting and Statutory Reporting (VC) (part)
Ms Clare Moorcroft, Committee Services Officer (minutes)

Minutes Ref.	Item	Action
AC(26)097	**Introductions and Apologies for Absence**	

Cllr. Rhodri Evans, Audit and Risk Assurance Committee (ARAC) Chair, welcomed everyone to the meeting. He explained that there would be slight changes to the order of certain agenda items, to facilitate attendance by presenters. Apologies for absence were received from:

- Dr Neil Wooding, Chair, Hywel Dda UHB
- Mrs Eleanor Marks, Vice-Chair, Hywel Dda UHB

- Miss Charlotte Wilmshurst, Assistant Director of Assurance and Risk

AC(26)098 **Declaration of Interests**

Mr Maynard Davies declared interests in item AC(26)109, noting that his son is a Consultant Radiologist in Northern Ireland, that his wife worked in Radiology for 26 years, and that he had managed the NHS Wales e-Library.

AC(26)099 **Minutes of the Meeting held on 14 April 2026**

Decision: RESOLVED – the Minutes from the meeting held on 14 April 2026 were approved as an accurate record.

AC(26)100 **Table of Actions**

An update was provided on the Table of Actions from the meetings held on 14 April and 7 May 2026, with Members noting that certain of these remain in progress. In terms of matters arising:

AC(25)171 – Mrs Joanne Wilson advised that the Standard Operating Procedure (SOP) is yet to be finalised. Whilst the stated timescale for this is July 2026, it may take longer. The operational team wish to take further steps to standardise the SOP. It was intended to re-audit this area in Quarter 1 of 2026/27; however, this has been postponed at the request of the Health Board. Consideration is being given to other audits which might be brought forward to replace it. The resulting impact on the Internal Audit programme at this early stage is not ideal.

AC(26)45 – the items for consideration by the Strategy and Planning Committee (SPC) and Quality, Safety and Experience Committee (QSEC) have now been added to the forward Workplans for these committees.

AC(26)76 – likewise, the item for consideration by the Digital, Data and Innovation Committee (DDIC) has been added to the forward Workplan for this committee.

AC(26)79 – Members heard that Mr Huw Thomas is leading on work in relation to contract management, and that an update on the Major Infrastructure Investment Programme Internal Audit has been scheduled for the August 2026 meeting.

AC(26)87 – with regard to the suggestion around inviting the Chair of QSEC to engagement meetings with Healthcare Inspectorate Wales (HIW), it was noted that there are processes already in place. It is probably more appropriate for the QSEC Chair to provide input via these routes.

AC(26)101 **Matters Arising not on Agenda**

There were no other matters arising.

AC(26)102 Committee Self-Assessment

Presenting the report, Mrs Wilson reminded Members that three areas for improvement had been identified in this year's Self-Assessment process. The first, in relation to the role of the Independent Member (IM) had been discussed at forums including IM development sessions. The second had been addressed via development of an SOP with Internal Audit, which has been shared with all Members. The third has been addressed by strengthening risk and assurance reporting.

Decision: The Committee **TOOK ASSURANCE** from the progress made against the actions being undertaken to improve its effectiveness.

AC(26)103 Annual Review of Committee Terms of Reference

Mrs Wilson introduced the report, which outlines the proposed changes following the annual review of ARAC's Terms of Reference. The suggested amendments are detailed within the report and approval of these is requested, prior to submission for ratification by the Board.

Decision: The Committee **APPROVED** the Audit and Risk Assurance Committee's Terms of Reference (version 20) for onward ratification by the Board on 30 July 2026.

AC(26)104 All Wales NHS Audit Committee Chairs' Meeting Update

Cllr. Evans reported from the All Wales NHS Audit Committee Chairs' (AWACC) meeting held on 1 June 2026, indicating that this had been both useful and interesting. As recorded in the notes, there had been a discussion around Internal Audit. Members heard that 6% of audits in organisations across Wales had received limited or unsatisfactory assurance ratings, which likely reflects the challenging environment. Only 66% of management responses are received on time, against a target of 85%. Cllr. Evans congratulated Mr Ben Rees on his appointment as Chair of the Counter Fraud Liaison Group. It was noted that Cardiff and Vale and Hywel Dda UHB Counter Fraud teams have the least staff resources. Despite this, the HDdUHB team manages the most referrals, detects the most frauds and recovers the most money.

The Committee thanked Mr Rees for his work and requested that he pass on these thanks to his colleague Mr Terry Slater. Whilst grateful for the recognition, Mr Ben Rees indicated that the team's success relies on support from colleagues across the Health Board and from ARAC. Referencing the Audit Wales Update, Mr Maynard Davies highlighted that a Deep Dive into the local Digital Transformation Review is scheduled for the next DDIC meeting.

Decision: The Committee **NOTED** the All Wales NHS Audit Committee Chairs' Meeting Update.

AC(26)105 **Financial Assurance Report**

Mr Thomas introduced the Financial Assurance Report, noting that there were no 'Alert' items to bring to the Committee's attention. In terms of 'Advise' items, firstly, the number of staff overpayments has decreased. Secondly, there is one loss exceeding £5k relating to drug wastage, details of which are provided in Schedule 4. The Health Board also signed off losses and write-offs less than £5k totalling £18,550, representing a reduction on the previous period. 'Assurance' items include the work progressing on 'No PO, No Pay', and Public Sector Payment Policy (PSPP) compliance. Finally, Mr Thomas drew Members' attention to the Quinquennial Revaluation of NHS Wales Estate outlined in Appendix 4 of the report.

Mr Davies wished to congratulate the team on the fact that no Single Tender Actions (STAs) had been made during 2025/26, or indeed since March 2024. He had never worked in an organisation where this had been achieved. Whilst welcoming the comment, Mr Thomas suggested that this position was 'hard won and easily lost', with frequent pressure to utilise STAs. Referencing Appendix 1a, Mr Davies noted that a number of contracts are awarded for clinical services. He enquired which forum or committee monitors whether these are delivering value for money. It would be useful, for example to undertake an exercise which contrasts the costs of external provision with provision by the Health Board, should it be fully-resourced to do so.

In response, Mr Thomas acknowledged that no forum fulfils this role currently, although the Finance and Performance Committee (FPC) would be the most appropriate. Given the value of certain of these contracts, and the scrutiny that contracts in other areas receive, he agreed that it would be reasonable to consider progressing this suggestion further. This also aligns with the work mentioned earlier around contract management. Mr Thomas indicated that an Artificial Intelligence (AI) model is being built, which will analyse contract data, invoice data and responses from managers on performance, and provide output on whether contracts are being effectively managed. He committed to provide a report to ARAC and DDIC on this topic. **HT**

Mr Davies noted that one of the contracts relates to Obstetric and Non-Obstetric Ultrasound Examinations, and queried whether this will serve to address some of the recommendations in the Audit Wales Radiology Review report. Whilst it was suggested that this may partially mitigate, Members were reminded that there are significant fragilities in relation to this service.

Decision: The Committee:

- **SCRUTINISED** the award of contracts listed
- **DISCUSSED** the staff overpayments as detailed and **TOOK ASSURANCE** that actions to control them are sufficiently embedded

- **DISCUSSED** losses as detailed and **APPROVED** the losses in excess of £5,000
- **NOTED** that no Single Tender Actions were awarded during the Financial Year 2025/26
- **TOOK ASSURANCE** from the actions taken to:
  a) Improve Purchase To Pay (P2P) compliance
  b) Manage breaches of Standing Financial Instructions (SFIs)
  c) Manage Single Tender Actions (STAs)

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

AC(26)106 Counter Fraud Update

Presenting the report, Mr Rees advised that delivery of the 2026/27 Counter Fraud Workplan is progressing as expected. The team has continued to deliver awareness and prevention activity across the Health Board, including Primary Care engagement with the ophthalmic sector, and targeted awareness with the Breast Care Unit at Prince Philip Hospital. This has been well-received. Two local proactive reviews have been completed. The first considered IR35 and off-payroll working risks linked to agency nursing arrangements and found a strong control framework, with no evidence of non-compliance in the sample tested. The second reviewed petty cash arrangements across the Health Board and provided positive assurance overall, whilst identifying certain opportunities to rationalise accounts, reduce reliance on petty cash and strengthen local controls, with recommendations made. Finally, the Counter Fraud SRT has now been uploaded to the NHS Counter Fraud Authority portal and digitally signed, and the required quarterly statistics have been submitted to Counter Fraud Services Wales.

Cllr. Evans enquired how the recommendations mentioned are tracked. In response, Members heard that it is intended to track Counter Fraud recommendations and report on these during the In-Committee ARAC session going forward. Liaison with services and departments will take place as required. Consideration had been given to the use of the Audit Management and Tracking (AMAT) system. However, due to the access settings on AMAT and the sensitivity of certain Counter Fraud recommendations, this is not appropriate.

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

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

Mr Ben Rees left the Committee meeting.

AC(26)107 **External Recommendations and Welsh Health Circulars Assurance Report**

Mrs Wilson introduced the report, highlighting in the first instance the section outlining progress since the previous report to ARAC. Development of an audit tracking performance dashboard has had to be placed on hold, due to prioritisation of work required in relation to Radiology. In terms of numbers, there has been an increase in the number of open reports from 134 to 142, with an increase in overdue reports from 49 to 50. Several reports have been closed, which are detailed. The main areas of concern are the Community and Integrated Medicine (CIM) Clinical Care Group (CCG), which remains in Level 3 for governance and has been for some time now. This CCG is also an outlier in relation to recommendations without revised timescales being completed. Estates and Facilities, despite being at Level 1, also has a number of outstanding recommendations.

Mrs Wilson recalled an ARAC request around Deep Dives into specific areas. Following the introduction of the new ways of working and placing of accountability with the Executive Director rather than the Corporate Governance team, such Deep Dives will be conducted by the Chief Operating Officer (COO). Mrs Wilson has, however, offered to attend these, along with the relevant Assurance and Risk Officer, if required. Monthly position reports will also be provided. Regarding the CIM CCG, Ms Claire Bird indicated that, whilst there has been an improvement in terms of the number of overdue recommendations, there has been an increase in those overdue by more than six months. The triumvirate team, with herself supporting, has met with representatives of each integrated system. Quarterly meetings to focus on AMAT are also planned. It is hoped that further improvements will result. Actions are being taken to add the reports currently missing from AMAT, which will provide a more representative view. With regard to the latter, Mrs Wilson highlighted that this will impact on numbers, increasing them further.

In respect of timescales, Mr Davies enquired whether any issues are due to external factors, with progress dependent on other organisations, for example. Ms Bird confirmed that this can be the case, whilst advising that there is a separate reporting status for reports or recommendations which fall into this category. Classification of them as such does, however, depend on the information provided by functions; it does sometimes become apparent at a later date that they are impacted by external factors. Members were advised that those reports classified as overdue are within the Health Board's control. Mrs Wilson reported that there had been a detailed discussion at QSEC around this issue, with the Chair undertaking to write to those Executive Directors responsible for audits and reviews under QSEC's remit. It had subsequently been decided to extend this correspondence to all Executive Directors.

Cllr. Evans enquired regarding how, when functions close reports and recommendations, it is ensured that there is continued progress or compliance. In response, Mrs Wilson indicated that closure requires sign-off by both the Lead Officer and Executive Director, with the latter being ultimately accountable. There are, however, instances where it subsequently becomes apparent that recommendations should not have been closed. This is generally only identified by further or follow-up audits and reviews.

Decision: The Committee **TOOK ASSURANCE** on the effectiveness of processes in place across the Health Board to track the progress made to implement recommendations identified by auditors, inspectorates and regulators, and implement Welsh Health Circulars (WHCs) issued by Welsh Government.

The Committee agreed to **ASSURE** the Board in relation to the External Recommendations and Welsh Health Circulars Assurance report.

AC(26)108 **Audit Wales Update Report**

Mr Andrew Carruthers joined the Committee meeting.

Mr David Williams introduced the Audit Wales Update report. In terms of financial audit work, the ISA 260 appears later on the agenda, together with the Health Board's accounts. This year's audit has gone well, and remains on track for certification later this week. Once finalised, the team will focus on the audit of the Health Board's charities' accounts. Moving onto the performance audit work, Ms Urvisha Perez advised that the Radiology review is complete and on today's agenda. The Cancer and Estates reviews are at the early stages of reporting, with the remainder of performance audit work at the planning stage.

This year's Structured Assessment will focus mainly on delivery of Integrated Medium Term Plans (IMTPs) or Annual Plans. They will assess the extent to which delivery is supporting financial sustainability, improved operational performance, effective risk management and robust oversight, scrutiny and governance. The change in approach will allow a stronger focus on effectiveness and impact. A letter will be issued in the next few weeks, explaining the changes. The draft project brief will be finalised in July 2026; in the meantime, Audit Wales staff will begin to observe relevant Board and committee meetings.

The report also includes links to relevant national outputs and to the Strategic Equality Plan. Audit Wales has also recently published two insight pieces, not included in the update report, one focused on Planned Care and the other on Urgent and Emergency Care. Both set out key themes from local work and challenges facing Welsh Government and the wider NHS. They also set out key questions for Welsh Government, the NHS and, in the case of the Urgent and Emergency Care piece, questions for local authorities as well.

With regard to national reviews, Mr Davies queried whether the Health Board prepares formal responses to those reports for which it is not officially the target audience. He highlighted that there may be learning within such reports which is relevant at a local level. Mrs Wilson indicated that there has been a suggestion at the most recent AWACC meeting that health boards will be expected in the future to develop local responses to national reports. At present, any relevant findings are taken forward on a more informal basis. Mr Andrew Carruthers indicated that all national reviews provide useful input, intelligence and potential learning; the key is to identify and apply this locally. Ms Perez confirmed that Audit Wales is currently considering how it follows up review recommendations. She would consult with colleagues and provide an update at the next meeting. In response to a query around delivery of the planned performance audit work, Ms Perez confirmed that this is currently on track. **UP**

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

The Committee agreed to **ASSURE** the Board in relation to the Audit Wales Update report.

AC(26)109 Review of Radiology Services

Ms Angela Bell joined the Committee meeting.

Mr David Murphy presented the Review of Radiology Services report, which is a follow-up to the 2017 Review of Radiology Services, during which 11 recommendations were made. The review examined the effectiveness of arrangements to manage current and future Radiology demand. Five of the 11 previous recommendations had been completed, with 6 outstanding and in progress at the time of review. Key messages were as follows:

- Whilst short-term performance improvements had been achieved, including reductions in very long waits and improved Cancer pathway reporting, Radiology demand remains high and performance is not yet sustainable.
- Improvement is partly reliant on targeted recovery actions, rather than underlying capacity changes.
- Overall, progress had been made; however, this remains fragile, with one of the Health Board's noted fragile services not yet delivering resilient service improvement.
- Waiting lists more than doubled between January 2020 and January 2026, reaching a peak of just under 15,000 pathways.
- Whilst there were long waits, these had been substantially reduced during 2025 to just under 3,000 still waiting over 8 weeks. Improvement was driven by focused backlog reduction, rather than sustained demand capacity balance.
- Ultrasound services remain the main pressure point, with the largest number of waits over 8 weeks and delays across all sites. Demand remains consistently high, making performance gains difficult to sustain.

- Underlying risks include the absence of an out-of-hours, non-obstetric ultrasound service; improvement sustained by non-recurrent funding, outsourcing and short-term recovery actions
- In terms of referral quality, there is no consistent Health Board-wide approach to routine reporting of impact.
- There are no fully costed, prioritised multi-year equipment replacement plans.
- With regard to workforce, there is a reliance on agency staff, outsourcing and overtime.
- Whilst governance has improved, assurance remains variable, particularly where services rely on temporary measures.
- Planning is fragmented, with no single integrated long-term radiology plan.

Following the review, 4 recommendations have been made, replacing the outstanding recommendations from 2017. These focus on out-of-hours ultrasound provision, referral quality, demand management, patient feedback and learning and the need for an integrated Radiology plan.

The Health Board's management response has been received, which includes phased actions. Certain of these begin in 2026; however, a number extend into 2027 and 2028. Delivery appears to be dependent on stabilising the workforce, leadership capacity, and development of the integrated plan. Acknowledging the phased approach to improvement, Audit Wales had found the overall response to be constructive.

Professor Philip Kloer joined the Committee meeting.

Mr Carruthers welcomed the review and its findings, which highlight a number of areas the Health Board recognises as challenging. These include demand, capacity, waiting times, quality and patient safety. Whilst already recognised, the review provides a helpful focus for ongoing work. As has been acknowledged, a number of these involve significant actions, and capacity issues will limit the pace of change; hence the need for a phased approach. Ms Angela Bell added her thanks to the Audit Wales team for the review. With regard to timescales for actions, she advised that a pragmatic approach had been applied, with delivery balanced against the need for service stabilisation. Recommendation 4 is a good example of one which the Health Board feels it may be able to achieve sooner, with the benefit of additional support. The aim in the management response had been to provide clear milestones for progress.

Recognising that the review's findings are challenging, Mr Thomas congratulated the team on its response. He emphasised that the findings and recommendations need to be owned by the wider organisation, not considered the sole responsibility of the service. Whilst the issue of additional resources has been partially addressed, alongside this an alignment of demand and capacity is required. This needs to form part of a comprehensive Health

Board-wide approach, contributing to it becoming a truly data-driven organisation.

Cllr. Evans enquired whether the current Organisational Change Process (OCP) will assist in addressing any of the review findings. In response, Mr Carruthers explained that the Radiology OCP has been somewhat challenging, in terms of agreeing the revised leadership model. It has required significant engagement with stakeholders, including trade unions, to agree a model acceptable to all parties, meaning that it has taken longer than anticipated. Positive progress has, however, now been made. Ms Bell confirmed that the consultation launched on 11 June 2026. It is hoped to commence recruitment into additional leadership roles throughout Quarter 3, with successful candidates in post by February 2027. A number of the dates in the management response and action plan are aligned to this increased leadership capacity. An example being Recommendation 3, around patient feedback, with the requirements for this aligning with the new quality manager role.

Declaring various personal interests in Radiology, Mr Davies noted that the way forward in relation to the Clinical Services Plan (CSP) has recently been agreed. He requested assurance that review recommendations and actions align with CSP outcomes in relation to Radiology. Ms Bell confirmed that this was the case, whilst highlighting that the Radiology aspect of the CSP is minimal, given that it relates to capacity to deliver X-Ray services on a specific site. In relation to Recommendation 2, Mr Davies noted the plan to establish a Radiology Referral Management Group. He wished firstly to enquire regarding progress on e-referrals. Secondly, he noted previous work by the Royal College of Radiology on the iRefer system, available from the NHS Wales e-Library. This sets out for all doctors the type of Radiological examinations appropriate for various medical conditions. He enquired how these elements will be incorporated into the work of the Referral Management Group. Ms Bell welcomed these useful queries, and committed to feed them back to the team reviewing the terms of reference for this group. **AB**

Mr Carruthers felt that this raised a wider issue for the Health Board around how it moves away from paper-based referrals. He suggested that there should come a point when the organisation only accepts electronic referrals. This is very much a ‘live’ conversation. Mr Thomas proposed that a report be drafted for DDIC on electronic test requests. Whilst predominantly a digital issue, this would naturally require clinical engagement. It was requested that this also consider Primary Care. Mr Davies’ final query was in relation to the management response to Recommendation 4, which commits to ‘Complete and submit the overarching Radiology plan… for committee oversight and agreement of committee update schedule by March 2028.’ He enquired which would be the receiving committee. Mrs Wilson advised that, whilst there is potential for this matter to require **HT**

discussion at various committees and at Board, it would likely be SPC in the first instance. **LD**

Whilst noting that certain improvements have been embedded, Cllr. Evans highlighted that these include temporary mitigations. In view of this, he requested assurance that improvements are sustainable, recognising in particular significant workforce fragilities. Mr Carruthers emphasised that the latter is a UK-wide issue. It requires innovative approaches to ensure that service models and rotas are created which will be attractive to potential applicants, a focus on 'growing our own' staff and consideration of the potential for digital and AI solutions to release capacity.

In response to a query around whether Audit Wales is content with the management response, Mr Murphy confirmed and expressed thanks for the support provided to the review team. Audit Wales recognise the reason for proposing extended timescales for certain actions. Whilst explaining that these were intended to be realistic, based on current capacity, Mr Carruthers emphasised that the Health Board will seek to make progress more quickly wherever possible. Following further discussion, it was agreed that a progress update should be scheduled for six months' time. **AC**

Decision: The Committee **NOTED** the Audit Wales Review of Radiology Services and associated management response.

The Committee agreed to **ASSURE** the Board in relation to the Audit Wales Review of Radiology Services report and associated management response.

Mr David Murphy and Ms Angela Bell left the Committee meeting.

AC(26)110 Internal Audit Plan Progress Report

Mr James Johns presented the Internal Audit Plan Progress Report, which provides the usual update on progress in delivering the Internal Audit Plan. Section 2 of the report details those audits finalised since the previous meeting, with this concluding delivery of the Plan for 2025/26. The Head of Internal Audit Opinion and Annual Report is also included on today's agenda.

Cllr. Evans noted the volume of audits being reported to this meeting and the challenges this presents for ARAC. He advised Members that a new protocol and approach has been discussed and agreed, which he hoped would prevent a similar situation in the future.

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

AC(26)111 Progress Update on Operational Governance Arrangements Internal Audit

Mr Carruthers introduced the report, advising that in addition to the ARAC discussions on this topic, the new ways of working had

also been considered at a recent Board Seminar. Various actions had been identified, and the report seeks to provide assurance regarding progress.

Mr Davies welcomed the report's clarity; however, highlighted that it focuses mainly on process. He enquired how it will be ensured that actions will achieve the desired outcomes, and whether there are defined objectives and timescales. Whilst recognising the need for certain CCGs to be de-escalated, Mr Carruthers suggested that the overall aim is to change the ways of working and empower local teams. He emphasised that this involves, in the longer-term, a much deeper cultural shift. It is his intention, however, to change behaviours more quickly. For example, earlier intervention on issues, to prevent them from escalating. He agreed, however, that certain key areas could be identified, where progress is required.

Cllr. Evans shared the view that the intended impact of changes to ways of working needs to be more closely defined. He highlighted the need to identify who will be undertaking checks and scrutiny, and how changes would ensure improvements in operational areas, including audit outcomes. In response, Mr Carruthers explained that the ultimate scrutiny will be at the monthly COO Integrated Operational Delivery meetings. At these, evidence will be required that CCGs are considering and documenting the pertinent issues, and that they are developing action plans. Mr Carruthers has deliberately set out to define expectations in this regard. Mrs Wilson felt that it is important to acknowledge that operational governance encompasses areas other than those within the COO's portfolio, such as Estates and Facilities, and corporate services. There may be issues in any of these, making this a Health Board-wide responsibility. As such, the Chief Executive has requested that all Executive Directors formulate a delivery agreement and focus on governance in their area.

Whilst recognising that the focus today is on operational governance as a result of the Internal Audit, Professor Philip Kloer confirmed that he has clearly stated that the issue is wider. He also reiterated that operational governance is not solely a COO responsibility, given that there are operational elements in a number of Director's portfolios. He suggested that the way in which ARAC oversees this issue probably requires further consideration. It may also impact on the Internal Audit Programme for future years.

Decision: The Committee **TOOK ASSURANCE** that all actions have been implemented within the agreed timescales to address the audit findings which strengthen operational governance arrangements.

The Committee agreed to **ASSURE** the Board in relation to the Progress Update on Operational Governance Arrangements Internal Audit.

Professor Phil Kloer left the Committee meeting.

AC(26)112 GP Out of Hours (Limited Assurance)

Mr Keith Jones joined the meeting.

Ms Sophie Corbett introduced the GP Out of Hours Internal Audit report. This audit had reviewed the processes and controls in place for the management of key systems and risk areas within GP Out of Hours, specifically controlled stationary and controlled drugs. It had identified 7 findings requiring management attention. In relation to the management of prescription pads, whilst procedures were in place, these required updating. Security of prescription pad stock during transportation between sites requires strengthening and stock check arrangements lack segregation of duties. In relation to controlled drugs, whilst there are Health Board-wide policies in place, these do not align with the arrangements within GP out of hours. At Glangwili Hospital (GGH), access to controlled drugs was not restricted to clinicians, with reception staff seen to access the key safe for the controlled drugs cabinet. There was inconsistency in controlled drugs registers in use at GGH and Prince Phillip Hospital (PPH) sites, and the entries in the register for PPH suggested that only drugs actually issued to patients are captured, rather than all stock movements. Finally, optimum stock levels have not been determined and, whilst stock checks were completed, these were inconsistent. An overall rating of Limited Assurance has been concluded.

Mr Carruthers thanked the Internal Audit team for their work. Whilst welcoming the report, he expressed disappointment at a rating of Limited Assurance, particularly in relation to the management of controlled drugs. The management response describes the actions already taken, including a number which were immediate. The time frame for other actions reflects the fact that processes and policies will need to be developed and progressed via the required routes. It is hoped that these will ensure future compliance.

Noting that there are a number of serious and concerning findings in the report, Cllr. Evans enquired regarding the actions which have been put in place already. He further enquired whether these are short-term mitigations while working towards full compliance. Mr Carruthers advised that, for Key Finding 4, work has commenced on formulating a policy and procedure. Various changes around security and keys have been implemented. Staff have been reminded of the processes and their responsibilities with regard to controlled drugs. Mr Carruthers confirmed that actions have been taken at pace and urgency, given the severity of the issues identified.

With regard to Key Finding 4, Mr Davies queried whether other sites allow non-clinical staff as a second signatory. He highlighted that supervision of the entire process is not necessarily as straightforward in this environment as in other ‘closed’ clinical environments such as wards. Given limited staff resources, it is

also possible that two clinical staff would not be available at the required point in time. Mr Carruthers committed to investigate further. Mr Thomas suggested that electronic prescribing processes would likely assist in this regard, and would seek to establish timescales for implementation. **AC** **HT**

Mr Weir shared others' concerns around the findings. With regard to the intention to develop policies and procedures, he suggested that these should have already been in place. He also felt that timescales should be sooner than September 2026, whilst recognising the need for due consultation. He requested clarification of the process required. In response, Mrs Wilson advised that there is a recognised process for approval of policies. Not all are considered at the Executive Team; however, the relevant corporate or operational team would need to liaise with the Health Board's Policy Co-Ordination Officer. It would be challenging to complete the required process by September.

Mr Carruthers indicated that certain findings have prompted immediate actions, others apply to only one site, others resulted from evidence not being available. Steps need to be taken to formalise processes and ensure that they are properly documented. He assured Members, however, that actions which require time will not preclude improvements in the short-term. Mrs Wilson advised that all recommendations will be added to the AMAT system and progress against them tracked.

Decision: The Committee **NOTED** the GP Out of Hours (Limited Assurance) Internal Audit report.

The Committee agreed to **ADVISE** the Board in relation to the GP Out of Hours (Limited Assurance) Internal Audit report, given their concerns around its findings.

AC(26)113 Commissioning Third Sector (Reasonable Assurance)

Mr Johns introduced the Commissioning Third Sector Internal Audit report. This had considered the management and monitoring arrangements for commissioning services provided by the Third Sector. As part of the audit, a sample of contracts in place between the Health Board and Third Sector providers were reviewed. Four medium priority findings were identified. These included the need to make improvements to contractual documents, to ensure that they contain all the key elements required; steps to address the absence of performance information submitted to the Health Board, to allow monitoring and scrutiny; a lack of procedural guidance to aid managers in the development of contracts; a need to enhance reporting through the organisational and CCG structure to ensure the appropriate level of monitoring over these arrangements. An overall rating of Reasonable Assurance has been concluded.

Mr Carruthers welcomed the report and its more positive outcome. Having reflected on the findings, and with recent changes in personnel and portfolios, he suggested that this spans a number

of areas. As such, it would be sensible for it to be overseen more centrally, and he had requested that the Director of Operational Planning and Performance takes a leadership role in this regard. Mr Keith Jones welcomed the report and endorsed all of its recommendations. It offers a number of extremely helpful and constructive suggestions. He agreed with Mr Carruthers that a greater degree of central oversight is required. Whilst there is a framework and structure in place, there is potential to improve the consistency of its application. It will be important to ensure that a Service Level Agreement (SLA) is applied to every contract, and evidence that review processes are in place. It is intended to introduce a twice-yearly review by those CCGs where contracts are in place, of compliance against both the principles of the SLA and the recording mechanism being undertaken to maintain oversight. Updates can be provided to the relevant committee.

Mr Thomas advised that he has been undertaking work in relation to outsourced and insourced service contract management, with a commitment to provide a report to FPC. Whilst the Health Board is adept at procuring services, it is less effective at managing these contracts subsequently. It is probably the case that Third Sector contract management should form part of these considerations, and Mr Thomas suggested that a discussion take place outside the meeting. By way of assurance, he further advised that contract management is included in his list of objectives for this year. It was noted that Long Term Agreements (LTAs) are separate and are the responsibility of the Director of Strategy and Planning. **HT/AC**

Mr Davies noted that there is also an information aspect to this topic. For example, if patient-facing services are commissioned from Third Sector organisations, whether and how information is entered onto patient records. Such data should feed into discussions around value for money and impact of interventions. Referencing Key Finding 4, Mr Davies enquired which Board level committee would receive the proposed review report. He was informed that this would be FPC.

Decision: The Committee **NOTED** the Commissioning Third Sector (Reasonable Assurance) Internal Audit report.

The Committee agreed to **ASSURE** the Board in relation to the Commissioning Third Sector (Reasonable Assurance) Internal Audit report.

Mr Keith Jones left the Committee meeting.

AC(26)114 Regional Joint Committee Governance Arrangements (Advisory Report)

Ms Corbett introduced the Regional Joint Committee Governance Arrangements Internal Audit report. The audit had considered the governance arrangements in place to support effective partnership working between Hywel Dda and Swansea Bay University Health Boards through the Regional Joint Committee (RJC), which was established to strengthen collaboration in the planning and

delivery of health services. The audit focused on the design of the arrangement, with a subsequent review of operational effectiveness planned for later in 2026/27. Good progress has been made in establishing the structure and defining regional priorities. Governance arrangements are operating as intended, with evidence of Board scrutiny, effective escalation and flexible decision making. There are opportunities to strengthen consistency and maturity across sub-groups, given variation in governance documentation, clarity and alignment of objectives, and the articulation of work programme outputs and success measures. A programme wide approach to risk management would also strengthen existing arrangements. As this is an advisory review, an assurance rating has not been assigned; however, four actions aligned to the findings have been identified.

Mrs Wilson advised that she and her equivalent at Swansea Bay UHB (SBUHB) have discussed the report with auditors. The Chair has also seen the report, which will be considered at the next RJC meeting. Most actions have already been implemented. Steps to address Action 4, Programme Risk Management, had also been requested by the RJC at its most recent meeting. The Director of Corporate Governance at SBUHB is leading on this work. It was felt that maturity assessments on the sub-groups may be somewhat excessive; however, a joint response will be prepared and actions added to AMAT. Members were advised that HDdUHB will be passing over responsibility for supporting the RJC to SBUHB in the near future.

It was noted that significant progress is evident between the work programmes in Appendices A and B. Mr Thomas expressed concern around capacity within the health boards to focus on regional work in addition to local priorities. Mrs Wilson indicated that this sentiment had been expressed by others at the most recent RJC meeting. Mr Davies suggested that there are certain areas and specialties which could potential benefit from a regional approach. In others, however, the two health boards have such different needs and starting points, as to make regional working unrealistic. In addition, it was highlighted that leading on regional work is challenging in the absence of authority over another body. Mr Carruthers also noted that regional clinical working requires engagement with two separate cohorts of clinicians, and involves significant staff resource.

Decision: The Committee **NOTED** the Regional Joint Committee Governance Arrangements (Advisory Report) Internal Audit report.

The Committee agreed to **ASSURE** the Board in relation to the Regional Joint Committee Governance Arrangements (Advisory Report).

Mr Andrew Carruthers left the Committee meeting.

AC(26)115 **WellSky System (Advisory Report)**

Ms Corbett introduced the WellSky System Internal Audit report. Members were advised that in August 2025, it was identified that transactions associated with the aseptic module of the WellSky pharmacy stock management system had not been correctly accounted for within Oracle, resulting in costs being overstated by just over £6m. Internal Audit had been asked to undertake an advisory review to establish the root causes, assess the effectiveness of corrective actions undertaken and identify any learning. The findings of our review concurred with an internal review undertaken by Finance and Pharmacy in December 2025. The error arose and persisted due to Pharmacy not properly engaging finance expertise during implementation of that module. Also weak oversight of the WellSky and Oracle system interfaces and accounting treatments. The review has confirmed that corrective action has been taken to address the historic mistakes and strengthen ongoing processes. As this is an advisory review, an assurance rating has not been assigned; however, one action relating to the establishment of the proposed task and finish group has been suggested.

Mr Thomas welcomed the audit and findings, apologising for the fact that the task and finish group had not been convened and committing to do so by the end of July 2026. Mr Thomas' main concern was to obtain assurance, both around WellSky going forward and regarding other systems, that such a situation will not recur. This will require extensive testing of systems; he would ensure that a timescale for the task and finish group to undertake the necessary actions is defined. Members heard that an action in relation to this report will be created on AMAT, which will be closed when the matter is addressed. It may also be appropriate to request Internal Audit undertake related follow-up work. **HT** **HT**

Decision: The Committee **NOTED** the WellSky System (Advisory Report) Internal Audit report.

The Committee agreed to **ASSURE** the Board in relation to the WellSky System (Advisory Report).

AC(26)116 **Infection Prevention and Control (Limited Assurance)**

Ms Sharon Daniel, Ms Rebecca Richards and Ms Cathie Steele joined the Committee meeting.

Ms Corbett introduced the Infection Prevention and Control (IPC) Internal Audit report. The audit focused on policies and procedures, training, improvement arrangements and governance. Whilst policies are aligned to national standards, they require review to ensure they remain current. Training compliance rates for medical and dental staff groups were particularly poor, with only 41% compliance. Various infection prevention and control compliance checks are undertaken within the Health Board; however these are not completed consistently across all sites and there was limited evidence of remedial actions. There was no

Health Board-wide IPC improvement programme in place for the period of review, although the Health Board is in the process of developing an Infection Prevention and Control assurance framework. This is in line with the requirements of the Quality Statement published by Welsh Government in February 2026.

The Infection Prevention team also has a work plan in place to drive infection prevention activities. At the time of the review, it required updating to strengthen and ensure that actions are SMART (Specific, Measurable, Achievable, Realistic/Relevant, Timely). Governance arrangements require review and updating, to clarify reporting arrangements and ensure that groups are operating as intended. Attendance at the Infection Prevention Strategic Steering Group (IPSSG) had been quite poor and there was no evidence of reporting by sub-groups during the period reviewed. An overall rating of Limited Assurance had been concluded, with four actions identified.

Ms Sharon Daniel thanked Ms Corbett, explaining that she had commissioned the audit to test IPC governance arrangements introduced following the OCP, to ensure that these were working effectively and not creating gaps in oversight and accountability. As noted, it has returned a Limited Assurance rating, having identified issues around training, compliance, the audit programme and work plan. The audit was undertaken over a three month period. Whilst Ms Daniel felt that the findings were valid, she suggested that they are consistent with a system undergoing a significant transition.

The audit was largely a controls-based audit focusing on policies, monitoring and reporting, which probably did not the initial request to test the OCP governance model. She was not sure that the recommendations fully align with the level of risk being implied. These views have been discussed with the Internal Audit team and Ms Daniel suggested that the audit should be recognised as a ‘snapshot’ during the transition. Significant work is underway to strengthen the arrangements, and the workplan has been refreshed. As noted, a performance assurance framework aligned to the Welsh Government requirements is being developed. Notwithstanding her concerns, Ms Daniel welcomed the report as a useful basis for strengthening the clarity and consistency and visibility of IPC arrangements. She was hopeful that the actions proposed will be implemented within the stated time frame.

Whilst recognising that certain actions have already been put in place, Cllr. Evans enquired whether these are sufficient as a ‘first measure’ to reduce operational and patient safety risks. Ms Daniel explained that, in terms of the recommendations relating to systems and controls, outcomes are monitored extremely closely within the organisation. The Improvement Plan had already been submitted to the Executive Team and QSEC. The focus going forward will be on strengthening the governance arrangements through to IPSSG, to ensure the correct systems and processes are in place, to impact on the outcomes. With regard to training,

Ms Rebecca Richards indicated that all staff are able to access the recommended IPC training via ESR. The team is also considering provision of more targeted training for staff, to address the key areas of concern. Cllr. Evans clarified that it is not the availability of training which is an issue, rather that it is one of compliance. He enquired how the required behavioural change and improved engagement might be achieved. Ms Daniel reiterated that the system is in transition, whilst acknowledging that face-to-face training, for example, may be more appropriate.

Mr Davies recorded his disappointment regarding the Limited Assurance rating, particularly with IPC being one of the Targeted Intervention criteria. He enquired whether the actions with completion dates of 30 June are on target, and whether anything more can be done to expedite those with longer timescales. In response, it was suggested that longer timeframes are required for a number of these, due to the need to embed processes and demonstrate impact and improvement. Returning to the issue of debate around the scope of this audit, Mrs Wilson assured Members that the new SOP in relation to Internal Audits sets a requirement for a clear audit scope, signed-off by the relevant Lead Executive.

Decision: The Committee **NOTED** the Infection Prevention and Control (Limited Assurance) Internal Audit report.

The Committee agreed to **ADVISE** the Board in relation to the Infection Prevention and Control (Limited Assurance) Internal Audit report, given their concerns around its findings.

Ms Sharon Daniel, Ms Rebecca Richards and Ms Cathie Steele left the Committee meeting.

AC(26)117 Medical Workforce Stabilisation (Reasonable Assurance)

Mr Mark Henwood and Ms Carly Hill joined the Committee meeting.

Mr Johns introduced the Medical Workforce Stabilisation Internal Audit report. The audit had examined the controls in place on managing medical variable pay as part of the broader Medical Workforce Stabilisation Programme. It had considered various elements and identified that there is currently no dedicated policy or procedure for use and management of medical variable pay, with inconsistent approaches within wards and specialties. This has led to instances of retrospective recording of requests and approval of shifts, no segregation of the requesting and approving officer, incorrect reasoning of requested shifts, with some approvers not being the budget holders. One high priority action around this matter had been noted and an overall rating of Reasonable Assurance returned.

Mr Mark Henwood welcomed the report and its findings. He suggested that the introduction of the Allocate rostering system has been extremely helpful in providing a structure now for

increased grip and control over rota management. As identified by the audit, the need now is for a prescribed policy and procedures around approval and segregation of duties, and to ensure that there is no retrospective submission of shifts. It is still the case that shifts are being submitted via paper-based systems; with Allocate having been rolled-out, this is unnecessary. The new medical rate card has also provided valuable structure and consistency around rates. Whilst there are some issues it has, on the whole, been well received. Mr Henwood was content with the suggestions made in the report, indicating that work has already commenced on developing the policy. He was also confident that the timescale for implementation is achievable.

Cllr. Evans noted the following statement in the report: '47% of the shifts retrospectively submitted to bank and approved/finalised by an officer taking 10 days or more to be recorded on Allocate after the shift had been worked.' He requested assurance that improved uptake of Allocate will address this matter. Mr Henwood recognised that this causes issues with reporting, and suggested that the challenge is a cultural and historical one. A policy will make it clear that there should be no paper-based submissions, barring exceptional circumstances. In response to a query around the October timescale for development of the policy, Members were advised that sufficient time to undertake the required consultation prior to implementation. Ms Carly Hill indicated that the first draft had been completed and is ready to share with stakeholders. The team is linking with the Corporate Policies Office to establish the correct procedure.

Decision: The Committee **NOTED** the Medical Workforce Stabilisation (Reasonable Assurance) Internal Audit report.

The Committee agreed to **ASSURE** the Board in relation to the Medical Workforce Stabilisation (Reasonable Assurance) Internal Audit report.

Ms Carly Hill left the Committee meeting.

AC(26)118 High Cost Drugs (Limited Assurance)

Ms Corbett introduced the High Cost Drugs Internal Audit report, which described the narrow-scope review focusing on the control of costs associated with high cost drugs dispensed in secondary care. High cost drugs are defined as those meeting or exceeding £5k per course or per year per patient. Drugs approved by the National Institute for Health and Care Excellence (NICE) or the All Wales Medicine Strategy Group are added to the Health Board formulary and do not require approval of costs. However, non-formulary medicines or formulary medicines proposed to be used for an indication other than that stated within the formulary require approval via a non-formulary request or Individual Patient Funding Request (IPFR).

Whilst arrangements for adding medicines to the formulary and the approval requirements for non-formulary drugs are set out

within the policy, this policy was in draft at the time of the review. This requires updating to reflect changes in operational governance arrangements and to provide greater clarity regarding approval requirements for use of non-formulary drugs during periods of supply shortages for the formulary alternative. The audit had identified instances where the formulary had not been updated appropriately. Also, instances where an Individual Patient Funding Request (IPFR) had not been completed or had been completed retrospectively and only covered part of the period reviewed. Costs relating to these cases (for the period reviewed) exceeded £82k and may have been recoverable if an IPFR had been submitted. There is no monitoring of high cost drug use at patient level to identify costs that could be recharged or to ensure that periodic clinical review is undertaken. Whilst data is available to enable this, it would require significant manual analysis in its current form. Finally, a centralised record of non-formulary and IPFR requests is needed, to enable oversight of approvals. Limited Assurance overall had been concluded, with seven actions identified.

Mr Henwood was in complete agreement with the report's findings, which had identified a lack of grip and control over high cross drugs, and acknowledged that significant work is required. He was content with the actions as suggested and that the proposed time frames for actions are considered achievable.

Mr Davies queried whether the advent of Electronic Prescribing and Medicines Administration (ePMA) is likely to have a significant impact on the issues identified within the report. Mr Thomas suggested that, whilst it will have some impact, it would not necessarily resolve all of the issues. In common with the WellSky system discussed earlier, it also relies on proper usage. Given that the action in relation to Key Finding 2 has a completion date of 31 May 2026, assurance was requested that this had been achieved. Ms Bird advised that no evidence was recorded on the AMAT system as yet. Cllr. Evans noted that the report infers significant financial risk exposure and potential cost avoidance. He enquired whether there has been any discussion around the prescribing of high cost drugs. In response, Mr Henwood recognised that processes are clearly not sufficiently rigorous, with a gap in financial governance.

Building on an earlier query, Mr Weir enquired whether implementing electronic prescribing at the patient level would assist in monitoring high cost drug usage and clinical governance, as opposed to the more mechanistic approach currently employed. He further enquired where responsibility for this area lies. Mr Henwood agreed that a structure will need to be put in place and regular audits conducted. Responsibility sits with both clinicians, in terms of appropriate prescribing and pharmacy, in terms of appropriate ongoing issuing of medications. Both parties' accountability will need to be clear.

Mr Weir suggested that a high-level accountability and overview is required, with oversight of drug budgets, including high cost drugs. This is where electronic prescribing may offer opportunities. Agreeing, Mr Henwood felt that there was potential to introduce a regular review process as part of clinical governance by clinical leads. Mr Thomas reiterated his earlier comment that ePMA will offer certain opportunities for improvement, although these are restricted. It will assist in administration and in reducing prescribing errors. It will also help in terms of data and Patient Reported Outcome Measures (PROMs) analysis. However, it will not address the issue of clinical appropriateness of prescribing.

Professor Phil Kloer and Mr Dilesh Khandhia joined the Committee meeting.

For context, Ms Corbett explained that the clinical aspect had not been examined as part of the audit. However, discussions with the lead pharmacist during the testing suggested that the majority of the patients in the sample are on long-term or lifelong treatments. The likelihood is that the vast majority of treatment plans have been in place for a number of years. Therefore, this could be a population of patients dating back quite some time, rather than new patients coming through the system. It is also possible that some of treatment plans may have been initiated outside of the Health Board by specialists in other health boards. Ensuring that approval processes are applied when such patients are transferred into HDdUHB's care may require further consideration.

Mr Davies noted that several of the recommendations make reference to data quality and availability, and emphasised the importance of ensuring that information is recorded correctly. He queried whether there might be opportunities to utilise AI to, for example, highlight trends or anomalies. Mr Thomas agreed that, once AI systems are in place, this should be revisited.

Mr Dilesh Khandhia explained that extensions on certain of the completion dates have been requested, due to staffing issues. He assured Members, however that the various actions are being progressed. He also assured the Committee that scrutiny and oversight are a high priority and more CCG visibility would be welcomed at the relevant meetings. In terms of ePMA, the potential to automatically flag non-formulary items and require completion of further information is being explored. A suite of documents will be available from the system, including a form for non-formulary items. It is hoped that these will help to provide checks and 'close loops'. Whilst this will be time-consuming, there is a plan in place. He had been assured by the ePMA team that these functions will be possible and they appear to work in testing.

Decision: The Committee **NOTED** the High Cost Drugs (Limited Assurance) Internal Audit report and **REQUESTED** that a progress update be provided to the December 2026 meeting. **MH**

The Committee agreed to **ADVISE** the Board in relation to the High Cost Drugs (Limited Assurance) Internal Audit report, given their concerns around its findings.

Mr Mark Henwood and Mr Dilesh Khandhia left the Committee meeting.

AC(26)119 **Follow Up and Action Implementation Review (Reasonable Assurance)**

Mr Johns introduced the Follow Up and Action Implementation Review, which considered these arrangements within the Health Board. It brings together a number of elements, including the corporate arrangements in place and the work undertaken on an ongoing basis by the Assurance and Risk team, considering the evidence uploaded in terms of closing down the actions. It also evaluated an additional sample of recommendations and encompassed the broader work undertaken on follow-up reviews throughout the year. It had concluded Reasonable Assurance overall and had found, as in previous years, that the corporate arrangements in place are robust and sound, with good processes in place and strong liaison with operational teams. The sampling of recommendations and actions had returned a mixed position, with certain showing sufficient evidence to justify an assertion of full implementation, and others where further work and evidence is required before recommendations can be closed.

Mrs Wilson welcomed the report and thanked both the Internal Audit team and her own Assurance and Risk team for their efforts. The only comment she wished to add was to note that, since the report was issued, the outstanding action in relation to the Estates Condition audit has been completed. Noting that this left only one audit with open recommendations, Vaccination and Immunisation, Cllr. Evans requested a progress update. Members heard that this is being taken forward, and that the Executive Director of Public Health is aware of the issue. Its status is highlighted in the regular report provided by the Assurance and Risk team. Whilst it was noted that an update is scheduled for SPC, there is currently no clear timeline for conclusion. Cllr. Evans requested that the importance of addressing the matters arising identified in the audit is emphasised to management, on behalf of the Committee. **JW**

<u>Decision</u>: The Committee **NOTED** the Follow Up and Action Implementation Review (Reasonable Assurance) Internal Audit report.

The Committee agreed to **ASSURE** the Board in relation to the Follow Up and Action Implementation Review (Reasonable Assurance) Internal Audit report.

AC(26)120 **Head of Internal Audit Opinion & Annual Report 2025/26**

Mr Johns presented the report, which is a key document prepared on an annual basis to provide the overall opinion of the risk governance and control arrangements operating within

the Health Board. Along with the opinion, it also provides a range of support and information in terms of the rationale around the opinion and how it has been developed. It also provides a breakdown of audit reports by assurance rating and a summary of overall findings. The report also contains a range of other information Internal Audit is required to report to the Committee on an annual basis, in relation to the scope of reviews, delivery of the plan, performance information, and how the workplan is delivered in compliance with the Global Internal Audit Standards. An additional document has been provided, in common with the last few years, which provides greater detail around formulation of the opinion and information on year to year comparisons around individual assurance ratings and opinions. The key message, set out in Section 1.2 of the main report, is the overall annual opinion, which has been concluded as Limited Assurance. The main driver of this is the number of limited assurance reports issued during the year. There have been ten such reports, as set out in Table 1 of the main report.

Cllr. Evans expressed that, whilst this opinion was disappointing, it does illustrate that the Health Board is engaging with the process as intended, by demonstrating openness and honesty in its responses. It would be easy for the organisation to ‘dilute’ the process by selecting areas where there is known to be good practice. However, this would not be beneficial or represent value for money. It is important to identify where there are issues and risks, and to face these ‘head on’. This process will provide robust recommendations which will serve to improve quality and safety.

Professor Kloer echoed the view that the overall opinion was disappointing, whilst respecting and recognising the rationale. He agreed that the Internal Audit Plan is seeking to target areas where the organisation wishes to learn and improve. He suggested, however, that the overall opinion is also partially related to actions not being implemented sufficiently at pace prior to follow-up audits. He felt that the Health Board needs to accept that it has agency in this respect to improve a number of these situations. In a large organisation, it would be surprising if there were not a certain number of incidents reported; likewise, if all an organisation’s internal audits were rated as reasonable or substantial assurance, it would be logical to question whether the approach being taken is balanced. Professor Kloer did enquire, however, whether Internal Audit or Audit Wales have a view or sense from their national viewpoint of whether HDdUHB’s approach is appropriately balanced, or not sufficiently targeted, or too harshly targeted.

In response, Mr Johns advised that there is a consistent risk-based approach to Internal Audit across Wales, which will, by its very nature, generate a certain number of Limited Assurance reports. As has been mentioned, in HDdUHB’s case, certain of the follow-up audits have demonstrated positive progress, others less so. There have also been instances where follow-ups have had to be deferred. Adding to this, and echoing comments by Professor

Kloer, Ms Corbett suggested that an opinion of Limited Assurance is perhaps to be expected, given the position the Health Board is in financially and in escalation terms. There are clearly risk areas requiring attention, and higher assurance would probably suggest that the audit programme was not focused on the correct areas. It is also potentially reflective of the organisation's commitment to utilise Internal Audit for its intended purpose, which is to drive improvement.

Noting that there have been a number of advisory reports during the year, Cllr. Evans enquired whether – if these had been assurance rated – the overall opinion would have differed. Ms Corbett advised that, whilst these reports are considered during compilation of the Annual Report, they do not contribute to the overall opinion. On this topic, Mr Thomas suggested that advisory reports still involve a great deal of organisational time and effort, and suggested that it would be appropriate for their inclusion in the Internal Audit programme to be approved by the ARAC Chair and Executive Lead. Mr Davies further added that advisory reports are sometimes included in place of rated audits, which is not necessarily beneficial. Noting that there has been a particularly high number of advisory reports this year, Mrs Wilson agreed with the suggestion around approval. She did emphasise, however, that the SOP developed and mentioned earlier seeks to make processes more transparent and robust. **JW**

Returning to the fact that ten Limited Assurance reports have been received this year, Mr Weir noted that these cover a wide range of topics. If they were in a particular area, it might be understandable; however, this is not the case. They do, however, provide indicators to where a focus on improvement is required. It also substantiates the independence of Internal Audit. Mr Weir felt that this year's report represents a fair summary of the Health Board's position and should be viewed as a positive platform for improvement and a starting point.

Decision: The Committee **CONSIDERED** the Head of Internal Audit Opinion and Annual Report 2025/26.

The Committee agreed to **ADVISE** the Board in relation to the Head of Internal Audit Opinion and Annual Report 2025/26, noting that it would also be discussed at the extraordinary Public Board meeting on 25 June 2026.

AC(26)121 Escalation Status Update Report

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

To provide additional context for this item, Professor Kloer highlighted changes to the accountability arrangements in Wales and steps taken to ensure executive oversight for each de-escalation criteria. HDdUHB's first Escalation Board meeting with Welsh Government had recently taken place, with the level of scrutiny having increased significantly. This had identified a need

to focus on clarity in responses, which will demand equivalent scrutiny and clarity via the committee structure. The other point of note is that Professor Kloer felt Welsh Government is supportive of and has a level of confidence in the Health Board in its endeavours to de-escalate. It does, however, need the organisation to demonstrate its route to achieving this and a commitment to work with Welsh Government.

Mr Shaun Ayres presented the report, suggesting that, whilst all 31 criteria are mapped to committees, facilitating the necessary oversight by ARAC, the focus now perhaps needs to move from ownership to triangulation and impact. This requires a more granular understanding of the data and where causal effect is more liable to have the greatest impact. The other issue, as previously identified, is one of capacity and ability to deliver multiple programmes of improvement concurrently. There are numerous expectations around simultaneously improving performance, reducing costs, protecting quality, stabilising fragile services, sustaining de-escalation areas and strengthening planning maturity. Whilst this might be possible to deliver, the capacity to do so may be limited by the fact that the same people are being asked to deliver system expectations and whether they can do this safely at the same time as driving performance improvement, financial improvement and quality control overall. It may be that, at certain points, certain areas or programmes will take priority or impact more greatly than others. This will necessitate robust, targeted plans at an early stage and may require additional support.

Professor Kloer wished to recognise Mr Ayres' important role and contribution as the interface between Executive Directors and CCGs. Whilst noting that all of the expectations identified are the Health Board's statutory responsibilities, he also recognised that achieving them involves significant challenges and demands on teams. The letter from Welsh Government is quite specific on the escalation domains, and the Health Board shares these views. He noted the need to ensure that committee agendas are appropriate apportioned to reflect this. Members heard that Professor Kloer would be meeting with the Executive Director of Finance and Executive Director of Strategy and Planning to discuss the route map to achieving financial balance. Whilst this had been discussed by the Board, it requires further discussion with Welsh Government.

Returning to the issue of capacity, Cllr. Evans queried the level of confidence that this exists to deliver on all expectations. Professor Kloer noted that the Health Board's Annual Plan submission and financial trajectory described therein had not met Welsh Government expectations. Whilst there has since been progress on this, his concern is that plans are not developed to a sufficient level at an early enough stage. This means that the first few months of the year are often spent developing and adjusting the detail of the plan, rather than on delivery. In response to a query around what the Committee might do to assist, Professor Kloer

suggested that the organisation needs to improve in defining workstreams, impact and timescales.

Mr Lee Davies noted that discussion of ARAC's role has been a recurring theme. He suggested that, if all de-escalation criteria were being delivered on, this role would not be required; however, it is clear that certain criteria present ongoing challenges. It may be that ARAC has a role in surfacing and identifying how these might be progressed, although this potentially encroaches on the remit of the Board. With regard to the capacity issue, Mr Ayres suggested that there are potentially two considerations aside from the physical resource and staff to deliver:

- Whether plans are clear, in terms of what they are targeting and whether this is backed by data
- Whilst the capacity to project manage may exist, whether there is the skillset to take programmes of work forward

Cllr. Evans added to this the issues of prioritisation and ownership.

Professor Kloer gave examples of de-escalation criteria which are proving particularly challenging. Healthcare Associated Infections (HCAIs) are a concern for both Welsh Government and the Health Board. Whilst at a relatively low level, this is an area which is proving persistently challenging to improve. Additional support has been requested. Likewise, additional support is required around grip and control in UEC, with Welsh Government having identified an individual who may be able to assist. Members were assured that the Health Board is taking a targeted approach in seeking support where it is most needed. There will, however, be areas where significant specialist input is required in order to support the necessary skillset for improvement.

Given the earlier Limited Assurance rating for an audit in IPC, Mr Maynard Davies suggested that this is an area where the Health Board needs to improve compliance internally before seeking external support. It is also vital to ensure that committees are escalating issues to ARAC. He enquired whether Committee Chairs are sufficiently clear on their responsibilities in this regard. In response, Mrs Wilson indicated that this is a planned topic for discussion at the next Committee Chairs' session. It was agreed that it would be helpful for Mr Lee Davies and Mr Ayres to attend. **JW**

Decision: The Committee:

- **NOTED** and **TOOK ASSURANCE** from the criteria map and commitments log, which discharges action AC(26)38, and from the boundary rules now operating across committees.
- **AGREED** that the register and a consolidated update of this kind come to each meeting, with referrals to lead committees where it identifies gaps.

- **CONSIDERED** organisational bandwidth as a corporate risk, as requested in February 2026, recognising the totality assessment of 'Alert'.
- **AGREED** to advise the Board that its concern remains deliverability of the whole, not the failure of any single part, consistent with the discussion in April 2026.

The Committee agreed to **ADVISE** the Board in relation to the Escalation Status Update Report, given its concerns around the organisation's capacity to deliver against both the Annual Plan and de-escalation requirements.

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

AC(26)122 HDdUHB Annual Report 2025/26

Mrs Wilson presented the HDdUHB Annual Report for 2025/26. She advised that all changes and comments have been tracked and is detailed in Appendices 1a and 1b. The finalised Head of Internal Audit Opinion has been incorporated, which had altered the narrative and conclusion. Minor typographical errors and corrections had also been made. Mrs Wilson wished to record her thanks to Miss Charlotte Wilmshurst for her work on the report, and to Audit Wales and Internal Audit for their support and feedback throughout the year. Mr Thomas added to this his thanks to the Performance, Communications and Governance teams. He was of the opinion that this year's report reads better than previous Annual Reports. Professor Kloer thanked all of those involved in what is a significant task. He welcomed the audit trail of feedback and changes.

Cllr. Evans enquired as follows:

- Whether there any judgments, disclosures, or wording choices where the Committee requires particular assurance before recommending onward progression?
- Whether the Annual Report fully and transparently reflects the areas where the organisation has not yet been able to provide assurance, particularly around governance, capacity and delivery?
- Whether the Chief Executive is personally confident that the balance between achievements and ongoing risks is fair?

In response to these queries, Mrs Wilson and Professor Kloer advised that:

- The main changes are the change to the conclusion, as a result of the finalised Head of Internal Audit Opinion; the Accountability Report clearly calls out that the Health Board has not met its statutory duties in relation to both finance and planning. These are the key issues of which the Committee should be aware.
- The wording within the Annual Report is consistent with what has been reported through the Integrated Performance

Assurance Report (IPAR) during the year, and is consistent with the Annual Accounts.
- As Chief Executive, he was confident that the balance is fair and demonstrates the Health Board's openness. Reflecting on the discussion around Internal Audit, he also felt that it reflects where the Health Board is as an organisation.

Mr Maynard Davies' only comment was that the diagram on page 132 is too small to be legible.
Decision: The Committee **AGREED** to provide assurance to the Board that a robust governance process was enacted during the year, and **RECOMMENDED** approval of the HDdUHB Annual Report 2025/26 to the Board, prior to its submission to Welsh Government, via Audit Wales, by 30 June 2026, and its subsequent presentation at the Annual General Meeting on 30 July 2026.

The Committee agreed to **ASSURE** the Board in relation to the HDdUHB Annual Report 2025/26.

AC(26)123 Final Accounts for 2025/26

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

Mr Thomas introduced the Final Accounts for 2025/26, recording his thanks to Ms Rhian Davies, Mr Tim Johns and the wider Finance team for their diligence in reaching this point. He also thanked the Corporate Governance and other corporate teams for their valuable input. Members heard that the Health Board's mature and constructive relationship with Audit Wales staff and robust processes have ensured that queries and issues have been addressed at an early stage. As this marks Ms Davies' final audit before retirement from the Health Board, Mr Thomas wished to thank her in particular for her significant contribution.

Ms Rhian Davies reminded Members that the draft accounts had been presented to ARAC at the meeting on 7 May 2026. In terms of the primary statements, she advised that there are no changes. The changes that have been made are minor typographical errors. There was one change to the employee costs on note 9.1, which was a simple misclassification of agency staff salaries. These were overstated, with conversely the permanent staff being understated. In the Remuneration Report, there was an update to the pay banding for one Executive Director. The Annual Accounts are being presented to ARAC for approval, prior to their ratification by the Board.

Cllr. Evans wished to add his thanks, on behalf of the Committee, to Ms Davies for all her efforts. He enquired regarding key messages from the Accounts for ARAC's consideration. In response, Mr Thomas drew Members' attention to the information within the presentation around the Health Board's performance against financial targets. The organisation had not met its statutory duties in terms of revenue resource performance and preparing a 3 year plan or IMTP.

AC(26)124 **Audit Wales ISA 260 and Letter of Representation**

Mr Williams presented the report, which summarises the main findings from the audit of the 2025/26 annual report and accounts at the time of preparing the report. Members' attention was drawn to the feedback sent by Mr Anthony Veale, who was unable to attend due to a clash with another Audit Committee. He was pleased to note that there was nothing of significance in the report, which reflects the quality of the accounts this year and the support from the Director of Finance and Finance team. He had been extremely satisfied with the way the audit has gone this year, and expressed his thanks.

Mr Williams advised that all outstanding audit work and review is complete. Audit Wales has received the assurances from the Shared Services audit team, referenced in the introduction to the report, with no issues noted. Page 6 of the report summarises the outcomes from the audit. Audit Wales intends to issue an unqualified, true and fair audit opinion, but a qualified regularity opinion. There are no significant matters to report, no uncorrected misstatements, and no audit recommendations in this report. The proposed audit report is set out at Appendix 3. The regularity opinion is qualified because the Health Board did not meet its revenue resource allocation over a three year period ending 31 March 2026. The Auditor General also intends to issue a substantive report explaining why the audit opinion in respect of the regularity of expenditure is qualified. That report will also refer to the fact that the Health Board did not meet its financial duty regarding a three year IMTP.

Appendix 2 provides a summary of the small number of corrections made to the draft accounts, as already mentioned. Appendix 4 details the standard letter of representation, which is due to be signed after the extraordinary Public Board meeting on 25 June 2026. Following Board approval of the annual report and accounts, the Auditor General intends to certify the accounts on 26 June 2026, with onwards formal submission to Welsh Government to meet the deadline for that of 30 June 2026. Mr Williams concluded by reiterating Audit Wales' satisfaction with the audit process and extending his thanks to everyone involved.

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

The Committee **APPROVED** the Audited Annual Accounts for 2025/26, for onward ratification by the Board.

The Committee agreed to **ASSURE** the Board in relation to the Audit Wales ISA 260 and Letter of Representation and Audited Annual Accounts for 2025/26.

Ms Rhian Davies and Mr Tim John left the Committee meeting.

AC(26)125 **ARAC Workplan 2026/27**

The Committee **NOTED** the Audit Work Programme 2025/26.

AC(26)126 **Any Other Business**

It was noted that, due to technical issues during the meeting, Mr Weir had submitted his queries in relation to item AC(26)109 via the MS Teams Chat facility, as follows:

1. Is referral management quality an issue across all NHS Wales health boards?
2. What is the risk of not having an out-of-hours Ultrasound service? Is this the case for other health boards?
3. The demand capacity issue facing Radiology really impinges upon early access - treatment to prevention - do we have the right level of resources and, if not, are there any opportunities for increased capacity through future technological advances i.e. RIS or PACs or remote access to Radiology reporting?
4. Some recommendation responses go to 2028 - in the interim this suggests that the Health Board is holding risk until then - so what are the mitigations? e.g. workforce plan for Radiology is stated for Jan 2028

It was agreed that these would be forwarded to Mr Carruthers and Ms Bell for response. **CM**

AC(26)127 **Matters and Risks for Escalation to the Board**

As noted.

AC(26)128 **Date and Time of Next Meeting**

9.30am, 13 August 2026

2.2

09:30, 5 Mins

2.2 - Table of Actions

Rhodri Evans (Hywel Dda UHB - Independent Member)

For assurance

Attachments

2.2 Table of Actions ARAC 23 June 2026.pdf

2.2 Appendix 1 - Responses to Queries re Radiology.pdf

AUDIT AND RISK ASSURANCE COMMITTEE (ARAC)/ PWYLLGOR ARCHWILIO A SICRWYDD RISG
23/06/2026
TABLE OF ACTIONS/TABL GWEITHREDOEDD

Key: AB-Angela Bell; AC-Andrew Carruthers; CM-Clare Moorcroft; HT-Huw Thomas; JW-Joanne Wilson; LD-Lee Davies; MH-Mark Henwood; PK-Philip Kloer; PS-Peter Skitt; UP-Urvisha Perez

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
14/10/2025	AC(25)171	Validation of Emergency Department Waiting Time Data (Limited Assurance) • To review and revise the SOP and take it forward via CCG and wider Health Board governance processes	PS	31/07/2026	Complete Due to operational pressures, it has not been possible to take the revised SOP through the governance process. Revised delivery date of end of March 2026 proposed. The Final Draft of the SOP is being commented on by Clinical teams led by the ED Lead Clinician, The introduction of the new ED system has delayed the progress with this action, along with alignment of reporting from a PAS perspective, this SOP will be completed by 31 July 2026. It is proposed that this action is closed from an ARAC perspective, as the SOP is under development. When Internal Audit undertake their follow-up review, part of the scope will be to test this has been completed and the SOP embedded.
09/12/2025	AC(25)187	Table of Actions • AC(25)171 – to clarify whether the revised Standard Operating Procedure (SOP) has been subject to the required governance processes	AC	31/07/2026	Complete See AC(25)171
14/04/2026	AC(26)045	Review of the Management of Outpatients • To consider at SPC the need for a longer term plan in relation to Outpatients, which takes account of demand and the potential use of Primary and Community services	AC	30/11/2026	Complete Considered for inclusion on the August 2026 SPC agenda at agenda-setting on 30 June 2026 and forward planned for the SPC meeting on 2 November 2026.

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
07/05/2026	AC(26)076	Digital Transformation Review • To consider the report at DDIC	HT	13/08/2026	Complete On workplan. Action complete.
07/05/2026	AC(26)079	Major Infrastructure Investment Programme (Reasonable Assurance) • To work with Mr Lee Davies, Mrs Joanne Wilson and Mr Rob Elliott, in dialogue with the Procurement team, to establish how greater assurance can be provided around contract management	HT	13/08/2026	In progress The advice of the Head of Procurement has been sought and has confirmed that Capital projects have been operating compliantly within the scope of the existing frameworks. The introduction of the Procurement Act 2023 (since February 2024) will bring additional requirements when the frameworks expire and are re-procured under the new regulations. A meeting was held on 8 July. This remains in progress.
07/05/2026	AC(26)087	Draft Audit and Risk Assurance Committee Annual Report 2025/26 • To suggest to Ms Daniel that it might be appropriate to invite the Chair of QSEC to engagement meetings with HIW	PK	13/08/2026	Complete There are engagement processes already in place and it has been agreed that it is probably more appropriate for the QSEC Chair to provide input via these routes.
07/05/2026	AC(26)093	Financial Grip and Control • To evaluate the assertion regarding OCPs that there is no additional cost, and provide a response via the Table of Actions	HT	13/08/2026	Complete Additional costs arising from OCP arrangements will be reported through to the Finance and Performance Committee and/or Board within the monthly finance report.
07/05/2026	AC(26)093	Financial Grip and Control • To consider further how to progress emphasising and enforcing compliance	HT	13/08/2026	Complete Financial Grip and control self-assessments has been provided to Level 4 escalated CCGs. This will be trialled with the Level 4 CCGs before rolling out further.
23/06/2026	AC(26)105	Financial Assurance Report • To provide a report to ARAC and DDIC on the AI model being built to analyse contract data, invoice data and responses from managers on performance, and provide output on whether contracts are being effectively managed	HT	13/08/2026	Complete With the Committee's agreement, this will be taken into the Finance and Performance Committee as part of our procurement reporting. Any lessons learned from this exercise will be included in our broader AI programme through DDIC.

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
23/06/2026	AC(26)108	Audit Wales Update Report • To consult with colleagues and provide an update at the next meeting on how Audit Wales proposes to follow up review recommendations	UP	13/08/2026	Complete Audit Wales is developing a more formal and consistent approach to monitoring progress being made by public sector bodies in implementing the auditor general's recommendations. National reports that make recommendations for local public sector bodies are likely to require a local management response. These recommendations will also need to be included in audit trackers so progress can be monitored. Audit Wales will update the Health Board once the approach has been finalised.
23/06/2026	AC(26)109	Review of Radiology Services • To ensure that the overarching Radiology Plan is submitted for committee oversight and agreement to SPC in the first instance	LD	13/08/2026	Complete This will be added to the SPC workplan.
23/06/2026	AC(26)109	Review of Radiology Services • Following further discussion, it was agreed that a progress update should be scheduled for six months' time	AC	13/08/2026	Complete Forward planned for December ARAC meeting
23/06/2026	AC(26)109	Review of Radiology Services • To draft a report for DDIC on electronic test requests	HT	13/08/2026	Complete This will be added to the DDIC workplan.
23/06/2026	AC(26)109	Review of Radiology Services • To feed back to the team reviewing the terms of reference for the Referral Management Group suggestions around e-referrals and the iRefer system	AB	13/08/2026	Complete The service has confirmed that electronic referrals form part of its improvement programme and that NICE and Royal College of Radiologists iRefer guidance is being used.
23/06/2026	AC(26)112	GP Out of Hours (Limited Assurance) • To investigate whether other sites allow non-clinical staff as a second signatory	AC	13/08/2026	Complete The suggested position has been tested and would be consistent with the rest of Wales.
23/06/2026	AC(26)112	GP Out of Hours (Limited Assurance) • To establish timescales for implementation of electronic prescribing processes	HT	13/08/2026	Complete This will be added to the DDIC workplan.

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
23/06/2026	AC(26)113	Commissioning Third Sector (Reasonable Assurance) • To discuss outside the meeting whether Third Sector contract management should form part of the work in relation to outsourced and insourced service contract management	HT	13/08/2026	Complete A comprehensive procurement exercise has been commenced for Third Sector contracting which will embed this. This is part of the procurement workplan.
23/06/2026	AC(26)115	WellSky System (Advisory Report) • To convene the task and finish group by the end of July 2026	HT	13/08/2026	Complete The Task and Finish Group's first meeting is on 20 July.
23/06/2026	AC(26)115	WellSky System (Advisory Report) • In order to obtain assurance that such a situation will not recur, to ensure that a timescale for the task and finish group to undertake the necessary actions is defined	HT	13/08/2026	Complete The Task and Finish Group's first meeting is on 20 July. The role of the T&F Group will be to ensure that lessons are learnt and that the learning is embedded.
23/06/2026	AC(26)118	High Cost Drugs (Limited Assurance) • To provide a progress update to the December 2026 meeting	MH	13/08/2026	Complete Forward planned for December ARAC meeting
23/06/2026	AC(26)119	Follow Up and Action Implementation Review (Reasonable Assurance) • To emphasise to management the importance of addressing the matters arising identified in the Vaccination & Immunisation IA	JW	13/08/2026	Complete Of the 5 remaining outstanding recommendations, revised dates have been provided ranging from August to December 2026. Progress against the implementation of these will continue to be monitored via the Health Board's internal escalation framework within the Governance domain, and support will continue to be provided to the function via the Assurance and Risk team
23/06/2026	AC(26)120	Head of Internal Audit Opinion & Annual Report 2025/26 • For the ARAC Chair and Executive Lead to approve all advisory reports	JW	13/08/2026	Complete Meeting held with the Head of Internal Audit Opinion, Chair of ARAC and the Director of Corporate Governanance on 6.7.26. It was agreed that all advisory reports must be authorised by the Chair of ARAC
23/06/2026	AC(26)121	Escalation Status Update Report • To invite Mr Lee Davies and Mr Shaun Ayres to attend next Committee Chairs' session, to provide guidance around committee oversight of escalation	JW	13/08/2026	Complete A lunch a learn session was held on 7.7.26 date with Independent Members

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
23/06/2026	AC(26)126	Any Other Business • To forward Mr Weir's queries in relation to Radiology to Mr Carruthers and Ms Bell for response	CM	13/08/2026	Complete Complete - responses to queries attached as Appendix 1

Responses to questions from ARAC meeting held 23.06.26
Agenda item: Audit Wales - Are Radiology Services Improving Report (May 2026)

The committee asked whether referral quality improvement work would include electronic referrals and use of the Royal College of Radiologists iRefer resource. The service has confirmed that electronic referrals form part of its improvement programme and that NICE and Royal College of Radiologists iRefer guidance is being used.

Additional queries raised by Winston Weir, following a brief period of technical difficulty during which the committee was unable to hear him, are answered below.

1. Is referral management quality an issue across all NHS Wales Health Boards?

   Referral quality is a recognised challenge across Wales and the wider UK. Hywel Dda is addressing this through clearer pathways, referrer education, senior oversight, the Radiology Referral Management Group and the Quality Lead Radiographer role, which will support regular audit and ongoing assurance.

2. What is the risk of not having an out of hours ultrasound service? Is this the case for other health boards?

   The main risks are delayed diagnosis, potential prolonged admission and reliance on alternative imaging where ultrasound would normally be preferred. Hywel Dda cannot confirm the position in every NHS Wales Health Board; however, national sonographer workforce constraints make comprehensive 24/7 non-obstetric ultrasound provision challenging. In Hywel Dda, out-of-hours and weekend emergency reporting is provided where available and supported by outsourcing, but this does not currently include direct clinical contact activity such as non-obstetric ultrasound. The risk is being managed through prioritisation, outsourcing and wider workforce planning.

3. The demand capacity issue facing radiology really impinges upon early access - treatment to prevention - do we have the right level of resources, probably not, and if not are there any opportunities for increased capacity through future technological advances i.e. RIS or PACs or remote access to radiology reporting?

   Remote reporting is already available and used, but reporting capacity remains constrained, requiring continued outsourced reporting at significant cost. Hywel Dda also operates an in-lieu locum reporting model, enabling substantive radiologists to undertake additional reporting at lower cost than outsourcing, although participation remains limited.

   Demand management is being progressed through referral governance, electronic referrals and scoping of clinical decision support with CGI. This could help embed national guidance and local pathways, reduce duplication, support prioritisation of urgent cases and improve collaboration across clinical teams.

4. Some recommendation responses go to 2028 - in the interim this suggests that the HB is holding risk until then - so what are the mitigations? e.g. workforce plan for radiology is stated for Jan 2028. The longer timelines reflect phased recurrent Radiology investment secured in 2024-25 to stabilise services and recruit key management, governance and clinical posts. Some recruitment is already progressing, including two trained sonographers appointed in June, further interviews planned for July, and two substantive Consultant Radiologist posts advertised on 8 July.

   In the interim, residual risk is being managed through insourced ultrasound capacity, outsourced reporting, temporary staffed mobile MRI and CT capacity, prioritisation and workforce planning. These mitigations do not remove the underlying workforce and demand risks but provide practical controls while longer-term actions are implemented.

Angela Bell

Assistant Director of Quality, Safety and Patient Experience, AH HS CCG, 13.07.26

2.3

09:35, 0 Mins

2.3 - Matters Arising not on Agenda

Rhodri Evans (Hywel Dda UHB - Independent Member)

For discussion

2.4

09:35, 15 Mins

2.4 - Escalation Status Update Report

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

For assurance

Attachments

2.4 ARAC Escalation Update - August 2026.pdf

ARAC Escalation Update

Consolidated assurance on the Escalation Arrangements

Audit and Risk Assurance Committee | 13 August 2026
Executive Lead – Lee Davies
Reporting Officer - Shaun Ayres

What we established in June, and what has changed

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Agreed at this committee, 23 June

- We noted and took assurance from the criteria mapping register and the boundary rules operating across committees, discharging action AC(26)38.
- We agreed that a consolidated update of this kind comes to each meeting, with referrals to lead committees where it identifies gaps. This is the second such update.
- We considered organisational bandwidth as a corporate risk, recognising the totality assessment of Alert.
- We agreed to advise the Board that our concern remains the deliverability of the whole, not the failure of any single part.
- We agreed to advise the Board on the Health Board's capacity to deliver both the Annual Plan and the de-escalation requirements in full. Although we recognised some natural overlap between the two areas.

What has changed since

- Correspondence across June and July forms one escalating line of challenge, rather than a series of separate requests.
- The 5 and 12 June letters raised delivery confidence, grip, capacity and capability. The 30 June direction and 1 July Chairs' letter added explicit programme, productivity, capacity, Board ownership and conditional funding tests; the 10 July review was structured around the same four-pillar actions.
- The Health Board's 20 July response showed material work in train, but recorded an incomplete diagnostic element. The 23 July letter is the culmination: the Plan remains unsupported and the statutory planning duty has not been met.

Architecture
Is every criterion owned by one committee, with no gaps?

Consistency
Is one account told internally and to Welsh Government?

Totality
Is the combined portfolio feasible at the required scale, within organisational capacity and capability?

The 23 July letter: the plan remains unsupported

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

What Welsh Government concluded

- "the current position... continues to be unsupportable and unacceptable"
- "The health board has therefore breached its statutory duty": the statutory planning and financial requirements of the NHS Wales Planning Framework have not been met, nor the de-escalation criteria for a credible annual plan.
- "the health board does not have an agreed or supported plan": progress will be monitored through the regular Escalation Board meetings.

What the letter requires	By when	Route
Demonstrate delivery in full of the in year and recurrent savings that underpin the £41m forecast deficit.	In year; evidenced at each Escalation Board	F&P; Board
Clarity and assurance on delivery of £41m as a minimum, and a finance recovery plan to balance including a fully triangulated workforce plan and impact assessment deliverable within resources.	Discussed at the next Escalation Board, 4 August	Board; F&P
Improved, ambitious trajectories for urgent and emergency care, planned care and cancer, developed with NHS Performance and Improvement.	Work ongoing; progress at 4 August	F&P
Review of the urgent and emergency care de-escalation criteria, focused on 45 minute ambulance handovers and 12 hour waits.	Agreed with Welsh Government; timing to be confirmed	F&P; Board

What the letter acknowledges

£21m of the £42.8m savings target is now assessed green or amber; April brought improvement in ambulance handovers over one hour, handovers within 45 minutes and 12 - hour emergency department waits. The letter also records deterioration in pathways of care performance.

The correspondence read together: improvement everywhere, at once

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Eight items of oversight correspondence and review in sixteen weeks, grouped into six exchanges. Each is well founded in its own terms; read together, they require improvement in every domain at the same time.

What must improve	**April** Plan scrutiny and Chairs' objectives	**5 June** Accountability framework meeting	**12 June** Escalation Board letter	**30 June and 1 July** Planned care national directive	**10 July** Second performance review	**23 July** Annual Plan update letter	**Retired/Stepped Down**
Savings delivery	●	●	●	●	●	● ○	**None retired since 18 February**
Financial recovery to balance	●	●	●		●	●	
Planned care waits	●	●	●	●	●	●	
Cancer		●	●		●	●	
Urgent and emergency care	●	●	●		●	● ○	
Quality and safety	●	●	●		●		
Workforce		●		●	●	●	
Planning and the Annual Plan	●	●	●	●	●	●	
Regional working	●		●	●	●		

● improvement required or requirement restated ○ progress acknowledged within the same exchange

The requirement set has only widened. Cancer, the one de-escalation this year (18 February), left escalation through a single sustained test, and the letter confirming it still asked for continued improvement. Every requirement raised since April remains open. P&I stated there is a risk of Cancer being re-escalated.

Finance: the cumulative tests against the current position

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

At month 3 the position is behind plan. Each of the letter's financial tests has a defined response, an owner and a date; detailed scrutiny sits with F&P.

The letter requires	Position at month 3	Action in train	By when
Savings delivered in full, in year and recurrent.	£21.0m of the £42.8m target identified; £5.1m recurrent against the £37.7m needed recurrently. Recurrent conversion is the core risk.	Variable pay opportunities of £27.9m under decision; £10m of care group offers tested through the internal Level 4 arrangements.	Offers tested 31 July; decisions by 31 August
Clarity and assurance on delivery of £41m as a minimum.	Year to date deficit £16.6m against a £10.2m plan; June £5.1m against £3.4m. The £41.0m forecast is held through £21.2m of mitigation.	Month 4 flash (highlights) position to the 30 July Board; a full forecast reassessment concludes by 5 September.	M4 initial highlights 31 July; reassessment 5 September
A recovery plan to financial balance, with a fully triangulated workforce plan.	Underlying deficit £68.9m; the letter notes assurance has not yet been provided on the planned underlying position for March 2027.	Route map to balance refined through the Executive Team for Board consideration in September, with workforce and finance triangulation built in.	Board, September

Performance: the cumulative tests against the current position

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The figures below are the figures Welsh Government sees: one account, reported through F&P and QESC and tested at the Escalation Board.

The letter's concern	Position today	Action in train	By when
Lack of commitment on 104 week waits; risk to the 104-week, 8 week diagnostic and 14 week therapy positions.	Without action, exposure builds to 5,672 waits over 104 weeks by March 2027.	Funded route submitted 20 July: productivity first, then targeted purchased capacity, with a £9.3m ask; regional cataract and orthopaedic models developed with Swansea Bay UHB; radiology completes the picture in the Board approved plan.	Board approved plan 31 July
The cancer backlog.	The April rise in the backlog was raised at the 3 June Escalation Board.	Refreshed cancer trajectory rebuilt/re affirmed with NHS Performance and Improvement alongside the planned care plan.	With the 31 July plan
Further improvement required on 45-minute handovers and 12 hour waits; pathways of care performance deteriorated.	June: 822 ambulance handovers over 45 minutes against a planned ceiling of 679; 12 hour waits 10.0% of attendances.	Scenario based trajectory rebuilt: the base case builds from 59.5% to 75.7% of handovers within 45 minutes by March 2027, with a costed stretch of 81.0% against the 95% expectation; de-escalation criteria review agreed.	Trajectories at 4 August; criteria review to follow

Ownership is confirmed. ARAC tests the whole

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Lead committees scrutinise each criterion. ARAC tests whether the combined portfolio is coherent and feasible at the required scale.

Board: the consolidated position and the relationship with the Escalation Board

ARAC: assurance on the system itself, including architecture, consistency, totality and feasibility of the combined portfolio

Finance and Performance Committee

Finance criteria 1 to 4; key performance metrics; operational delivery including planned care (25 to 33) and urgent and emergency care (16 to 19).

Quality, Safety and Experience Committee

Quality and safety criteria, including healthcare associated infections, nationally reportable incidents, never events, complaints and patient experience.

Strategy and Planning Committee

Planning criteria 5 to 9: the annual plan, integrated planning, the clinical services plan, planning maturity and regional planning.

De-escalated and sustained at routine oversight: cancer performance (February 2026) and CAMHS. Sustaining these positions remains part of the whole.

The August rhythm

Committee reporting confirmed through workplans, with single route reporting operating. Escalation Board 4 August; this update to ARAC on 13 August; the consolidated position to Board. The criteria mapping register remains the working tool beneath this picture.

Our assessment: assure on the system, alert on the whole

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Architecture June: Advise **August: Assure (proposed)**	Every criterion has one owning committee and a workplan route. The register is operating and no unowned issue has arisen this cycle.	This changes if a criterion loses its route, or a referral is not acted on via any new framework being released
Consistency June: Assure **August: Assure**	The June and July correspondence does not create a separate governance route. It reinforces the account already reported by committees. The 20 July response demonstrates material work in train, but also records an incomplete diagnostic element; the 23 July letter therefore confirms that the Annual Plan remains Alert.	This changes if external oversight surfaces anything our reporting has not.
Totality June: Alert **August: Alert**	Lead committees can oversee individual criteria. The remaining question is aggregate feasibility: whether all 31 criteria, the Annual Plan and routine delivery form a coherent portfolio with clear programmes, outcomes, ownership, milestones, capacity and capability, dependencies, benefits and trade-offs. Within a fixed level of capacity, that requires an explicit order of effort.	This changes when every material criterion has a clear programme response and the combined portfolio is demonstrably sequenced, resourced and feasible.

Capacity, capability and the order of effort

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The question beneath the totality assessment has already been posed, in terms, by the correspondence itself.

> "The question was posed as to whether there was sufficient capacity and capability within the organisation to make the necessary changes."
>
> Welsh Government letter, 12 June 2026, following the 3 June Escalation Board

Four priorities in twelve weeks

"Ensure Patient Safety is a priority." **Chairs' objectives, April**

"Handover 45 will be a significant priority for implementation ahead of winter." **5 June**

"The priority is clear: the elimination of waits over 104 weeks." **30 June**

"The immediate priority is to de-risk and improve your performance and financial positions in-year, alongside the requirement to develop a financial recovery plan to balance." **23 July**

Each is right in its own terms. Read together, they are concurrent, and the capacity behind each is the same.

Where the test was single, the position moved

Cancer: one criterion, 63% for three months. Met, and de-escalated on 18 February.

Nationally reportable incidents: one number, from 38 open investigations to no more than 19. 32 open at 22 July, on a controlled closure profile to October.

The agreed review of the urgent care criteria points the same way: it narrows the test to two measures, 45 minute handovers and 12 hour waits.

Concentrated effort behind a defined test is the Health Boards demonstrated route to delivery.

Where the requirement is broad, the judgement hardened

5 June: "we were all clear on the seriousness of the current planning position."

12 June: "the organisation does not have sufficient grip on its most significant challenges."

23 July: "breached its statutory duty... does not have an agreed or supported plan."

The same letters acknowledge progress in individual areas. The judgement on the whole has moved one way.

The assurance question for the committee

The whole remains the requirement; an explicit order of effort is the mechanism for delivering it. The committee can seek assurance that the Board's portfolio shows which improvements are resourced first, what each is expected to deliver by when, the capacity each consumes, and the accepted consequence for the pace of the remainder.

The 30 June directive models the same discipline nationally: a clear first call on effort, internal capacity before external provision, funding following evidence. The organisational bandwidth corporate risk, agreed by this committee in June, is the route for pursuing it.

The correspondence converges on the 4 August Escalation Board

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

24 July
Return of the three commissioned actions to Welsh Government

30 July
Board: planned care plan for approval; M4 flash; clinical services plan and stroke updates

31 July
Board approved plan, radiology and refreshed cancer trajectory submitted

3 August
Evidence pack submitted in advance

4 August
Escalation Board: discursive review of the evidence

13 August
This committee meets; next NHS Performance and Improvement review

Commissioned action (3 June)	Position at drafting	Complete by
A clear roadmap to the required financial position and a route map to balance.	Response returned 24 July; route map refined through the Executive Team for the September Board.	24 July; September Board
A 50% reduction in open nationally reportable incident (NRI) investigations: 38 to no more than 19.	32 open at 22 July, with a controlled closure profile through to October and learning from the two never events embedded.	Profile runs to October
Clear and ambitious trajectories for planned care, cancer and urgent and emergency care.	Rebuilt with NHS Performance and Improvement; planned care and cancer land with the 31 July plan; urgent care base and stretch cases modelled.	31 July; 4 August

[To be added following the 4 August Escalation Board: outcome and any revised requirements: presenting officers, by 8 August] – if papers are issued before this can be updated, then please can member note the purpose of this box/space and seek a verbal update.

Matters for the committee

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The committee is asked to:

NOTE	the cumulative June and July correspondence, culminating in the 23 July conclusion that the Health Board has breached its statutory planning duty and does not have an agreed or supported plan.
SEEK ASSURANCE	that every material criterion is aligned to a clear programme or workstream, and that the combined portfolio rests on an explicit order of effort: which improvements are resourced first, what each is expected to deliver by when, the capacity each consumes, and the accepted consequence for the pace of the remainder.
TAKE ASSURANCE	from the alignment between the June and July correspondence and what lead committees have already reported, and from the confirmed mapping of all 31 criteria to owning committees.
ADVISE	the Board that aggregate deliverability remains a material concern until the portfolio is demonstrably sequenced, resourced and feasible, with any trade-offs reflected in Board prioritisation decisions.

3

09:50, 0 Mins

3 - Audit Wales

3.1

09:50, 5 Mins

3.1 - Audit Wales Update Report

Anne Beegan, Urvisha Perez

For assurance

Attachments

3.1 Audit Wales ARAC Update (August 2026).pdf

Archwilio Cymru
Audit Wales

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

Date issued: August 2026

Contents

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Introduction

This document provides the Audit Risk and Assurance Committee with an update on our current and planned accounts and performance audit work at Hywel Dda University Health Board (the Health Board). We presented our most recent Audit Plan to the committee in April 2026.

We also provide additional information on:

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

Accounts audit update

Audit of the 2025-26 Health Charities Annual Report and Accounts

- **Executive Lead:** Director of Finance
- **Focus of the work:** To provide an audit opinion on the Health Charities 2025-26 Annual Report and Accounts
- **Status:** In progress – audit planning
- **Expected committee date:** January 2027

Performance audit update

Review of cancer services

- **Executive Lead:** Director of Operations
- **Focus of the work:** This work follows on from the review of national leadership arrangements for cancer services. The work has focused on whether the Health Board is taking the necessary action to provide timely and equitable access to cancer diagnosis and treatment, in line with national targets, standards and plans.
- **Status:** Clearance – draft report issued July 2026
- **Expected committee date:** October 2026

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

- **Executive Lead:** Director of Allied Health Professions and Health Science/Director of Strategy and Planning
- **Focus of the work:** This work examined the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.
- **Status:** Reporting
- **Expected committee date:** October 2026

Structured Assessment 2026

- **Executive Lead:** Director of Corporate Governance
- **Focus of the work:** The 2026 structured assessment will examine proper arrangements for the efficient, effective, and economical use of resources and track progress against previous audit recommendations. It will also inform our thinking on whether to undertake future work on hosted bodies' governance arrangements, particularly the Joint Commissioning Committee (JCC) and the NHS Wales Shared Services Partnership (NWSSP).
- **Status:** Project brief to be issued in August 2026
- **Expected committee date:** December 2026

Review of eye care services

- **Executive Lead:** Director of Operations
- **Focus of the work:** This work will focus on the Health Board's eye care services to ensure they are delivered efficiently, effectively, and economically. It will also examine whether there are robust plans in place to meet both current and future population needs.
- **Status:** Planning
- **Expected committee date:** February 2027

Review of the management and prevention of diabetes

- **Executive Lead:** Director of Public Health
- **Focus of the work:** This work will examine the extent to which NHS bodies are improving the management and prevention of diabetes across Wales. The exact focus of this work is still to be determined, but it will focus on the ambitions set out in the Tackling Diabetes Together Programme, and is likely to consider the extent to which NHS bodies are implementing initiatives such as the All-Wales Diabetes Prevention Programme, and the high value impact pathway for diabetes.
- **Status:** Planning
- **Expected committee date:** April 2027

Other relevant publications

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

NHS struggling to control day-to-day costs despite continued funding increases / NHS Wales Finances Data Tool 2025–26	July 2026
NHS urgent and emergency care – a system under constant pressure	June 2026
NHS planned care – fit for the future?	June 2026

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

Catherine Mealing-Jones takes up role as Auditor General for Wales	July 2026
Audit Wales publishes new Code of Audit Practice of the Auditor General for Wales / The Code of Audit Practice of the Auditor General for Wales	July 2026

There are no relevant Audit Wales consultations currently underway.

Further information

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

Visit our website to find:

Our publications which cover our audit work at public bodies.

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

Data tools to help you better understand public spending trends.

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

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

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We welcome correspondence and telephone calls in Welsh and English.

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

3.2

09:55, 0 Mins

3.2 - Review of Cancer Services

Anne Beegan, Urvisha Perez

DEFERRED to 15 October 2026 meeting

For assurance

3.3

09:55, 0 Mins

3.3 - Deep Dive Review of the Arrangements to Manage Estates

Anne Beegan, Urvisha Perez

DEFERRED to 15 October 2026 meeting

For assurance

4

09:55, 0 Mins

4 - Financial Focus

4.1

09:55, 5 Mins

4.1 - Financial Assurance Report

Huw Thomas (Hywel Dda UHB - Director of Finance)

For assurance

Attachments

4.1 SBAR Financial Assurance Report ARAC August 2026.pdf

4.1 Financial Assurance Report ARAC August 2026.pdf

4.1 Appendices 1-4 - Financial Assurance Report ARAC August 2026.pdf

Pwyllgor Archwilio a Sicrwydd Risg/ Audit and Risk Assurance Committee

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	13 AUGUST 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Financial Assurance Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Tim John, Head of Accounting and Statutory Reporting

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/ For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

The Standing Orders require that ARAC provides assurance to the Board that the University Health Board's assurance processes are operating effectively. Critical to this is Financial Assurance, which cannot be measured only by the Health Board'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: No issues to report

Advise:

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

b) While the level of staff overpayments increased in May and June 2026, the average recovery period has decreased from 15 to 4 months. Further details are provided on Schedule 3 of the Report. The target is to have no overpayments; however, the total

overpaid during May and June 2026 represents 0.24% of the average monthly net pay costs (March and April 2026 – 0.2%).

c) There was one individual loss exceeding £5,000 in May and June 2026 in respect of drugs wastage (£5.7k); details are provided on Schedule 4 of the Report. In addition, there were losses and write offs less than £5,000 in the period totalling £25,610, an increase on the previous two month period for this category of loss.

Assure:

a) Purchase To Pay (P2P)

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

   ii. Public Sector Payment Policy (PSPP) compliance remains on target for delivery for the year – the target is to pay 95% of all non-NHS invoices within 30 days. Budget holders are continually pursued to authorise invoices promptly, as e-mail requests from NWSSP Accounts Payable are often ignored.

   A joint Hywel Dda and NWSSP action plan has been agreed to address IOH through three linked areas: process and system improvements, targeted supplier interventions, and focused management of aged items. Early progress has been made on the CTM receipting reminder pilot, the potential use of Scan4Safety, benchmarking with other Health Boards, and review of managed print arrangements. The next phase will focus on translating these actions into measurable reductions in invoice holds, strengthening compliance arrangements, and eliminating invoices aged over 180 days by 31 October 2026, excluding targeted supplier categories. ARAC support is being sought for the overall approach, including the potential to escalate persistent non-compliance where appropriate. Appendix 4 provides further details.

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

Argymhelliad / Recommendation

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

- **SCRUTINISE** the award of contracts listed in Appendix 1a.
- **DISCUSS** losses as detailed in Appendix 3 and **APPROVE** the loss in excess of £5,000.
- **DISCUSS** the P2P action plan as detailed in Appendix 4 and **APPROVE** the three themed approach, including potential access withdrawal for persistent non-compliance
- **DISCUSS** the breaches of Standing Financial Instructions (SFIs) as detailed in Appendix 1b.
- **DISCUSS** the staff overpayments as detailed in Appendix 2 and seek assurance that actions to control them are sufficiently embedded.
- Take **ASSURANCE** from the actions taken to:
  a) Improve Purchase To Pay (P2P) compliance (Appendix 4)
  b) Manage breaches of Standing Financial Instructions (SFIs)
  b) Manage Single Tender Actions (STAs).

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	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, Teitl a Sgôr Risg 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 Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	Not Applicable
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	10. Not Applicable

Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	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 cyfarfod hwn: Parties / Committees consulted prior to this meeting:	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.
Tegwch Iechyd: **Health Equity:**	Not applicable
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

5.1 Financial Assurance Report for the period 1 May to 30 June 2026
Audit and Risk Assurance Committee

13 August 2026

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 appropriate	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	Advise 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 • Project Bank Accounts	As appropriate/ Following approval of annual capital plan	Compliant	Schedule 5
Compliance with Tax requirements	• Compliance with VAT requirements	Bi-monthly	Compliant	N/a – no changes
	• Compliance with employment taxes	Bi-monthly	Compliant	N/a – no changes
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 fin[illegible]nts	Annually	Compliant	Schedule 5

2a. Compliance with Purchase to Pay requirements

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

IOH

May and June 2026
No. 96; Value £905k

March and April 2026
No. 222; Value £2,715k

Cumulative to end June 2026
No. 200; Value £1,495k*

Cumulative to end April 2026
No. 129; Value £1,245k

PSPP

Non – NHS (statutory target > 95%)
May 2026 – 96.3%
June 2026 –95.6%

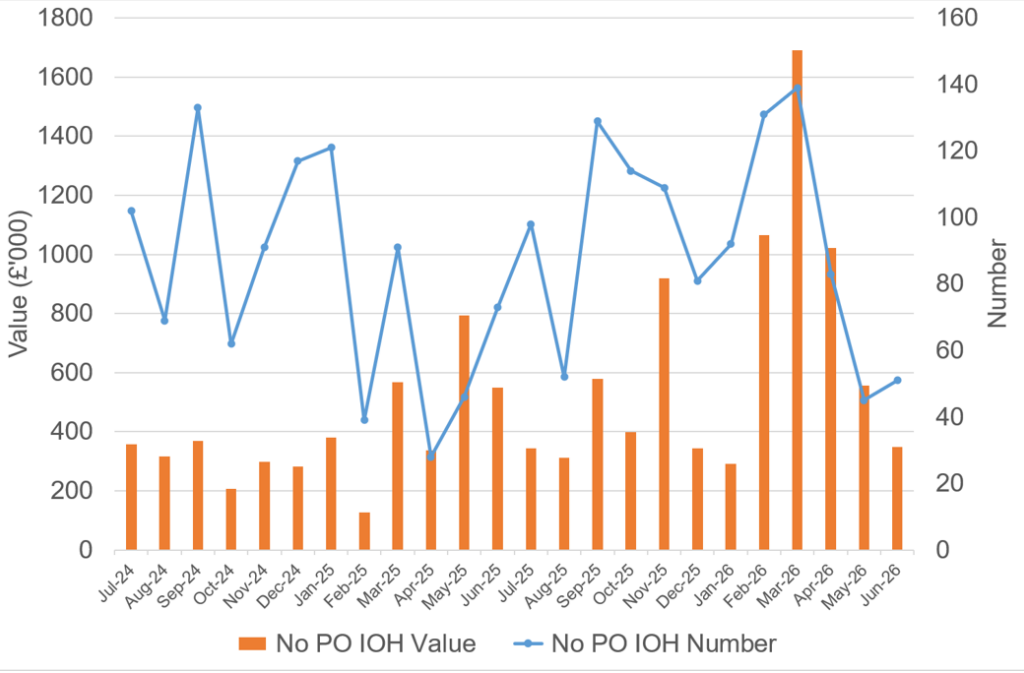
Cumulative to 30 June 2026
96.1%

NHS (no statutory target)
May 2026 – 63.2%
June 2026 – 85.1%

Cumulative to 30 June 2026
78.5%

*Increase in cumulative value due in the main to additional invoices in respect of ID Medical insourcing costs (totalling £243k).

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



Reducing IOH (invoices on hold)

Supplier Non-Compliance exceeding £50,000:	No. of invoices	Value £
Suppliers		
ID Medical	18	372,539
Everlight Radiology Ltd	2	289,476
Civica UK Limited	1	144,292
Health Board Non-Compliance exceeding £50,000:	**No. of invoices**	**Value £**
Clinical Care Groups/Executive function		
Operational Allied Health and Health Sciences/various	10*	291,529
Planned and Specialist Care/various	22	313,882

*includes one invoice, Everlight Radiology Ltd - £264,860

- Of the 32 invoices above (totalling £605k) 20 have now been released from IOH and paid in full. 12 invoices totalling £168k remain as IOH, including 9 invoices in respect of Planned and Specialist Care/Theatre Services, Anaesthetics and Critical Care (ID Medical - insourcing costs).
- Details of the NWSSP and Health Board improvement plan is referenced in the accompanying SBAR and Appendix 4.

2b. Compliance with Purchase to Pay requirements

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

STA	**May and June 2026** **No. 0; Value £0** *March and April 2026* *No. 0; Value £0*	
Tenders Awarded (>£25k)	**May and June 2026** **No. 11; Value £13,629,343** *March and April 2026* *No. 27; Value £13,039,945*	
Consultancy	**May and June 2026** **No. 0; Value £0** *March and April 2026* *No. 0; Value £0*	

Top 5 Tenders Awarded (>£25k)

Supplier	Description	Value £	Department
RK	Dental Services - Ceredigion	5,300,000	Primary Care
PJJ / Brecon DC Limited	Dental Services - Pembrokeshire	5,300,000	Primary Care
PSL Print Management Limited	Hybrid Print and Post Solution Extension	1,343,215	Digital
Trustmarque Solutions Limited	Cisco Enterprise Agreement	652,180	Digital
LW	QS Professional Services for Major Infrastructure Team	516,652	Estates
Total		**13,112,047**	

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

Contracts Awarded	Number	Value £	Details
Post competitive tender	11	13,629,343	**Appendix 1a**
Direct awards via Framework agreement	-	-	-
Direct awards via Transparency Process	-	-	-
Total	**11**	**13,629,343**	
Consultancy Contracts	-	-	-
Breaches of SFIs	**4**	**59,478**	**Appendix 1b**
Contract Awards reported retrospectively	-	-	-

3. Compliance with Income to Cash

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Salary Overpayments

May and June 2026
No. 44; Value £68,804
(Appendix 2)

March and April 2026
No. 39; Value £50,729

Debt balance at 30 June 2026: £283k; average recovery period of 4 months

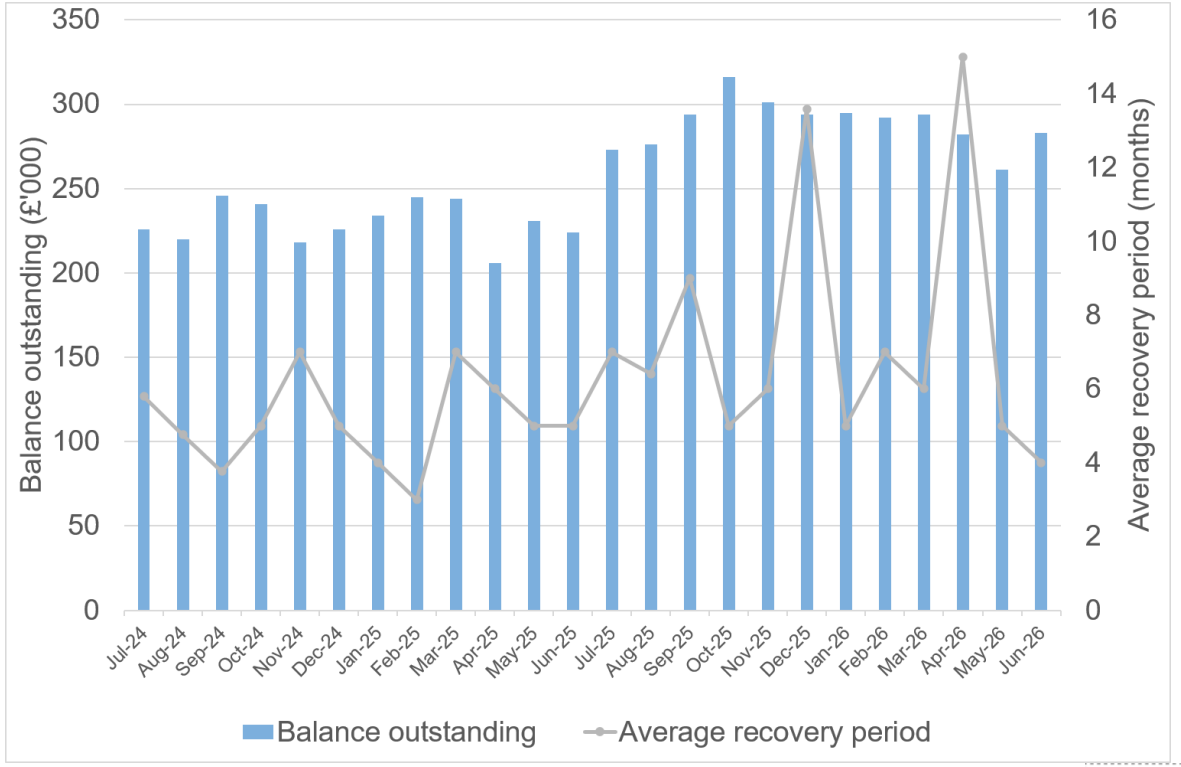
30 April 2026: £282k; average recovery period of 15 months

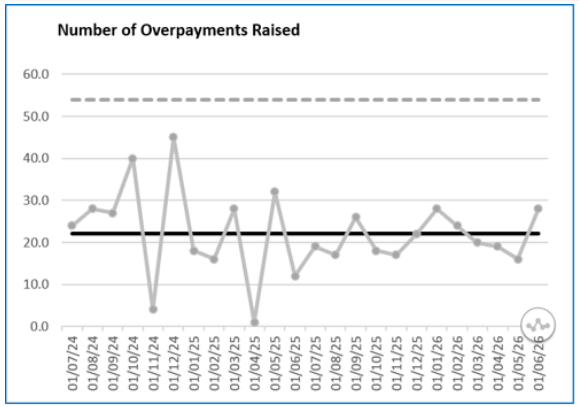
	June-26	Apr-26
Avge no of invoices raised	**22**	24
Avge value	**£31k**	£31.5k
Avge no paid	**22**	21
Avge value	**£31k**	£31.5k

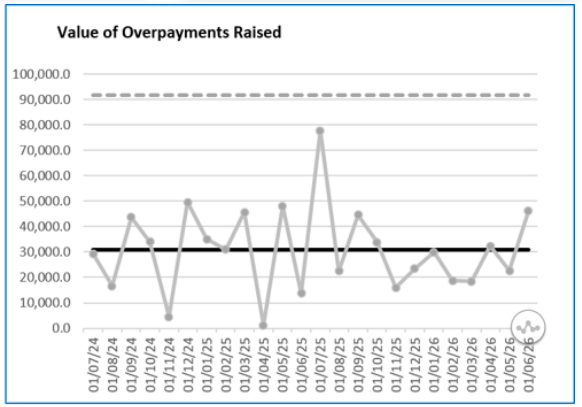
Underpayments May and June 2026 - £22,867

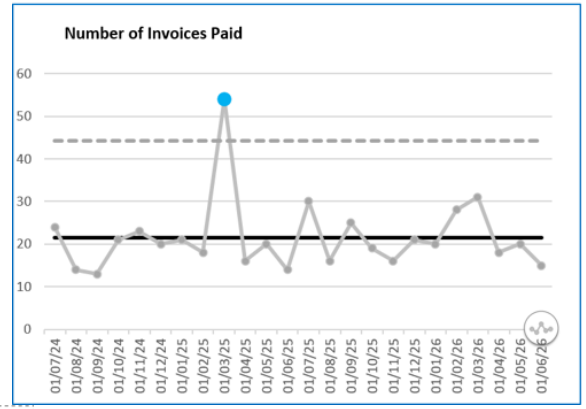
March and April 2026 - £18,930

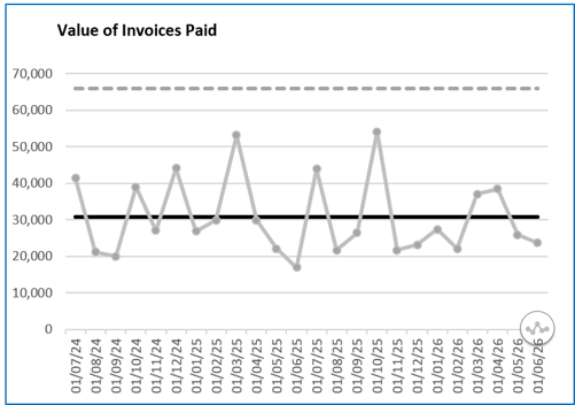
Trend of aged overpayments and recoveries











4. Losses and Special Payments

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Losses £5k and over requiring ARAC Approval	May and June 2026 £5,676 *March and April 2026 £5,206*	Losses under £5k approved by DoF and CEO	May and June 2026 £25,610 (Appendix 3) *March and April 2026 £18,550*

Losses – Requiring Approval from ARAC	£
Pharmacy wastage – BGH expired stock; power failure in BGH, which affected the fridges storing the drug (Ranibizumab (Ongavia))	5,676
All Other Losses	
Ex gratia	225
Overpayments of salaries, salary sacrifice, accommodation, Wagestream, private patient income, overseas patient income etc	805
4b Other causes* - expired stock, wastage, breakages	24,580
Total Losses	**31,286**

* 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

Project Bank Account (PBA)

The Withybush Fire Upgrade Phase 2 project meets the criteria for use of a Project Bank Account. The contractor set up an account with Barclays, which WG confirmed is a compliant provider, and payments have been made by the Health Board to this account since March 2026. The Health Board is actively engaged with the contractor to establish read only access to the account in order to monitor the account for compliance with governance and operational requirements.

Compliance with Tax Requirements

Compliance with VAT Requirements – No updates to report.

Compliance with Employment Tax Requirements – No updates to report.

Compliance with Reporting requirements

Annual Accounts 2025/26 – Audit certification by the Auditor General for Wales occurred on 26 June 2026 and submission to Welsh Government was prior to 30 June 2026.

Charities SORP (Statement of Recommended Practice) – SORP 2026 will apply to reporting periods starting on or after 1 January 2026; for Hywel Dda Health Charities the first year of implementation will be in respect of the 2026/27 annual accounts. Details of any relevant changes will be presented to the Charitable Funds Committee.

5.1 Financial Assurance Report for the period 1 May to 30 June 2026
Audit and Risk Assurance Committee

13 August 2026

Appendices 1-4

Appendix 1a: Contracts awarded

Contracts Awarded Post Competitive Tender:

Title	Supplier	Term	Contract End Date Inc Extensions	Directorate	Total Contract Value ex VAT including extension period	Consultancy Y/N	Professional Services Y/N	Date of Board Approval
Dental Services - Ceredigion	RK	5 Years with an option to extend for a further 5 Years	31/07/2036	Primary Care	£ 5,300,000.00	No	No	Jan-26
Dental Services - Pembrokeshire	PJJ / Brecon DC Limited	5 Years with an option to extend for a further 5 Years	31/07/2036	Primary Care	£ 5,300,000.00	No	No	Jan-26
Hybrid Print and Post Solution Extension	PSL Print Management Limited	2 Years with no option to extend	31/05/2028	Digital Services	£ 1,343,214.70	No	No	May-26
Cisco Enterprise Agreement	Trustmarque Solutions Limited	3 Years with no option to extend	05/06/2029	Digital Services	£ 652,179.69	No	No	N/A
QS Professional Services for Major Infrastructure Team	LW	3 Years with no option to extend	31/03/2029	Estates	£ 516,652.47	No	Yes	N/A
Weight Management (Ceredigion)	Primary Care Dietitians	2 Years with an option to extend for a further 1 Year	30/06/2029	Primary Care	£ 180,000.00	No	No	N/A
Arts Referral Pathway (HARP)	Lot One (Ceredigion) - A4W Innovation CIC (£18,260) Lot Two (Pembrokeshire) - Span Arts (£18,260) Lot Three (Carmarthenshire A) - People Speak Up (£18,260) Lot Four (Carmarthenshire B) - Arts Care Gofal Celf (£18,260)	1 Year with an option to extend for a further 1 Year	31/03/2028	Arts in Health	£ 146,080.00	No	No	N/A
Arts Boost 5	Lot One (Ceredigion) - Small World Theatre (£9,700) Lot Two (Narberth) - Span Arts (£9,695.40) Lot Three (Llanelli) - People Speak Up (£9,700)	7 Months with an option to extend for a further 1 Year	31/12/2027	Arts in Health	£ 58,190.80	No	No	N/A
North Pembrokeshire Wellbeing & Creative Recovery Pilot	V C Gallery	1 Year with no option to extend	31/05/2027	Primary Care	£ 56,900.00	No	No	N/A
Ad-Hoc Recruitment Campaigns	Four Communications Limited	1 Year with no option to extend	31/08/2027	Workforce	£ 50,000.00	No	No	N/A
Kace Legacy Unlimited Licence Renewal	Softcat Plc	2 Years with no option to extend	17/05/2028	Digital Services	£ 26,125.29	No	No	N/A

Appendix 1b: Breaches of SFIs

Title	Supplier	Recurring or One Off	Contract Start	Contract End	Value (Ex VAT)	L4 Directorate	Action Taken	If recurring added to Workplan
Hire of HPAC30 415V Air Conditioning Unit - 01.06.26 to 31.05.27	Andrew Sykes Hire Limited	Recurring	01/06/2026	31/05/2027	£ 20,475.76	Operational Allied Health and Health Sciences (Pathology)	End User & Budget Holder Educated with Template Email and Relevant Director Informed for Awareness and Action. Also, breach added to Workplan.	Yes
Security Services to WGH	Safestyle Security Services Limited	Recurring	12/03/2025	18/03/2025	£ 20,258.40	Community and Integrated Medicine (Unscheduled Care Withybush)	End User & Budget Holder Educated with Template Email and Relevant Director Informed for Awareness and Action. Also, breach added to Workplan.	Yes
BD Body Guard T-Syringe Driver and Lockbox	Becton Dickinson (CME) UK Limited	One Off	N/A	N/A	£ 11,544.00	Community and Integrated Medicine (Pembrokeshire County)	End User & Budget Holder Educated with Template Email and Relevant Director Informed for Awareness and Action.	No
Stroke Services Consultation BSL Video	Helen Foulkes Translations	One Off	N/A	N/A	£ 7,200.00	Chief Executive (Communcations)	End User & Budget Holder Educated with Template Email and Relevant Director Informed for Awareness and Action.	No

Appendix 2: Overpayment of Salaries

	Period covered by this report: 1 May 26 – 30 June 26		
Ref	**Reason for Overpayment**	**Value (£)**	**Number of invoices**
1	Processing Error	1,875.21	1
2	Late Notification of Changes	50,010.36	27
3	Late Notification of Termination	12,414.06	8
4	Late Notification of Absence	4,504.86	8
5	No Notification of Return to Work	-	-
		68,804.49	**44**

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

2026/27	WRITE OFF LIST		
	Period covered by this report:	1st May to 30 June 2026	
	Losses and Special Payments Category	**Value (£)**	**Explanation**
	Total Write Off	**-**	
	4b Other	1,030.36	P02-27 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	1,146.82	P02-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	1,270.00	P02-27 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	1,800.00	P02-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1,879.20	P02-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	2,750.75	P02-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	3,549.13	P03-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
	Total Other/Ex Gratia	**13,426.26**	
	Total	**13,426.26**	

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

2026/2	WRITE OFF LIST		
	Period covered by this report:	1st May to 30 June 2026	
	Losses and Special Payments Category	**Value (£)**	**Explanation**
	OVERPAYMENT OF SALARY	0.03	UNDERPAID OF INVOICE
	OVERPAYMENT OF SALARY	0.03	UNDERPAID OF INVOICE
	SALARY SACRIFICE	52.65	COLLECTION EFFORTS EXHAUSED - NOT VIABLE FOR CCI
	OVERPAYMENT OF SALARY	562.55	CCI COLLECTION EFFORTS EXHAUSED
	Total Write Off	**615.26**	
	4b Other	- 7,200.00	P02-27 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	- 626.40	P02-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	- 7.02	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	- 6.79	P02-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	0.03	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.06	P02-27 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	0.07	P02-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	0.08	P03-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.08	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.10	P03-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.10	P02-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	0.11	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.13	P03-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.14	P02-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.16	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.19	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.23	P02-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	0.26	P03-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.27	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.28	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.32	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.34	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.35	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.38	P02-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	0.38	P03-27 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	0.45	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.45	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.45	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.55	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.59	P03-27 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	0.78	P03-27 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	0.83	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.84	P02-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.84	P02-27 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	0.87	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.91	P03-27 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	0.96	P02-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	0.97	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.98	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.98	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.19	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.21	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.29	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	1.47	P03-27 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	1.53	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	1.59	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.70	P02-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	1.75	P02-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	1.91	P03-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	1.92	P02-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	2.02	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	2.04	P02-27 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	2.06	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.12	P02-27 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	2.16	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	2.28	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.30	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	2.35	P02-27 Withybush Hospital~~W WASTAGE / BREAKAGES WGH

	4b Other	2.40	P02-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.40	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	2.47	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	2.53	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.92	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	3.04	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	3.05	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	3.10	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	3.23	P03-27 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	3.28	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	3.67	P02-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	3.82	P03-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	3.84	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	3.92	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	3.95	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	4.13	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	4.24	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	4.49	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	4.61	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	4.80	P02-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	4.86	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	4.91	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	4.92	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	5.03	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	5.10	P02-27 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	5.29	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	5.40	P02-27 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	5.57	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	5.82	P02-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	5.94	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	6.09	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	6.22	P02-27 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	6.51	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	6.53	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	6.58	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	6.90	P03-27 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	7.20	P02-27 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	7.20	P02-27 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	7.55	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	7.65	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	7.74	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	7.80	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	7.83	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	8.40	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	8.93	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	8.99	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	9.48	P03-27 WDA - HDUHB~~E EXPIRED STOCK WDA
	4b Other	10.04	P02-27 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	10.07	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	10.50	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	10.53	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	10.68	P02-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	11.52	P02-27 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	12.34	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	12.67	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	12.68	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	13.12	P02-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	13.80	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	13.90	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	14.40	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	14.76	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	15.14	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	16.34	P02-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	16.51	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	16.58	P02-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	16.74	P03-27 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	17.14	P03-27 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	17.71	P03-27 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	18.31	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	18.34	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	18.61	P03-27 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	18.72	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	18.86	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	19.12	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	20.10	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	20.38	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	20.44	P02-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
	4b Other	20.52	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	20.52	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	20.65	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH

	4b Other	21.60	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	22.34	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	23.57	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	23.96	P02-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	24.00	P03-27 Withybush Hospital~~Z ASEPTICS EXPIRED STOCK
	4b Other	24.05	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	24.16	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	24.80	P03-27 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	25.10	P03-27 Bronglais Hospital~~B EXPIRED STOCK BGH
	11 EX-GRATIA	26.00	Travel costs for cancelled appointment - AWP
	4b Other	26.15	P02-27 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	27.24	P02-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
	4b Other	27.25	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	27.77	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	27.89	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	29.45	P03-27 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	30.00	P02-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	11 EX-GRATIA	30.00	Ex-Gratia - Lost Property
	4b Other	30.05	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	30.49	P02-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	30.78	P02-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	31.20	P03-27 Withybush Hospital~~Z ASEPTICS EXPIRED STOCK
	4b Other	31.78	P02-27 Withybush Hospital~~Z ASEPTICS EXPIRED STOCK
	4b Other	33.58	P02-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	34.87	P02-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
	4b Other	35.15	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	39.48	P03-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	39.79	P02-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	40.15	P03-27 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	40.77	P02-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	42.00	P03-27 Withybush Hospital~~Z ASEPTICS EXPIRED STOCK
	4b Other	42.72	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	43.20	P02-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	43.20	P02-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
	4b Other	43.67	P02-27 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	48.43	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	50.00	Loss of Petty Cash Float - Ty Llewelyn
	4b Other	50.40	P02-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	54.00	P03-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	54.61	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	55.30	P02-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
	4b Other	56.11	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	56.38	P03-27 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	56.58	P03-27 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	58.21	P02-27 Prince Philip Hospital~~P EXPIRED STOCK PPH
	11 EX-GRATIA	59.99	Ex-Gratia - Lost Property
	4b Other	62.17	P02-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	62.88	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	63.06	P03-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	64.80	P03-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
	4b Other	65.99	P03-27 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	66.00	P02-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	66.23	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	66.24	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	67.71	P02-27 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	69.00	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	69.14	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	70.20	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	71.40	P02-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
	4b Other	71.54	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	78.30	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	80.64	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	80.77	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	81.55	P02-27 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	84.12	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	85.20	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	87.90	P02-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	87.90	P02-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	87.90	P02-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	91.80	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	92.40	P02-27 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	105.64	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	105.64	P03-27 Glangwili Hospital~~W EXPIRED STOCK WGH
	11 EX-GRATIA	109.50	Ex-Gratia - Lost Property
	4b Other	117.84	P02-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH

	4b Other	117.84	P02-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	118.08	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	119.58	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	120.12	P03-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	127.26	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	127.27	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	131.18	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	134.40	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	140.55	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	143.94	P02-27 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	165.60	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	167.48	P02-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	186.14	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	190.00	Band 2/3 overpayment
	4b Other	192.00	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	207.00	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	212.40	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	212.99	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	240.00	P03-27 Withybush Hospital~~Z ASEPTICS EXPIRED STOCK
	4b Other	241.15	P02-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	242.40	P02-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	254.02	P02-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	259.71	P02-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	268.32	P03-27 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	286.92	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	288.43	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	291.31	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	294.17	P02-27 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	298.40	P02-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	306.72	P03-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	309.04	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	311.03	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	335.52	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	342.00	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	342.62	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	374.88	P03-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	393.60	P02-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
	4b Other	397.27	P03-27 Withybush Hospital~~Z ASEPTICS EXPIRED STOCK
	4b Other	429.84	P03-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	458.33	P02-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
	4b Other	486.00	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	498.46	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	583.49	P02-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	617.04	P03-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	769.82	P02-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	876.28	P02-27 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	965.66	P02-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	Sub total	**11,568.20**	
	Total	**12,183.46**	

Appendix 4: Hywel Dda and NWSSP P2P Improvement Plan (Action Plan Summary and Progress to Date)

Executive summary

Following exploratory discussions between senior Finance and NWSSP colleagues, a three-themed action plan has been developed to reduce the volume and age profile of Invoices on Hold (IOH), with practical actions now underway around receipting reminders, Scan4Safety opportunities, targeted supplier review, and management of aged items. Ongoing oversight is expected through Senior Finance Group, Non-Pay Group and ARAC.

1. Overall objective

The objective is to reduce and sustainably manage Invoices on Hold (IOH) by improving receipting compliance, strengthening Procure-to-Pay controls, prioritising recurring problem areas, and introducing clearer escalation routes for persistent non-compliance.

2. What has been achieved to date

Action plan agreed: Hywel Dda and NWSSP have agreed three priority workstreams: process/environment improvements, targeted supplier reviews, and focused management of aged invoices on hold.

CTM receipting reminder pilot progressed: Local Procurement have met with CTM counterparts regarding the CTM receipting reminder pilot, and the necessary steps are now being progressed to get this operational as quickly as possible.

Scan4Safety opportunity explored: NWSSP has raised the potential expansion of Scan4Safety technology and requested an implementation timeline, with store locations identified as potential pilot areas.

Cross-Health Board learning initiated: Local Procurement have contacted other Health Boards to understand how they manage provisions, managed print and other high-volume invoice categories.

Managed print review commenced: A preliminary meeting has been arranged with the Digital Director to discuss the current managed print position, future plans and procurement timelines.

Governance route identified: Progress updates are expected through Senior Finance Group and/or Non-Pay Group, with the overall action plan also intended for ARAC consideration.

Oracle systems engagement planned: Once more information is available on the CTM reminder pilot and system requirements, a session will be arranged including the Oracle systems team.

3. Forward plan

Workstream	Action	Lead / forum indicated	Output / target
Process and system improvements	Pilot Scan4Safety / scanner-based receipting, initially considering NWSSP store locations.	NWSSP	Implementation timeline to be confirmed.

Process and system improvements	Implement CTM approval hierarchy reminders for receiptors who have not actioned invoices on hold reminders.	NWSSP / Hywel Dda	Pilot to be progressed and system requirements clarified.
Process and system improvements	Arrange a session with the Oracle systems team once further information is available.	Hywel Dda	Ensure system colleagues are aware and able to support.
Compliance and control	Review repeated non-compliance and draft criteria for escalation or possible access revocation.	Hywel Dda	Proposal to be considered through ARAC.
PO compliance	Consider raising purchase orders for manual invoices for NHS Wales and Local Authorities, mirroring the Aneurin Bevan approach if appropriate.	Hywel Dda	Assess feasibility and relevance to IOH volume.
Targeted suppliers	Review provisions suppliers and approach, linked to high-volume quantity-related holds.	Hywel Dda / NWSSP	Identify good practice and potential pilot approach.
Targeted suppliers	Review managed print arrangements, current position, future plans and procurement timelines.	Hywel Dda / NWSSP	Reduce recurring maximum shipment / managed print invoice holds.
Aged IOH management	Review all items older than 180 days, excluding targeted suppliers.	Hywel Dda	Reduce to zero by 31 October 2026 and maintain.
Aged IOH management	Review implications of moving the aged IOH profile to only items under 90 days.	Hywel Dda	Assess potential target from 31 January 2027.

4. Governance and oversight

- Senior Finance Group and/or Non-Pay Group to receive ongoing updates and maintain momentum.
- The three-themed action plan is to be summarised for the next appropriate ARAC meeting.
- ARAC support is expected to be sought for the proposed approach, including potential access revocation for persistent breaches of agreed criteria.
- The Non-Pay Group provides a regular touchpoint with the Director of Finance and Deputy Director of Finance and is expected to be an appropriate forum for ongoing catch-up.

5. Suggested immediate next steps

- Confirm the implementation route and timetable for the CTM receipting reminder pilot.
- Obtain the Scan4Safety implementation timeline and agree whether NWSSP stores should proceed as pilot sites.
- Complete benchmarking with other Health Boards and summarise transferable good practice.
- Complete the managed print discussion and draw out procurement or contract-related actions.
- Develop a draft repeat-offender escalation/access revocation framework for discussion.

- Establish a tracker for >180-day items to monitor delivery against the 31 October 2026 target.

4.2

10:00, 5 Mins

4.2 - Counter Fraud Update

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

For information

Attachments

4.2 SBAR Counter Fraud Update ARAC August 2026.pdf

4.2 Counter Fraud Update August 2026.pdf

4.2 Appendix A - NHS Wales Fighting Fraud Strategy.pdf

Pwyllgor Archwilio a Sicrwydd Risg/ Audit and Risk Assurance Committee

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	**13 AUGUST 2026**
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Counter Fraud Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Benjamin Rees, Head of Local Counter Fraud Services

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)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	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, Teitl a Sgôr Risg 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:	Not Applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	Not Applicable
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	10. Not Applicable
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Not applicable.
Rhestr Termau: Glossary of Terms:	Not applicable.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	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.
Tegwch Iechyd: **Health Equity:**	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 13 August 2026

For clarity of reporting, the Counter Fraud Workplan has been structured around the key areas of activity aligned to the NHS Counter Fraud Authority's framework. These are summarised as follows:

- **Pro-active related activity** (Previously Prevent and Deter, Inform, and Involve and Strategic Governance)
- **Reactive related activity** (Previously Hold to Account)

Overall resource utilisation remains broadly proportionate at this stage of the reporting period, with 147 days recorded against the 440-day annual plan as of 31 July 2026. Activity continues to be balanced across proactive prevention, deterrence and awareness work, alongside reactive investigation activity.

AREA OF ACTIVITY	2026/27 Resource (days)	Resource Used as at 31/07/2026	Resource Used (%) as at 31/07/2026)
PRO-ACTIVE RELATED ACTIVITY	255	79 Days	31%
REACTIVE RELATED ACTIVITY	185	68 Days	36%
TOTAL	**440**	**147 Days**	**33%**

Work Area	*Summary of work areas completed*
Pro-active related activity	• 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 and to new students via Aberystwyth University. • A Fraud Awareness and Conflict of Interest presentation was delivered to administrative and nursing staff working within the Breast Care Unit at Prince Philip Hospital. The session was arranged following requests from the department's Service Delivery Manager and Hywel Dda Health Charities, following a review of governance arrangements associated with an external charity linked to the service. The relevant charity is recorded as the Peony Breast Care Unit Fund on the Charity Commission website and as the Prince Philip Breast Care Unit Fund in the most recent Charity Commission accounts; charity number 1140533 refers. It is noted that the Charity contact address is listed as Prince Philip Hospital, Bryngwyn Mawr, Dafen, Llanelli. SA14 8QF. The presentation was well received, and constructive advice was provided on the importance of declaring any potential conflicts of interest and complying with Health Board policies and procedures. • Counter Fraud currently participates in the quarterly HDdUHB Local Intelligence Network (LIN), where advice is provided on current fraud trends associated with controlled drugs. Where relevant, the team also provides wider advice to raise awareness of fraud risks within the NHS. • Over the last six months, the Head of Counter Fraud for Betsi Cadwaladr UHB, Counter Fraud Services Wales, the Director of Finance for NHS Wales Shared Services Partnership (NWSSP) and Head of Counter Fraud for Hywel Dda UHB undertook a review and rewrite of the NHS Wales Fighting Fraud Strategy, which was published earlier this month. A copy of the Strategy is appended to this report, Appendix A refers.

	In summary, the four-year strategy sets out a comprehensive, collaborative approach to preventing, detecting, and responding to fraud, bribery, and corruption, with the aim of safeguarding NHS resources for patient care. It supports a resilient, intelligence-led, and collaborative counter fraud culture, underpinned by strong governance, quality assurance, workforce development and partnership working across NHS Wales and UK agencies. The Strategy also sets out clear strategic objectives and priorities for action, including embedding fraud risk management, enhancing data analytics, improving investigation efficiency, and strengthening transparency and accountability by 2030. A copy of the Strategy has been circulated to all staff via Viva Engage. The review group will now develop an all-Wales delivery plan, with the first meeting scheduled to take place on 29 July 2026. As part of the strategy, there is a requirement that Health Boards and Counter Fraud Services Wales work collaboratively to deliver key objectives. Such an approach offers an opportunity to explore greater collaborative activities between Health Boards, something that is currently being explored at a regional level.
Reactive related activity	• New referrals have been received by the department over the last two months, with significant work undertaken to progress those matters. A detailed report covering all new, existing, and closed investigations has been provided to the Committee separately through the In-Committee report.
Strategic Governance	• Quarterly statistics have been submitted to Counter Fraud Services Wales in accordance with Welsh Government directions.

Report Provided by:

Benjamin Rees – Head of Local Counter Fraud Services

For presentation: 13 August 2026.

Report agreed by:

Huw Thomas

Executive Director of Finance

Fighting Fraud

Safeguarding Every Pound for Patient Care

GIG CYMRU NHS WALES

Fighting Fraud Strategy for NHS Wales

2026 – 2030

Table of Contents

Foreword

"I am pleased to be able to introduce this second iteration of the Fighting Fraud Strategy, first published in 2019. This strategy reinforces the focus on prevention as Fraud, bribery, and corruption threaten the very resources that keep NHS Wales running. Every pound lost to economic crime is a pound taken away from patient care and therefore this strategy is not just a document—it is a call to action because protecting NHS Wales from economic crime is everyone's responsibility.

The Welsh Government is unequivocal: economic crime against NHS Wales will not be tolerated. It is important to remember that these crimes are not victimless; they undermine trust and steal funding meant for frontline services. Together, we can protect these resources and hold offenders to account.

The approach in NHS Wales is clear:

- *to raise awareness to stop fraud before it starts.*
- *to strengthen controls and systems to prevent it.*
- *to pursue offenders and recover stolen funds for patient care.*

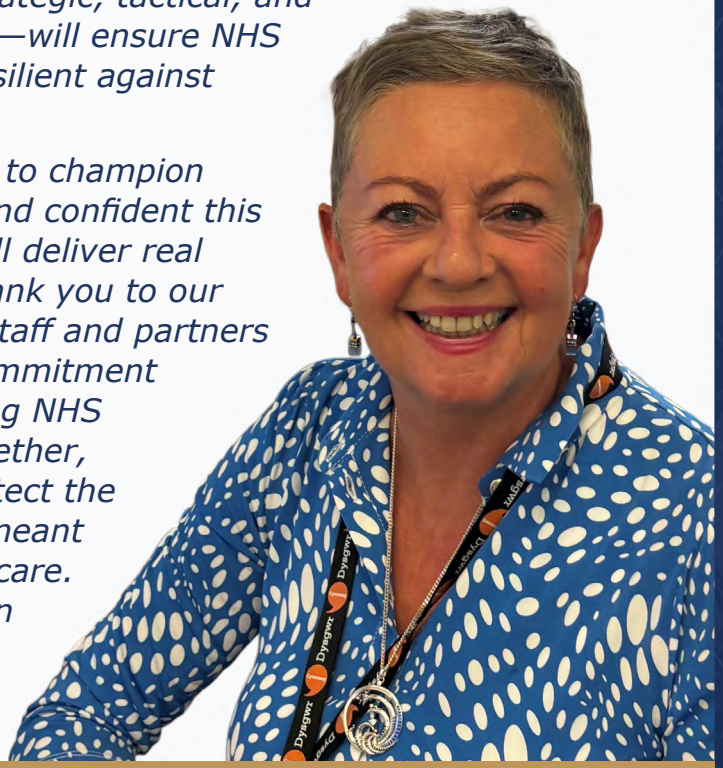
By making best use of intelligence, seeking out innovation and by developing our counter fraud workforce we can stay ahead of evolving risks exploited by criminals. Everyone plays a vital role.

You can make a difference when you:

- ***Champion fraud awareness** within your teams and networks.*
- ***Report concerns promptly—every report matters.***
- ***Embed strong controls** in your service area to support prevention.*
- ***Complete required training and engage with campaigns** to stay informed.*
- ***Stay vigilant and take proactive action** to reduce the risk of fraud in your area.*

Your engagement is vital. A coordinated response which is strategic, tactical, and operational—will ensure NHS Wales is resilient against fraud.

I am proud to champion this work and confident this strategy will deliver real impact. Thank you to our dedicated staff and partners for your commitment to protecting NHS Wales. Together, we can protect the resources meant for patient care. Every action matters. "



Jacqueline Totterdell
Chief Executive, NHS Wales

Executive Summary

Fraud, bribery, and corruption are growing threats that divert vital NHS funds, increase costs, and erode public trust. Every pound lost is a pound taken from patient care.

Our Vision

To build a resilient, intelligence-led, and collaborative counter fraud culture across NHS Wales to ensure resources are protected for patient care.

Our Strategy

Our strategy focuses on proactive prevention, rapid detection, and decisive action to safeguard NHS resources.

- **Prevent fraud before it happens.**
- **Detect and investigate swiftly.**
- **Apply sanctions and recover stolen funds.**
- **Build expertise and capability across NHS Wales.**

How We Will Deliver

- Use intelligence to identify and target fraud risks.
- Raise awareness among staff, patients, and suppliers.
- Act decisively against offenders.
- Invest in staff training, tools, and resources to enhance effectiveness.

In the last five years, NHS Wales has applied 59 sanctions and recovered a total of £3,322,427, returning funds to patient care. Fraud risks are ever evolving—from procurement and contract fraud through to cybercrime—and we must stay ahead.

Fraud is one of the most prevalent crimes in England and Wales, and the National Crime Agency estimates that around 67% of reported fraud is cyber-enabled[1] and the NHS is a prime target. With NHS Wales processing billions of transactions and sensitive data, the stakes have never been higher.

This strategy builds on the previous *Fighting Fraud Strategy (2019)* recognising new and emerging risks. This strategy raises the bar with refreshed objectives and will be underpinned with a delivery plan and measurable indicators. It also aligns with UK-wide counter fraud strategies and Welsh Government priorities.

This strategy is our commitment to safeguarding every pound for patient care. Together, we will make NHS Wales resilient against fraud.

Fraud prevention is everyone's responsibility.

All NHS staff must remain vigilant and report any suspected fraud to their Local Counter Fraud Specialist or NHS Counter Fraud Services Wales.

Strategic Objectives

To protect NHS Wales resources and maintain public trust, we must adopt a proactive and coordinated approach to tackling fraud. Our Strategic Objectives provide the foundation for this work, focusing on prevention, early detection, decisive response, and building the capability needed to stay ahead of evolving risks. By investing in our people, connecting intelligence, and strengthening collaboration with partners across Wales and the UK, we will create a resilient system that protects funding so it can be directed where it matters most—patient care.

Strategic Objective	Description
Prevent 	Assess the risk, strengthen systems and controls and promote awareness to stop fraud before it occurs.
Detect 	Use data, intelligence and advanced analytics to help prioritise resources and link fraud risks early.
Respond 	Investigate thoroughly, recover losses, and apply appropriate sanctions swiftly.
Build Capability 	Invest in our people by providing specialist training and equipping counter fraud teams with latest tools and technology.
Collaborate 	Foster strong partnerships across NHS Wales, other Welsh public bodies, Welsh Government, and UK agencies such as HMRC and DWP to share intelligence and best practice.

Key Enablers

Delivering our Strategic Objectives requires more than intent—it requires investment in the right tools, skills, and partnerships.

This includes:

- the Welsh Government Directions, which establish the legal framework for the responsibilities and functions of NHS Counter Fraud services across NHS Wales, including requirements for cooperation with partners; and
- the local counter fraud specialists and the national counter fraud service across NHS Wales, whose ongoing and collaborative work -enabled by these Directions - forms a core enabler of effective prevention, detection, and response. Their contribution will be fundamental to delivering the objectives set out below.

To strengthen NHS Wales' resilience against fraud, we have identified a set of **Key Enablers** that will underpin our approach. These enablers provide the infrastructure, technology, and expertise needed to prevent fraud, detect risks early, respond effectively, and build capability across the system. By aligning each enabler with our objectives, we ensure a clear, coordinated path to success.

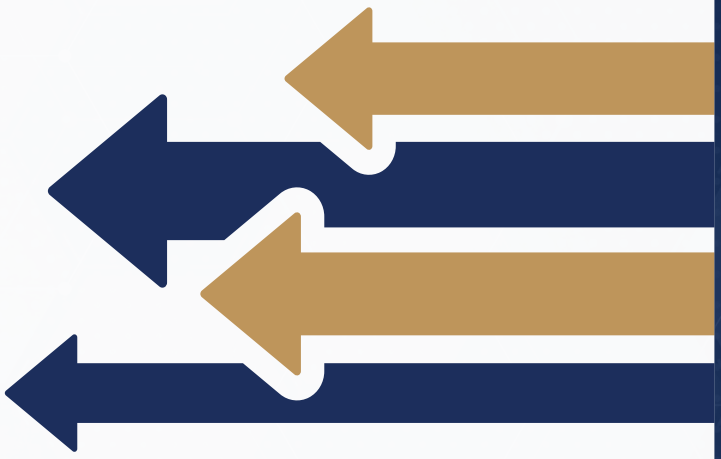
Strategic Objective	Key Enabler	Impact
Prevent 	Functional Standards: Benchmarking & Assurance. Counter Fraud Culture: Led from the top, fostering a proactive, NHS-wide culture that empowers everyone to prevent fraud and manage risk effectively. All NHS employees should complete the e-learning Fraud Awareness training module.	Sets clear benchmarks for counter fraud activity and provides assurance that controls are robust and effective and that standards are being met across NHS Wales. Building a strong anti-fraud culture increases awareness and helps identify fraud risks early. Prevention through good practice is the most effective way to reduce fraud in the NHS.

Strategic Objective	Key Enabler	Impact
Detect 	Encourage all staff and stakeholders to report fraud whenever they have a concern. Collaborative approach to Risk Assessments and use of Data Analytics & AI.	Enables early identification of fraud risks through use of data analytics and AI driven tools to improve intelligence-led decision-making across Wales, enabling a proactive and front-footed response to both existing and emerging threats.
Respond 	Digital Forensics, CLUE System & Proceeds of Crime Act 2002. Investment in investigative resources and training.	Delivers enhanced investigation tools for robust evidence gathering, case management, and recovery of stolen funds.
Build Capability 	Continuous professional development through the Centre for Specialist Learning.	Provides professional development, specialist training, and accreditation to strengthen counter fraud capability and to equip staff with the skills needed to tackle evolving fraud risks.
Collaborate 	Counter Fraud Liaison Group. Counter Fraud Steering Group. Directors of Finance Group.	Promotes operational collaboration, sharing of best practice, and consistency across Health Boards, Special Health Authorities and Trusts.

Priorities for Action

Accountability and progress tracking are central to this strategy. Each Strategic Objective will be monitored against planned actions, with regular reporting to the Counter Fraud Steering Group and Welsh Government. This ensures transparency, drives continuous improvement, and keeps NHS Wales focused on safeguarding resources for patient care.

Together, the following planned actions will create a proactive, coordinated system that safeguards NHS resources and ensures funding is directed to patient care.



Strategic Objective	Description	What will 2030 and beyond look like
Prevent	To reduce opportunities for fraud before they arise, we will strengthen assurance frameworks and embed fraud risk management across NHS Wales. **We will:** • implement annual benchmarking reviews against Functional Standards, • develop local and national assurance dashboards, • implement a process for tracking actions and follow up of national proactive exercises. • undertake fraud risk assessments using a consistent and efficient methodology • publish an annual Counter Fraud Assurance Report. These measures will set clear expectations and provide transparency on progress.	Fraud risk management will be embedded into everyday processes, making it a standard part of governance and decision-making rather than a reactive measure. Staff across NHS Wales will have a clear understanding of fraud risks and their role in mitigating them. Local and national dashboards will provide real-time visibility of fraud risk indicators, enabling quick interventions and informed decision-making.

Detect 	Early detection is critical to minimising financial loss and protecting patient care. **We will:** • deploy advanced data analytics and AI-driven tools to identify anomalies in financial transactions, • integrate fraud risk indicators into core systems, • establish a central data-sharing protocol to enhance intelligence across NHS Wales. Quarterly fraud trend analysis will inform proactive interventions and ensure resources are directed where they are most needed.	Predictive models identify emerging fraud risks before they materialise, enabling pre-emptive action. A secure, NHS Wales-wide data-sharing protocol ensures that intelligence from one health organisation is instantly available to all others. Patterns of fraud detected in one region inform preventive measures everywhere, creating a network effect of protection.
Respond 	When fraud occurs, we must act decisively and recover stolen funds. **We will:** • work with the NHS CFA to enhance the case management system to improve investigation efficiency, • put in place arrangements for counter fraud specialists to access data analytics expertise, • implement a rapid response protocol in collaboration with national and local Cyber teams for cyber-enabled fraud incidents. Recovery methods and achievements will be monitored to ensure accountability and continuous improvement.	The case management system is fully enhanced, enabling investigators to manage cases seamlessly, track evidence, and collaborate across health organisations in real time. A rapid response protocol is triggered immediately when cyber-enabled fraud is detected—like an emergency response system. NHS Wales publishes transparent recovery data, reinforcing public trust and demonstrating continuous improvement.

Build Capability 	A skilled and knowledgeable workforce is essential to staying ahead of evolving fraud risks. **We will:** • deliver structured CPD programmes, • introduce career pathways including technician roles and consider secondment opportunities with NHS CFA in areas such as data analytics and digital forensics, • Require all NHS Wales employees to complete the e-learning fraud awareness module. Annual Counter Fraud Conferences will provide opportunities to share best practice and emerging trends.	Counter fraud roles have clear career pathways, including technician-level positions and advanced roles in analytics and digital forensics. The e-learning fraud awareness training is accessible to all NHS Wales employees—from clinical staff to executives. Increased awareness helps to reduce fraud. Annual Counter Fraud Conferences are major events, bringing together experts, health organisations, and other partners to share best practices and emerging trends.
Collaborate 	Fraud prevention and detection require strong partnerships. The Counter Fraud Steering Group will work with Directors of Finance and the Counter Fraud Liaison Group to drive operational collaboration, share intelligence, and promote consistency across Health Boards, Special Health Authorities, and Trusts. **We will:** • strengthen the sharing of intelligence across Wales, between the four nations and other public bodies including police forces, • publish joint guidance documents, • and establish cross-organisation arrangements, working with the NHSCFA to tackle high-risk areas such as procurement and cybercrime.	Collaboration is no longer ad hoc—it's structured, consistent, and strategic, ensuring alignment across the entire NHS Wales system. Enhanced intelligence sharing across the UK and public bodies enabling real-time access to fraud alerts, case updates, and emerging risk patterns. This shared intelligence helps identify cross-organisational trends early, allowing faster and more coordinated action. NHS Wales publishes standardised guidance documents co-developed by all partners, ensuring consistency in fraud prevention and response.

Key Outcomes by 2030

1

Fraud prevention is system-wide, not siloed—intelligence flows freely, and responses are coordinated.

2

NHS Wales is recognised as a leader in collaborative fraud prevention, influencing UK-wide policy.

3

Public confidence is strengthened because the system demonstrates collaboration, transparency, and effectiveness.

Staff Responsibility

Fraud prevention is everyone's responsibility.

All NHS staff must remain vigilant and report any suspected fraud to their LCFS or CFSW.

Governance Structure

Strong governance is essential to ensure accountability, consistency, and effectiveness in tackling fraud across NHS Wales. This governance structure provides a clear line of accountability from local services through to national oversight, ensuring NHS Wales remains resilient against fraud risks and focused on protecting resources for patient care.

Counter Fraud Steering Group (CFSG)

The CFSG provides strategic oversight of counter fraud services across NHS Wales and advises Welsh Government on actions and opportunities for improvement.

Meetings: Quarterly

Chair: NWSSP Director of Finance and Corporate Services

Membership:

- Welsh Government representative
- NHS Wales Finance Directors
- Audit Committee Chairs
- NHS Counter Fraud Authority
- Head of Counter Fraud Services Wales
- Chair of the Counter Fraud Liaison Group
- Audit Wales (Observer)

The CFSG ensures alignment with national priorities, reviews performance, and recommends enhancements to strengthen fraud prevention and detection.

Counter Fraud Liaison Group

Established in 2025, this group brings together Local Counter Fraud Specialists (LCFS) and NHS Counter Fraud Services Wales. Its primary purpose is peer to peer support and to share best practice, promote consistency, and support operational delivery across Health Boards, Special Health Authorities and Trusts.

Members report direct to their respective Director of Finance and can collectively raise common issues and opportunities through the Directors of Finance Group to raise with the Counter Fraud Steering Group. The Chair and Vice Chair also attend the Counter Fraud Steering Group meetings.

Local Governance

Operationally, local counter fraud specialists report to Finance Directors and are monitored by Audit Committees within each NHS body. These Committees review annual work plans, progress reports, and outcomes to ensure robust oversight and accountability.

The Head of Counter Fraud Services Wales provides professional support, direction and strong leadership to the network of local counter fraud specialists within NHS bodies in Wales as well as operational line management of the NHS Counter Fraud Services Wales team. They advise NHS Wales Directors of Finance and Welsh Government officials, and work in close partnership with the NHS Counter Fraud Authority, National Crime Agency, regional police forces, HMRC, and the Department for Work and Pensions.

Quality Assurance

The quality of counter fraud services within NHS Wales is assessed against the Government Functional Standards 013 Counter Fraud, facilitated by the NHS Counter Fraud Authority (NHSCFA) and adopted across NHS Wales.

These standards ensure that measures to prevent, detect, and respond to fraud, bribery, and corruption are implemented in line with the Cabinet Secretary for Health and Social Services' Directions and the Service Level Agreement between Welsh Government and the NHSCFA.

Purpose of the Standards

The Functional Standards provide a consistent framework to:

- Embed robust counter fraud controls across NHS Wales.
- Ensure compliance with statutory and contractual obligations.
- Deliver transparency and accountability in fraud prevention and detection.

Quality Assurance Programme

The programme comprises **two core processes**:

1. **Assurance**
   - Each NHS organisation completes an annual self-review against the Functional Standards.
   - Results are reported to the NHS organisation's Audit Committee and submitted to the NHSCFA for analysis and thereafter to the UK Government.
   - This process ensures compliance, highlights areas for improvement, and supports continuous development.
2. **Assessment**
   - The NHSCFA Quality and Compliance team conducts independent assessments.
   - Using the Self-Review Tool, supporting evidence, and inspection procedures, the team evaluates:
     - **Counter fraud resources.**
     - **Performance against standards.**
     - **Effectiveness of implemented controls.**
   - Any recommended improvements should be addressed promptly, to maintain high standards and strengthen capability.

Governance Reviews

In addition to above Quality Assurance Programme the Counter Fraud Service Wales (CFSW) team undergoes a cyclical governance assurance review conducted by the NHSCFA, ensuring alignment with national standards and best practice.

Resources to support Counter Fraud Arrangements in NHS Wales

Local Counter Fraud Specialists

The Welsh Government Directions on Counter Fraud require every Health Body to appoint qualified Local Counter Fraud Specialists (LCFS), accredited by the Counter Fraud Professional Accreditation Board or equivalent. There are 23.38 whole time equivalent (WTE) LCFS staff in Wales, all directly employed by NHS bodies.

LCFS act as the primary point of contact for all economic crime concerns within their organisation. They agree annual work plans with their Health Body, balancing proactive activities (fraud awareness, risk assessment and detection) and reactive work (investigations), aligned to the Fraud, Bribery and Corruption Standards for NHS Bodies (Wales).

NHS Counter Fraud Services Wales (CFSW)

The NHS Counter Fraud Service Wales is an independent team funded by Welsh Government and employed by the NHS Wales Shared Services Partnership (NWSSP) hosted by Velindre University NHS Trust. It provides a specialist independent investigation resource to all health bodies in Wales and provides operational oversight on all counter fraud activities in NHS Wales, to ensure compliance with the Welsh Government Directions.

CFSW serves as the professional and strategic lead for NHS Wales on proactive and investigative counter fraud matters, promoting a consistent, high quality approach across health bodies in line with relevant legislation. Its experienced, accredited investigators manage large and complex economic crime cases, provide specialist guidance to the LCFS network, and are authorised to exercise financial investigation powers under the Proceeds of Crime Act 2002.

Specialist Support from NHS Counter Fraud Authority (NHSCFA)

Under a Section 83 Government of Wales Act 2006 arrangement, NHSCFA provides specialist operational support services to NHS Wales, including Forensic Computing and Specialist Dental Services, funded via an annual Service Level Agreement with Welsh Government.

Other Key NHS Wales Functions Supporting Counter Fraud

- **Primary Care Services (PCS):** The Post Payment Verification (PPV) team check claims in General Medical, Ophthalmic, and Pharmacy services. Dental checks are delivered via NHS England Business Services Authority. These checks ensure claims are accurate and services meet NHS specifications. Any concerns are referred to LCFS or CFSW under an Information Sharing Protocol.
- **Audit & Assurance:** NWSSP Audit & Assurance provides internal audit services to all NHS bodies. While not directly responsible for detecting fraud, their work highlights control weaknesses and potential breaches. They collaborate with LCFS under an Information Sharing Protocol.
- **Auditor General for Wales:** External audits may uncover system weaknesses or fraud indicators. Regular liaison occurs between auditors, NHS bodies, Welsh Government and CFSW to address concerns.
- **National Fraud Initiative (NFI):** Led by the Auditor General under statutory powers, NFI matches data across public bodies every two years to identify anomalies. Since inception, NFI has uncovered £56.5M in fraud and overpayments across Wales, including £7.1M in the latest exercise.

Reporting Fraud

Report NHS fraud securely and confidentially by using the
NHS Counter Fraud Authority online reporting tool
or by calling our free phone line on 0800 028 40 60.

Contact Details

NHS Counter Fraud Service Wales
1st Floor
Block B
Mamhilad House
Mamhilad Park Estate
Pontypool
NP4 0YP

Ymladd Twyll

Diogelu Pob Punt ar gyfer Gofal i Gleifion

Strategaeth Ymladd Twyll ar gyfer GIG Cymru

2026 – 2030

Tabl Cynnwys

Rhagair

"Rwy'n falch o allu cyflwyno'r ail fersiwn hon o'r Strategaeth Ymladd Twyll, a gyhoeddwyd gyntaf yn 2019. Mae'r strategaeth hon yn atgyfnerthu'r ffocws ar atal gan fod twyll, llwgrwobrwyo a llygredd yn bygwth yr adnoddau sy'n cadw GIG Cymru i redeg. Mae pob punt a gollir oherwydd troseddau economaidd yn bunt a gymerir oddi wrth ofal i gleifion. Felly nid dogfen yn unig yw'r strategaeth hon—mae'n alwad i weithredu oherwydd bod diogelu GIG Cymru rhag troseddau economaidd yn gyfrifoldeb i bawb.

Mae Llywodraeth Cymru yn ddiamwys ei barn na fydd yn goddef troseddau economaidd yn erbyn GIG Cymru. Mae'n bwysig cofio nad yw'r troseddau hyn heb ddioddefwyr; maent yn tanseilio ymddiriedaeth ac yn dwyn cyllid a fwriadwyd ar gyfer gwasanaethau rheng flaen. Gyda'n gilydd, gallwn ddiogelu yr adnoddau hyn a dwyn troseddwyr i gyfrif.

Mae'r dull gweithredu yn GIG Cymru yn glir:

- *codi ymwybyddiaeth er mwyn atal twyll cyn iddo ddechrau.*
- *cryfhau rheolaethau a systemau i'w atal.*
- *mynd ar ôl troseddwyr ac adennill arian a gafodd ei ddwyn ar gyfer gofal i gleifion.*

Drwy wneud y defnydd gorau o ddeallusrwydd, chwilio am arloesedd a datblygu ein gweithlu gwrth-dwyll, gallwn aros ar flaen y gad o ran risgiau sy'n esblygu y mae troseddwyr yn eu hecsbloetio.

Mae pawb yn chwarae rhan hanfodol. Gallwch chi wneud gwahaniaeth drwy wneud y canlynol:

- ***Hyrwyddo ymwybyddiaeth o dwyll** o fewn eich timau a'ch rhwydweithiau.*
- ***Rhoi gwybod am bryderon yn brydlon — mae pob adroddiad yn bwysig.***
- ***Ymgorffori rheolaethau cryf** yn eich maes gwasanaeth i gefnogi atal.*
- ***Cwblhau'r hyfforddiant gofynnol ac ymgysylltu ag ymgyrchoedd** i gael yr wybodaeth ddiweddaraf.*
- ***Bod yn wyliadwrus a chymryd camau rhagweithiol** i leihau'r risg o dwyll yn eich maes.*

Mae eich ymroddiad yn hanfodol. Bydd ymateb cydlynol sy'n strategol, yn dactegol ac yn weithredol yn sicrhau bod GIG Cymru yn wydn yn erbyn twyll.

Rwy'n falch o hyrwyddo'r gwaith hwn ac yn hyderus y bydd y strategaeth hon yn cael effaith wirioneddol. Diolch i'n staff a'n partneriaid ymroddedig am eich ymrwymiad i ddiogelu GIG Cymru. Gyda'n gilydd, gallwn ddiogelu'r adnoddau a fwriadwyd ar gyfer gofal i gleifion. Mae pob gweithred yn bwysig."

Jacqueline Totterdell
Prif Weithredwr, GIG Cymru

Crynodeb Gweithredol

Mae twyll, llwgrwobrwyo a llygredd yn fygythiadau cynyddol sy'n dargyfeirio cronfeydd hanfodol y GIG, yn cynyddu costau ac yn erydu ymddiriedaeth y cyhoedd. Mae pob punt a gollir yn bunt a gymerir o ofal i gleifion.

Ein Gweledigaeth

Meithrin diwylliant gwrth-dwyll gwydn, cydweithredol sy'n cael ei arwain gan ddeallusrwydd, ar draws GIG Cymru i sicrhau bod adnoddau'n cael eu diogelu ar gyfer gofal i gleifion.

Ein Strategaeth

Mae ein strategaeth yn canolbwyntio ar atal rhagweithiol, canfod cyflym, a chamau pendant er mwyn diogelu adnoddau'r GIG.

- **Atal twyll cyn iddo ddigwydd.**
- **Canfod ac ymchwilio'n gyflym.**
- **Rhoi sancsiynau ar waith ac adennill arian wedi'i ddwyn.**
- **Meithrin arbenigedd a galluogrwydd ar draws GIG Cymru.**

Sut Byddwn yn Cyflawni

- Defnyddio deallusrwydd i nodi a thargedu risgiau twyll.
- Codi ymwybyddiaeth ymhlith staff, cleifion a chyflenwyr.
- Gweithredu'n bendant yn erbyn troseddwyr.
- Buddsoddi mewn offer, adnoddau ac hyfforddiant i staff er mwyn gwella effeithiolrwydd.

Yn ystod y pum mlynedd diwethaf, mae GIG Cymru wedi rhoi **59 o sancsiynau** ar waith ac wedi adennill **£3,322,427**, ac wedi dychwelyd arian ar gyfer gofal i gleifion. Mae risgiau twyll yn esblygu'n barhaus—o dwyll caffael a chontractau hyd at seiberdroseddu—a rhaid i ni aros ar flaen y gad.

Twyll yw un o'r troseddau mwyaf cyffredin yng Nghymru a Lloegr, ac mae'r Asiantaeth Troseddu Cenedlaethol yn amcangyfrif bod tua 67% o'r twyll a adroddir yn enghreifftiau o seiberdroseddu ac mae'r GIG yn darged amlwg. Gan fod GIG Cymru yn prosesu biliynau o drafodion a data sensitif, nid yw'r risgiau erioed wedi bod yn uwch.

Mae'r strategaeth hon yn adeiladu ar y Strategaeth Ymladd Twyll (2019) flaenorol ac mae'n cydnabod risgiau newydd a risgiau sy'n dod i'r amlwg. Mae'r strategaeth hon yn codi'r safon gydag amcanion wedi'u hadnewyddu a bydd cynllun cyflawni a dangosyddion mesuradwy yn sail iddi. Mae hefyd yn cyd-fynd â strategaethau gwrth-dwyll ledled y DU a blaenoriaethau Llywodraeth Cymru.

Y strategaeth hon yw ein hymrwymiad i ddiogelu pob punt ar gyfer gofal i gleifion. Gyda'n gilydd, byddwn yn gwneud GIG Cymru yn wydn yn erbyn twyll.

Mae atal twyll yn gyfrifoldeb pawb.

Rhaid i holl staff y GIG barhau i fod yn wyliadwrus ac adrodd am unrhyw dwyll a amheuir i'w Harbenigwr Gwrth-dwyll Lleol neu Wasanaeth Atal Twyll GIG Cymru.

Amcanion Strategol

Er mwyn diogelu adnoddau GIG Cymru a chynnal ymddiriedaeth y cyhoedd, rhaid inni fabwysiadu dull rhagweithiol a chydlynol o fynd i'r afael â thwyll. Mae ein Hamcanion Strategol yn darparu'r sylfaen ar gyfer y gwaith hwn. Maent yn canolbwyntio ar atal, canfod yn gynnar, ymateb yn bendant, ac adeiladu'r galluogrwydd sydd ei angen i aros ar flaen y gad o ran risgiau sy'n esblygu. Drwy fuddsoddi yn ein pobl, cyd-gysylltu deallusrwydd, a chryfhau cydweithio â phartneriaid ledled Cymru a'r DU, byddwn yn creu system wydn sy'n diogelu cyllid fel y gellir ei gyfeirio lle mae'n bwysicaf—gofal i gleifion.

Yr Amcan Strategol	Disgrifiad
Atal 	Asesu'r risg, cryfhau systemau a rheolaethau a hyrwyddo ymwybyddiaeth i atal twyll cyn iddo ddigwydd.
Canfod 	Defnyddio data, deallusrwydd a dadansoddi uwch i helpu i flaenoriaethu adnoddau a chysylltu risgiau twyll yn gynnar.
Ymateb 	Ymchwilio'n drylwyr, adennill colledion, a rhoi sancsiynau priodol ar waith yn gyflym.
Meithrin Galluogrwydd 	Buddsoddi yn ein pobl drwy ddarparu hyfforddiant arbenigol ac arfogi timau gwrth-dwyll â'r offer a'r dechnoleg ddiweddaraf.
Cydweithio 	Meithrin partneriaethau cryf ar draws GIG Cymru, cyrff cyhoeddus eraill Cymru, Llywodraeth Cymru, ac asiantaethau'r DU fel CThEF a'r Adran Gwaith a Phensiynau i rannu deallusrwydd ac arferion gorau.

Galluogwyr allweddol

Mae cyflawni ein Hamcanion Strategol yn gofyn am fwy na bwriad—mae'n gofyn am fuddsoddiad yn yr offer, y sgiliau a'r partneriaethau cywir.

Mae hyn yn cynnwys:

- Cyfarwyddiadau Llywodraeth Cymru, sy'n sefydlu'r fframwaith cyfreithiol ar gyfer cyfrifoldebau a swyddogaethau Gwasanaeth Atal Twyll y GIG ar draws GIG Cymru, gan gynnwys gofynion ar gyfer cydweithredu â phartneriaid; a'r
- arbenigwyr gwrth-dwyll lleol a'r gwasanaeth atal twyll cenedlaethol ar draws GIG Cymru, y mae eu gwaith parhaus a chydweithredol - sy'n cael ei alluogi gan y Cyfarwyddiadau hyn - yn ffurfio galluogwr craidd ar gyfer atal, canfod ac ymateb yn effeithiol. Bydd eu cyfraniad yn hanfodol i gyflawni'r amcanion a nodir isod.

Er mwyn cryfhau gwydnwch GIG Cymru yn erbyn twyll, rydym wedi nodi set o Alluogwyr Allweddol a fydd yn sail i'n dull gweithredu. Mae'r galluogwyr hyn yn darparu'r seilwaith, y dechnoleg a'r arbenigedd sydd eu hangen i atal twyll, canfod risgiau'n gynnar, ymateb yn effeithiol a meithrin galluogrwydd ar draws y system. Drwy alinio pob galluogwr â'n hamcanion, rydym yn sicrhau llwybr clir a chydlynol i lwyddiant.

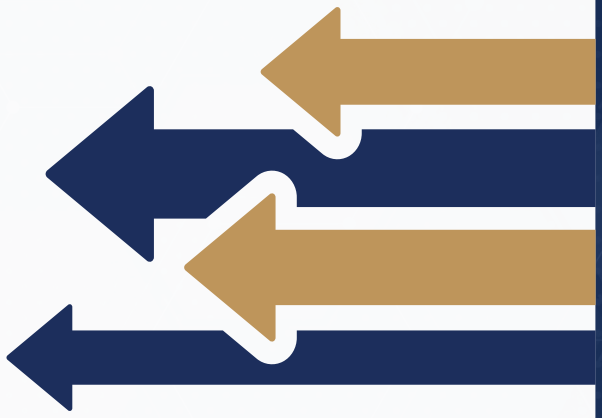
Yr Amcan Strategol	Y Galluogwr Allweddol	Yr Effaith
Atal	Safonau Swyddogaethol: Meincnodi a Sicrwydd. Diwylliant Gwrth-dwyll: Yn cael ei arwain o frig y sefydliad, gan feithrin diwylliant rhagweithiol ar draws y GIG er mwyn grymuso pawb i atal twyll a rheoli risg yn effeithiol. Dylai holl weithwyr y GIG gwblhau'r modiwl hyfforddi e-ddysgu ar Ymwybyddiaeth o Dwyll.	Bydd yn gosod meincnodau clir ar gyfer gweithgarwch gwrth-dwyll ac yn rhoi sicrwydd bod y rheolaethau'n gadarn ac yn effeithiol a bod safonau'n cael eu bodloni ar draws GIG Cymru. Bydd meithrin diwylliant gwrth-dwyll cryf yn cynyddu ymwybyddiaeth ac yn helpu i nodi risgiau twyll yn gynnar. Atal drwy arferion da yw'r ffordd fwyaf effeithiol o leihau twyll yn y GIG.

Yr Amcan Strategol	Y Galluogwr Allweddol	Yr Effaith
Canfod 	Annog yr holl staff a rhanddeiliaid i roi gwybod am dwyll pryd bynnag y bydd ganddynt bryder. Dull cydweithredol tuag at Asesiadau Risg a defnyddio Dadansoddeg Data a Deallusrwydd Artiffisial.	Bydd yn galluogi adnabod risgiau twyll yn gynnar trwy ddefnyddio dadansoddeg data ac offer sy'n cael eu llywio gan ddeallusrwydd artiffisial er mwyn gwella gwneud penderfyniadau sy'n seiliedig ar ddeallusrwydd ledled Cymru. Bydd yn galluogi ymateb rhagweithiol ac arloesol i fygythiadau presennol a rhai sy'n dod i'r amlwg.
Ymateb 	Fforensig Digidol, System CLUE a Deddf Enillion Troseddau 2002. Buddsoddi mewn adnoddau ymchwiliol a hyfforddiant.	Bydd yn darparu offer ymchwilio gwell ar gyfer casglu tystiolaeth gadarn, rheoli achosion ac adennill arian wedi'i ddwyn.
Meithrin Galluogrwydd 	Datblygiad proffesiynol parhaus drwy'r Ganolfan Dysgu Arbenigol.	Bydd yn darparu datblygiad proffesiynol, hyfforddiant arbenigol ac achrediad i gryfhau'r galluogrwydd i wrthsefyll twyll ac i arfogi staff â'r sgiliau sydd eu hangen i fynd i'r afael â risgiau twyll sy'n esblygu.
Cydweithio 	Grŵp Cyswllt Gwrth-dwyll. Grŵp Llywio Gwrth-dwyll. Cyfarwyddwyr y Grŵp Cyllid.	Bydd yn hyrwyddo cydweithio gweithredol, rhannu arferion gorau, a chysondeb ar draws Byrddau Iechyd, Awdurdodau Iechyd Arbennig ac Ymddiriedolaethau.

Blaenoriaethau ar gyfer Gweithredu

Mae atebolrwydd ac olrhain cynnydd yn ganolog i'r strategaeth hon. Bydd pob Amcan Strategol yn cael ei fonitro yn erbyn camau gweithredu a gynlluniwyd, gydag adroddiadau rheolaidd i'r Grŵp Llywio Gwrth-dwyll a Llywodraeth Cymru. Bydd hyn yn sicrhau tryloywder, yn ysgogi gwelliant parhaus, ac yn sicrhau bod GIG Cymru yn parhau i ganolbwyntio ar ddiogelu adnoddau ar gyfer gofal i gleifion.

Gyda'i gilydd, bydd y camau gweithredu canlynol a gynlluniwyd yn creu system ragweithiol, gydlynol sy'n diogelu adnoddau'r GIG ac yn sicrhau bod cyllid yn cael ei gyfeirio at ofal i gleifion.



Yr Amcan Strategol	Disgrifiad	Sut olwg fydd ar 2030 a thu hwnt
Atal	Er mwyn lleihau cyfleoedd ar gyfer twyll cyn iddynt godi, byddwn yn cryfhau fframweithiau sicrwydd ac yn ymgorffori gweithdrefnau rheoli risg twyll ar draws GIG Cymru. **Byddwn yn gwneud y canlynol:** • gweithredu adolygiadau meincnodi blynyddol yn erbyn Safonau Swyddogaethol, • datblygu dangosfyrddau sicrwydd lleol a chenedlaethol, • gweithredu proses ar gyfer olrhain camau gweithredu a mynd ar drywydd ymarferion rhagweithiol cenedlaethol. • cynnal asesiadau risg twyll gan ddefnyddio methodoleg gyson ac effeithlon cyhoeddi Adroddiad Sicrwydd Gwrth-dwyll blynyddol. Bydd y mesurau hyn yn gosod disgwyliadau clir ac yn darparu tryloywder ar gynnydd.	Bydd rheoli risg twyll yn cael ei ymgorffori mewn prosesau bob dydd, gan ei wneud yn rhan safonol o brosesau llywodraethu a gwneud penderfyniadau yn hytrach na mesur adweithiol. Bydd gan staff ar draws GIG Cymru ddealltwriaeth glir o risgiau twyll a'u rôl wrth eu lliniaru. Bydd dangosfyrddau lleol a chenedlaethol yn darparu gweledigaeth amser real o ddangosyddion risg twyll, a fydd yn galluogi ymyriadau cyflym a gwneud penderfyniadau ar sail gwybodaeth.

Canfod 	Mae canfod cynnar yn hanfodol er mwyn lleihau colled ariannol a diogelu gofal i gleifion. **Byddwn yn gwneud y canlynol:** • defnyddio dadansoddeg data uwch ac offer sy'n cael eu llywio gan ddeallusrwydd artiffisial i nodi anomaleddau mewn trafodion ariannol, • integreiddio dangosyddion risg twyll i systemau craidd, • sefydlu protocol rhannu data canolog i wella deallusrwydd ar draws GIG Cymru. Bydd dadansoddiad chwarterol o dueddiadau twyll yn llywio ymyriadau rhagweithiol ac yn sicrhau bod adnoddau'n cael eu cyfeirio lle bydd eu hangen fwyaf.	Bydd modelau rhagfynegol yn nodi risgiau twyll sy'n dod i'r amlwg cyn iddynt ddod i'r amlwg, a fydd yn galluogi camau rhagataliol. Bydd protocol rhannu data diogel, ledled GIG Cymru, yn sicrhau bod deallusrwydd o un sefydliad iechyd ar gael ar unwaith i bob sefydliad arall. Bydd patrymau twyll a ganfyddir mewn un rhanbarth yn llywio mesurau ataliol ym mhobman, gan greu rhwydwaith o ddiogelu.
Ymateb 	Pan fydd twyll yn digwydd, rhaid i ni weithredu'n bendant ac adennill arian sydd wedi'i ddwyn. **Byddwn yn gwneud y canlynol:** • gweithio gydag Awdurdod Atal Twyll y GIG i wella'r system rheoli achosion er mwyn gwella effeithlonrwydd ymchwiliadau, • rhoi trefniadau ar waith i arbenigwyr gwrth-dwyll gael mynediad at arbenigedd dadansoddeg data, • rhoi protocol ymateb cyflym ar waith mewn cydweithrediad â thimau Seiber cenedlaethol a lleol ar gyfer digwyddiadau twyll o ganlyniad i seiberdroseddu. Bydd dulliau a chyflawniadau adennill yn cael eu monitro i sicrhau atebolrwydd a gwelliant parhaus.	Bydd y system rheoli achosion wedi'i gwella'n llawn, gan alluogi ymchwilwyr i reoli achosion yn ddi-dor, olrhain tystiolaeth, a chydweithio ar draws sefydliadau iechyd mewn amser real. Bydd protocol ymateb cyflym yn cael ei sbarduno ar unwaith pan ganfyddir twyll o ganlyniad i seiberdroseddu—fel system ymateb brys. Bydd GIG Cymru yn cyhoeddi data adennill tryloyw, gan atgyfnerthu ymddiriedaeth y cyhoedd a dangos gwelliant parhaus.

Meithrin Galluoedd 	Mae gweithlu medrus a gwybodus yn hanfodol i aros ar flaen y gad o ran risgiau twyll sy'n esblygu. **Byddwn yn gwneud y canlynol:** • cyflwyno rhaglenni DPP strwythuredig, • cyflwyno llwybrau gyrfa gan gynnwys rolau technegwyr ac ystyried cyfleoedd secondiad gydag Awdurdod Atal Twyll y GIG mewn meysydd fel dadansoddeg data a fforensig digidol, • Bydd gofyn i holl weithwyr GIG Cymru gwblhau'r modiwl e-ddysgu ar ymwybyddiaeth o dwyll. Bydd Cynadleddau Gwrth-dwyll blynyddol yn darparu cyfleoedd i rannu arferion gorau a thueddiadau sy'n dod i'r amlwg.	Bydd gan rolau gwrth-dwyll lwybrau gyrfa clir, a fydd yn cynnwys swyddi lefel technegydd a rolau uwch ym meysydd dadansoddeg a fforensig digidol. Bydd yr hyfforddiant e-ddysgu ar ymwybyddiaeth o dwyll ar gael i holl weithwyr GIG Cymru—o staff clinigol i weithredwyr. Bydd ymwybyddiaeth gynyddol yn helpu i leihau twyll. Bydd Cynadleddau Gwrth-dwyll blynyddol yn ddigwyddiadau mawr, a fydd yn dod ag arbenigwyr, sefydliadau iechyd a phartneriaid eraill ynghyd i rannu arferion gorau a thueddiadau sy'n dod i'r amlwg.
Cydweithio 	Mae atal a chanfod twyll yn gofyn am bartneriaethau cryf. Bydd y Grŵp Llywio Gwrth-Dwyll yn gweithio gyda Chyfarwyddwyr Cyllid a'r Grŵp Cyswllt Gwrth-Dwyll i sbarduno cydweithio gweithredol, rhannu deallusrwydd, a hyrwyddo cysondeb ar draws Byrddau Iechyd, Awdurdodau Iechyd Arbennig, ac Ymddiriedolaethau. **Byddwn yn gwneud y canlynol:** • cryfhau'r broses o rannu deallusrwydd ledled Cymru, rhwng y pedair gwlad a chyrff cyhoeddus eraill gan gynnwys heddluoedd, • cyhoeddi dogfennau canllaw ar y cyd, • a sefydlu trefniadau traws-sefydliadol, gan weithio gyda Gwasanaeth Atal Twyll y GIG i fynd i'r afael â meysydd risg uchel fel caffael a seiberdroseddu.	Ni fydd cydweithio bellach yn ad hoc—bydd yn strwythuredig, yn gyson, ac yn strategol, a fydd yn sicrhau aliniad ar draws system gyfan GIG Cymru. Rhannu deallusrwydd yn well ar draws y DU a chyrff cyhoeddus gan alluogi mynediad amser real at rybuddion twyll, diweddariadau achosion, a phatrymau risg sy'n dod i'r amlwg. Bydd y deallusrwydd hwn a rennir yn helpu i nodi tueddiadau traws-sefydliadol yn gynnar, a fydd yn ganiatáu gweithredu thŷ-doriadau a mwy cydlynol. Bydd GIG Cymru yn cyhoeddi dogfennau canllaw safonol a ddatblygwyd ar y cyd gan yr holl bartneriaid, a fydd yn sicrhau cysondeb wrth atal twyll ac ymateb iddo.

Y Canlyniadau Allweddol erbyn 2030

1

Bydd atal twyll yn digwydd ar draws y system, nid yn ynysig—bydd deallusrwydd yn llifo'n rhydd, a bydd yr ymatebion yn cael eu cydlynu.

2

Bydd GIG Cymru yn cael ei gydnabod fel arweinydd ym maes atal twyll ar y cyd, ac yn dylanwadu ar bolisi ledled y DU.

3

Bydd hyder y cyhoedd yn cael ei gryfhau oherwydd bydd y system yn amlygu cydweithio, tryloywder ac effeithiolrwydd.

Cyfrifoldeb Staff

Mae atal twyll yn gyfrifoldeb pawb.

Rhaid i holl staff y GIG barhau i fod yn wyliadwrus a rhoi gwybod am unrhyw dwyll a amheuir i'w LCFS neu CFSW.

Strwythur Llywodraethu

Mae llywodraethu cryf yn hanfodol i sicrhau atebolrwydd, cysondeb ac effeithiolrwydd wrth fynd i'r afael â thwyll ar draws GIG Cymru. Mae'r strwythur llywodraethu hwn yn darparu llinell atebolrwydd glir o wasanaethau lleol hyd at oruchwyliaeth genedlaethol. Mae'n sicrhau bod GIG Cymru yn parhau i fod yn wydn yn erbyn risgiau twyll ac yn canolbwyntio ar ddiogelu adnoddau ar gyfer gofal i gleifion.

Grŵp Llywio Gwrth-Dwyll (CFSG)

Mae'r CFSG yn darparu goruchwyliaeth strategol o wasanaethau gwrth-dwyll ar draws GIG Cymru ac yn cynghori Llywodraeth Cymru ar gamau gweithredu a chyfleoedd i wella.

Cyfarfodydd: Bob chwarter

Cadeirydd: Cyfarwyddwr Cyllid a Gwasanaethau Corfforaethol PCGC

Aelodaeth:

- Cynrychiolydd Llywodraeth Cymru
- Cyfarwyddwyr Cyllid GIG Cymru
- Cadeiryddion y Pwyllgor Archwilio
- Awdurdod Atal Twyll y GIG
- Pennaeth Gwasanaeth Atal Twyll Cymru
- Cadeirydd y Grŵp Cyswllt Gwrth-dwyll
- Archwilio Cymru (Sylwedydd)

Mae'r CFSG yn sicrhau aliniad â blaenoriaethau cenedlaethol, yn adolygu perfformiad, ac yn argymell gwelliannau i gryfhau atal a chanfod twyll.

Grŵp Cyswllt Gwrth-dwyll

Wedi'i sefydlu yn 2025, mae'r grŵp hwn yn dwyn ynghyd Arbenigwyr Gwrth-dwyll Lleol (LCFS) a Gwasanaeth Atal Twyll GIG Cymru. Ei brif bwrpas yw darparu cefnogaeth gan gymheiriaid a rhannu arferion gorau, hyrwyddo cysondeb, a chefnogi darpariaeth weithredol ar draws Byrddau Iechyd, Awdurdodau Iechyd Arbennig ac Ymddiriedolaethau.

Mae'r aelodau'n adrodd yn uniongyrchol i'w Cyfarwyddwr Cyllid priodol a gallant godi cyfleoedd a materion cyffredin ar y cyd drwy'r Grŵp Cyfarwyddwyr Cyllid i'w codi gyda'r Grŵp Llywio Gwrth-dwyll. Mae'r Cadeirydd a'r Is-gadeirydd hefyd yn mynd i gyfarfodydd y Grŵp Llywio Gwrth-dwyll.

Llywodraeth Leol

Yn weithredol, mae arbenigwyr gwrth-dwyll lleol yn adrodd i'r Cyfarwyddwyr Cyllid ac yn cael eu monitro gan Bwyllgorau Archwilio o fewn pob corff GIG. Mae'r Pwyllgorau hyn yn adolygu cynlluniau gwaith blynyddol, adroddiadau cynnydd, a chanlyniadau i sicrhau goruchwyliaeth ac atebolrwydd cadarn.

Mae Pennaeth Gwasanaeth Atal Twyll Cymru yn darparu cefnogaeth broffesiynol, cyfarwyddyd ac arweinyddiaeth gref i rwydwaith yr arbenigwyr gwrth-dwyll lleol o fewn cyrff GIG Cymru yn ogystal â rheolaeth llinell weithredol ar gyfer tîm Gwasanaethau Atal Twyll GIG Cymru. Maent yn cynghori Cyfarwyddwyr Cyllid GIG Cymru a swyddogion Llywodraeth Cymru, ac yn gweithio mewn partneriaeth agos ag Awdurdod Atal Twyll y GIG, yr Asiantaeth Troseddu Cenedlaethol, heddluoedd rhanbarthol, CThEF, a'r Adran Gwaith a Phensiynau.

Sicrhau Ansawdd

Caiff ansawdd gwasanaethau gwrth-dwyll o fewn GIG Cymru ei asesu yn erbyn Safonau Swyddogaethol y Llywodraeth (013 Gwrth-dwyll), a hwylusir gan Awdurdod Atal Twyll y GIG (NHSCFA) ac a fabwysiadwyd ar draws GIG Cymru.

Mae'r safonau hyn yn sicrhau bod mesurau i atal, canfod ac ymateb i dwyll, llwgrwobrwyo a llygredd yn cael eu rhoi ar waith yn unol â Chyfarwyddiadau Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol a'r Cytundeb Lefel Gwasanaeth rhwng Llywodraeth Cymru ac NHSCFA.

Diben y Safonau

Mae'r Safonau Swyddogaethol yn darparu fframwaith cyson i wneud y canlynol:

- Ymgorffori rheolaethau gwrth-dwyll cadarn ar draws GIG Cymru.
- Sicrhau cydymffurfedd â rhwymedigaethau statudol a chontractiol.
- Darparu tryloywder ac atebolrwydd wrth atal a chanfod twyll.

Y Rhaglen Sicrhau Ansawdd

Mae'r rhaglen yn cynnwys **dwy broses graidd**:

1. **Sicrwydd**
   - Mae pob sefydliad GIG yn cwblhau hunanadolygiad blynyddol yn erbyn y Safonau Swyddogaethol.
   - Adroddir y canlyniadau i Bwyllgor Archwilio sefydliad y GIG a'u cyflwyno i'r NHSCFA i'w dadansoddi ac wedi hynny i Lywodraeth y DU.
   - Mae'r broses hon yn sicrhau cydymffurfedd, yn tynnu sylw at feysydd i'w gwella, ac yn cefnogi datblygiad parhaus.
2. **Asesiad**
   - Mae tîm Ansawdd a Chydymffurfedd yr NHSCFA yn cynnal asesiadau annibynnol.
   - Gan ddefnyddio'r Offeryn Hunan-adolygu, tystiolaeth ategol, a gweithdrefnau arolygu, mae'r tîm yn gwerthuso:
     - **Adnoddau gwrth-dwyll.**
     - **Perfformiad yn erbyn safonau.**
     - **Effeithiolrwydd y rheolaethau a roddwyd ar waith.**
   - Dylid mynd i'r afael â'r gwelliannau a argymhellir ar unwaith, er mwyn cynnal safonau uchel a chryfhau galluogrwydd.

Adolygiadau Llywodraethu

Yn ogystal â'r Rhaglen Sicrhau Ansawdd uchod, mae tîm Gwasanaeth Atal Twyll Cymru (CFSW) yn cael adolygiad sicrhau llywodraethu cylchol a gynhelir gan yr NHSCFA, sy'n sicrhau ei fod yn alinio â safonau cenedlaethol ac arferion gorau.

Adnoddau i gefnogi Trefniadau Gwrth-dwyll yn GIG Cymru

Arbenigwyr Gwrth-dwyll Lleol

Mae Cyfarwyddiadau Llywodraeth Cymru ar Wrth-dwyll yn ei gwneud yn ofynnol i bob Corff Iechyd benodi Arbenigwyr Gwrth-dwyll Lleol (LCFS) cymwys, wedi'u hachredu gan y Bwrdd Achredu Proffesiynol Gwrth-dwyll neu gyfwerth. Ar hyn o bryd, mae 23.38 Arbenigwr Gwrth-dwyll Lleol yng Nghymru, ac mae pob un yn cael ei gyflogi'n uniongyrchol gan gyrff y GIG.

Mae'r Arbenigwyr Gwrth-dwyll Lleol yn gweithredu fel y prif bwynt cyswllt ar gyfer pob pryder ynghylch troseddau economaidd o fewn eu sefydliad. Maent yn cytuno ar gynlluniau gwaith blynyddol gyda'u Corff Iechyd, gan gydbwyso gweithgareddau rhagweithiol (ymwybyddiaeth o dwyll, asesu a chanfod risg) a gwaith adweithiol (ymchwiliadau), wedi'u halinio â Safonau Twyll, Llwgrwobrwyo a Llygredd ar gyfer Cyrff y GIG (Cymru).

Gwasanaeth Atal Twyll GIG Cymru (CFSW)

Mae Gwasanaeth Atal Twyll GIG Cymru yn dîm annibynnol a ariennir gan Llywodraeth Cymru ac sy'n cael ei gyflogi gan Bartneriaeth Cydwasanaethau GIG Cymru (PCGC) a letyir gan Ymddiriedolaeth GIG Prifysgol Felindre. Mae'n darparu adnodd ymchwilio annibynnol arbenigol i bob corff iechyd yng Nghymru ac yn darparu goruchwyliaeth weithredol ar bob gweithgaredd gwrth-dwyll yn GIG Cymru, er mwyn sicrhau cydymffurfedd â Chyfarwyddiadau Llywodraeth Cymru.

Mae CFSW yn gwasanaethu fel yr arweinydd proffesiynol a strategol i GIG Cymru ar faterion gwrth-dwyll rhagweithiol ac ymchwiliol. Mae'n hyrwyddo dull cyson o ansawdd uchel ar draws cyrff iechyd yn unol â deddfwriaeth berthnasol. Mae ei ymchwilwyr profiadol, achrededig yn rheoli achosion troseddau economaidd mawr a chymhleth, yn darparu arweiniad arbenigol i rwydwaith yr LCFS, ac wedi'u hawdurdodi i arfer pwerau ymchwilio ariannol o dan Ddeddf Enillion Troseddau 2002.

Cymorth Arbenigol gan Awdurdod Atal Twyll y GIG (NHSCFA)

O dan drefniant Adran 83 o Ddeddf Llywodraeth Cymru 2006, mae NHSCFA yn darparu gwasanaethau cymorth gweithredol arbenigol i GIG Cymru, sy'n cynnwys Cyfrifiadura Fforensig a Gwasanaethau Deintyddol Arbenigol, a ariennir trwy Gytundeb Lefel Gwasanaeth blynyddol gyda Llywodraeth Cymru.

Swyddogaethau Allweddol Eraill GIG Cymru sy'n Cefnogi Atal Twyll

- **Gwasanaethau Gofal Sylfaenol (PCS):** Mae'r tîm Dilysu ar ôl Talu (PPV) yn gwirio hawliadau mewn gwasanaethau Meddygol Cyffredinol, Offthalmig a Fferylliaeth. Darperir archwiliadau deintyddol trwy Awdurdod Gwasanaethau Busnes GIG Lloegr. Mae'r archwiliadau hyn yn sicrhau bod hawliadau'n gywir a bod gwasanaethau'n bodloni manylebau'r GIG. Cyfeirir pryderon at LCFS neu CFSW o dan Brotocol Rhannu Gwybodaeth.
- **Archwilio a Sicrwydd:** Mae Gwasanaethau Archwilio a Sicrwydd PCGC yn darparu gwasanaethau archwilio mewnol i holl gyrff y GIG. Er nad ydynt yn gyfrifol yn uniongyrchol am ganfod twyll, mae eu gwaith yn tynnu sylw at wendidau rheoli a thoriadau posibl. Maent yn cydweithio ag LCFS o dan Brotocol Rhannu Gwybodaeth.
- **Archwilydd Cyffredinol Cymru:** Gall archwiliadau allanol ddatgelu gwendidau mewn systemau neu ddangosyddion twyll. Mae cysylltiad rheolaidd yn digwydd rhwng archwilwyr, cyrff y GIG, Llywodraeth Cymru a CFSW i fynd i'r afael â phryderon.
- **Y Fenter Twyll Genedlaethol (NFI):** Dan arweiniad yr Archwilydd Cyffredinol ac o dan bwerau statudol, mae'r NFI yn paru data ar draws cyrff cyhoeddus bob dwy flynedd i nodi anomaleddau. Ers ei sefydlu, mae'r NFI wedi datgelu £56.5 miliwn mewn twyll a gordaliadau ledled Cymru, gan gynnwys £7.1 miliwn yn yr ymarfer diweddaraf

Rhagair
Crynodeb Gweithredol
Amcanion Strategol
Blaenoriaethau ar gyfer Gweithredu
Strwythur Llywodraethu
Sicrhau Ansawdd
Adnoddau i gefnogi Trefniadau Gwrth-dwyll yn GIG Cymru
Tudalen 16

Rhoi Gwybod am Dwyll

Rhowch wybod am dwyll y GIG mewn modd diogel a chyfrinachol drwy ddefnyddio ***offeryn adrodd ar-lein Awdurdod Atal Twyll y GIG*** neu drwy ffonio ein llinell ffôn am ddim ar 0800 028 40 60.

Manylion Cyswllt

Gwasanaeth Atal Twyll GIG Cymru

Llawr 1af

Bloc B

Tŷ Mamhilad

Ystâd Parc Mamhilad

Pont-y-pŵl

NP4 0YP

5

10:05, 0 Mins

5 - NWSSP – Audit and Assurance Services - Internal Audit

5.1

10:05, 10 Mins

5.1 - Internal Audit Plan Progress Report

James Johns (NWSSP - Internal Audit)

For assurance

Attachments

5.1 SBAR IA Progress Report ARAC August 2026.pdf

5.1 HDUHB IA Progress Report ARAC August 2026.pdf

Pwyllgor Archwilio a Sicrwydd Risg/ Audit and Risk Assurance Committee

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	13 AUGUST 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit & Assurance Services Progress Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Head of Internal Audit
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Internal Audit

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/ For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Audit & Assurance Services progress report provides the Audit & Risk Assurance Committee (ARAC) with an update in relation to the delivery of the approved Internal Audit Plan for 2025/26, any updates to the plan 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, from the outcomes of the finalised audit reports, and approve the proposed updates to the plan.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	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, Teitl a Sgôr Risg 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
Nodau Cynllunio 2026/27 Planning Goals 2026/27	All Planning Goals Apply

Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	10. Not Applicable
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Internal Audit Plan, Mandate and Charter Individual Internal Audit reports. Evidence gathered from the Health Board as part of the delivery of audit assignments. Health Board Risk Registers. Board and Committee Papers.
Rhestr Termau: Glossary of Terms:	Contained within the reports.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Director of Corporate Governance Audit & Risk Assurance Committee Chair 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.
Tegwch Iechyd: Health Equity:	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 2026

Audit & Assurance Services
Internal Audit Progress Report

CONTENTS

Audit and Assurance Services conform with the Institute of Internal Auditors (IIA's) professional standards and to the Global Internal Audit Standards in the UK Public sector, validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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 2026/27 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
Capital Equipping	 Limited

3. Planning and Delivery Update

3.1 The assignment status schedule highlighting the updated planned delivery timelines and current progress with the 2026/27 plan is shown in Appendix A.

3.2 Work has commenced on the delivery of the 2026/27 Internal Audit Plan, one audit has been completed and the report finalised, with several others at work in progress and planning stages.

3.3 As part of planning discussions commence individual audits issues were raised with the four audits highlighted below requests from management which have required two audits requiring to be rescheduled from quarter one to quarter four of the 2026/27 audit year impacting on delivery for this Committee meeting, along with the deferral of two audits to a future year. Each of these has been subsequently discussed and agreed with both the Director of Corporate Governance and the ARAC Chair. The rationale for the reschedule and deferrals is set out in the table below.

ED Data Validation Re audit	Implementation of previous agreed action had not been completed	Reschedule Q4
Emergency Escalation Continuity Arrangements	Significant new national guidance being implemented later in 2026	Reschedule Q4
CHC Direct Payments	Timing of implementation of the new arrangements	Defer
IRMER	Other inspection work undertaken within the service area	Defer

The Committee is asked to note the amended timelines and approve the deferrals from the 2026/27 audit plan.

Appendix A – HDUHB Internal Audit Plan 2026/27 – Assignment Status Schedule

Audit Output	Executive Lead	Planned start	Planned ARAC	Progress Status	Assurance
Regional Joint Committee	Chief Executive	Q3/4	April		
Operational Governance Arrangements	COO	Q3	Feb		
Financial Management: Grip & Control	Finance	Q2	Oct	Planning	
Cost Management & Savings Schemes	Finance	Q2/3	Dec	Planning	
Cleanliness Standards	AHPHS	Q3/4	April		
Organisational Change Process Operational Structure (Advisory)	COO	Q2	Oct	Planning	
Health & Safety	AHPHS	Q3	Dec		
Workforce Planning	WOD	Q2/3	Oct	Planning	
Staff Experience & Wellbeing	WOD	Q2	Oct	WIP	
Complaints	NQPE	Q3	Feb		
Quality Management System	NQPE	Q2	Dec		
Rostering	WOD	Q2	Dec	Planning	
Management of Service Change	COO	Q3	Feb	Planning	
Validation of Emergency Department Performance & Waiting Time Data	COO	Q4	April	Planning	
Business continuity - Emergency Escalation	COO	Q4	April	Planning	
Primary Care Prescribing	COO	Q2	Dec	Planning	
Pathways of Care Delays	COO	Q1/2	Oct	WIP	
~~IRMER~~	~~AHPHS~~	~~Q2/3~~	~~Defer~~		
~~Continuing Healthcare~~	~~COO~~	~~Q2/3~~	~~Defer~~		
Capital Equipping	**Strategy & Planning**	**Q1/2**	**Aug**	**Final**	**Limited**
Theatre Stock System Implementation	COO	Q4	April		

Patient Demographic Information	Finance	Q2/3	Dec		
Primary Care Community by Design	COO	Q4	April		
Vaccination & Immunisation	Public Health	Q4	April		
Follow Up and Agreed Action Implementation Tracking	Corporate Governance	Q2-4	Feb		
Digital Partner Contract	Finance	Q2/3	Dec	Planning	
Artificial Intelligence & Robotic Process Automation	Finance	Q3	Feb		
Radiology Informatics System Programme	Finance	Q2	Oct	WIP	
Heath Records Management	Finance	Q3	Feb		
Estates Assurance – Control of Contractors	Strategy & Planning	Q2/3	Feb		
Capital Systems - Targeted Estates Funding	Strategy & Planning	Q3/4	Feb		
Integrated Audit & Assurance Plans – Aseptic Scheme	Strategy & Planning	Q112	Dec	WIP	

Office details: Audit & Assurance Services West Team
Contact details: james.johns@wales.nhs.uk
Webpage: Audit & Assurance Services - NHS Wales Shared Services Partnership

5.2

10:15, 10 Mins

5.2 - Correspondence Regarding Audit Participation and Implementation of Recommendations

Rhodri Evans (Hywel Dda UHB - Independent Member), Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair), Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

For discussion

Attachments

5.2 ARAC Chair Email July 2026.pdf

5.2 QSEC Chair Letter June 2026.pdf

Clare Moorcroft (Hywel Dda UHB - Committee Services Officer)

From:	Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)
Sent:	07 July 2026 18:30
To:	Rhodri Evans (Hywel Dda UHB - Independent Member); Alwena Hughes Moakes (Hywel Dda UHB - Communications and Engagement Director); Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer); Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health); Huw Thomas (Hywel Dda UHB - Director of Finance); James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science); Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning); Lisa Gostling (Hywel Dda UHB - Director of Workforce & OD/Deputy CEO); Mark Henwood (Hywel Dda UHB - Executive Medical Director); Philip Kloer (Hywel Dda UHB - Chief Executive); Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience)
Cc:	Emily Price (Hywel Dda UHB - PA to Director of Corporate Governance/Board Secretary); Charlotte Wilmshurst (Hywel Dda Health Board - Assistant Director of Assurance and Risk); James Johns (NWSSP - Internal Audit)
Subject:	Internal Audit Plan 2026/27 – Maintaining Delivery and Avoiding Further Deferrals
Attachments:	4.2 Internal Audit Plan 2026-27.pdf
Follow Up Flag:	Follow up
Flag Status:	Flagged

Email sent from ARAC Chair

Dear Executive Director Colleagues,

I am writing regarding the recently approved Internal Audit Plan for 2026/27, which has been shared and discussed with all Executive Directors.

I am concerned that within the first two weeks of the new audit year, four requests have already been received to defer planned audit reviews. This is particularly disappointing given the extensive discussions we have had over recent months regarding the impact that delays and deferrals have on the delivery of the audit programme, the efficient use of audit resources, and ultimately the assurance available to the Audit and Risk Assurance Committee. These concerns have been highlighted previously through the Internal Audit Improvement Plan, which emphasised the need to eliminate avoidable deferrals and strengthen planning and accountability.

The cumulative effect of these early deferral requests is that the programme is already under pressure and, if this pattern continues, will inevitably create a backlog of audits towards the end of the year. This is precisely the position we were seeking to avoid.

The Internal Audit team is now actively reviewing the programme to identify areas where audits can be brought forward to minimise the impact on overall delivery. However, there are limits to the flexibility available, and continued movement within the plan risks undermining the balanced scheduling that was agreed at the outset of the year. The audit plan is intended to spread assurance activity across the year and align delivery with ARAC reporting requirements.

I have therefore reattached the approved Internal Audit Plan and would ask each Executive Director to review carefully the audits scheduled within their respective portfolios and, in particular, the quarters in which those reviews are due to be undertaken.

It is essential that appropriate planning and engagement takes place now to ensure reviews can proceed as scheduled. Unless there are exceptional circumstances, we cannot accommodate further deferrals and still maintain delivery of the overall programme.

I would be grateful for your personal support in ensuring that audit leads and operational teams prioritise the audits within their areas and engage proactively with Internal Audit to facilitate timely delivery.

Thank you for your cooperation.

Kind regards,

Rhodri Evans
Chair, Audit and Risk Assurance Committee
Hywel Dda University Health Board

Joanne Wilson
Cyfarwyddwr Llwyodraethu Corfforaethol (Ysgrifenyddes y Bwrdd)/Director of Corporate Governance (Board Secretary)
Bwrdd Iechyd Prifysgol Hywel Dda/ Hywel Dda University Health Board
Adeilad Springfield/ Springfield Block
Ysbyty Cyffredinol Llwynhelyg/ Withybush General Hospital
Heol Abergwaun/ Fishguard Road
Hwlffordd/Haverfordwest
Sir Benfro/Pembrokeshire
SA61 2PZ

WHTN 01720 4498 or 01825 4637
Rhif Ffôn/ Telephone Number: 01437 834498 or 01267 239637
E-bost: Email: joanne.wilson4@wales.nhs.uk

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Swyddfeydd Corfforaethol, Ail Lawr, Bloc C.
Adeiladau'r Llywodraeth, Heol Picton,
Caerfyrddin, Sir Gaerfyrddin, SA31 3BT

Corporate Offices, Second Floor, Block C,
Government Buildings, Picton Terrace,
Carmarthen, Carmarthenshire, SA31 3BT

Ein cyf/Our ref: Cha.20755

Gofynnwch am/Please ask for:

Lia Mapuranga

Dyddiad/Date: 17/06/2026

Dear Colleagues,

At its meeting on 11 June 2026, the Quality, Safety and Experience Committee considered the organisation's progress in implementing recommendations arising from audits, inspections and regulatory reviews (QSEC Assurance and Risk Report). Whilst the Committee recognises the work undertaken to date, it also wishes to formally set out a number of concerns identified during its scrutiny.

The Committee recognised the significant operational pressures across the organisation and the range of improvement activity underway. However, members noted the pace of implementation of recommendations remains slow, with a significant number of recommendations exceeding their agreed implementation dates. In several cases, there were no identified barriers to delivery identified, which raises concern regarding the level of prioritisation and focus being applied. The Committee also observed a lack of clear accountability and ownership for delivering some of the oldest and most longstanding recommendations. This limits the Committee's ability to gain assurance that actions will be completed in a timely and sustainable way and was a recurring theme throughout the meeting discussions. It was highlighted that missed timescales and limited demonstrable progress are undermining confidence in the organisation's ability to translate learning into quality improvement at pace.

The Committee reflected on the quality of the responses to recommendations including actions that are not consistently SMART and timescales that are unrealistic, leading to repeated slippage. In this context, Executive Directors are asked to support the following improvements:

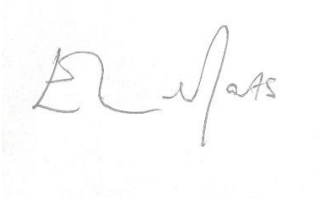
- Clear named Executive and officer ownership for all recommendations, particularly the oldest and of highest risk
- Appropriate and constructive challenge is made to auditors or inspectorates at the outset, where recommendations are not deliverable or proportionate, to ensure expectations are achievable
- Responses to recommendations are SMART (Specific, Measurable, Achievable, Relevant and Time-bound), outcome-focused and clearly linked to measurable improvement
- Realistic and deliverable timescales are set and avoid overly optimistic deadlines which contribute to repeated missed dates of implementation
- A focused approach is taken to address the backlog of overdue recommendations, with particular attention to those where no barriers have been identified

The Committee remains committed to working collaboratively with colleagues to support improvement and to ensure that learning from reviews and inspections is translated into

meaningful and timely change for patients. However, members expect to see tangible improvement in the trajectory of delivery over the coming months, including clearer evidence of ownership, pace and impact. If we are unable to evidence progress in line with Board expectations, I intend to progress this matter to Board for a wider organisational conversation.

Executive Directors are asked to review their respective areas and ensure that the approach to managing recommendations reflects these expectations. The Committee will continue to monitor progress closely and will expect strengthened assurance in future Assurance and Risk reports.

Yours sincerely,



Eleanor Marks
Chair, Quality, Safety and Experience Committee

5.3

10:25, 20 Mins

5.3 - Capital Equipping (Limited Assurance)

James Johns (NWSSP - Internal Audit), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning)

For assurance

Attachments

5.3 Capital Equipping Final Internal Audit Report.pdf

Capital Equipping

Final Internal Audit Report

2026/27

Hywel Dda University Health Board

Limited Assurance

Contents

Review Reference	HDU-2627-20
Fieldwork	June – July 2026
Executive Sign Off	5 August 2026
Audit Committee	August 2026
Executive Lead	Lee Davies, Executive Director of Strategy and Planning
Audit Team	James Johns, Head of Internal Audit
	Sophie Corbett, Deputy Head of Internal Audit

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

Executive Summary

Purpose

To review and provide assurance on the adequacy and effectiveness of the governance arrangements and internal controls in place for the procurement of equipment for capital schemes.

Overview

The Capital Equipping Team is responsible for coordinating equipment requirements across capital schemes. This includes supporting the development of room sheets, business cases and working in partnership with finance and NWSSP Procurement Services ('Procurement') to ensure that equipment is acquired in line with legislative and internal governance requirements.

Weaknesses were identified in the governance and procurement arrangements for capital equipping. There is currently no consistently applied or agreed process to determine when capital equipping procurement activity should be routed through or supported by NWSSP Procurement Services. As a result, NWSSP Procurement Services has been involved in some but not all schemes and purchases which has led to instances where the appropriate procurement route has not been followed based on aggregate spend; non-completion of declarations of interests; and non-compliance with internal reporting requirements. The absence of formal operating procedures reduces clarity over the capital equipping process and circumstances in which NWSSP Procurement Services should be engaged.

We have concluded **Limited** assurance on this area. Full details of matters arising are detailed within the Key Findings table on page 3.

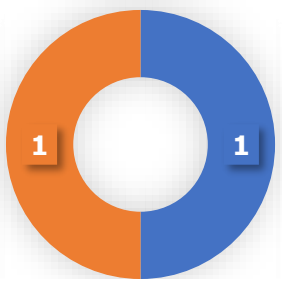
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Contracts for goods and services are subject to competitive procurement and supported with sufficient evidence to demonstrate compliance with the requirements of relevant policies and procedures, Procurement Act 2023, Standing Orders and Standing Financial Instructions.	1, 2	**Limited**

Management Actions

2	-
High Priority	Medium Priority

Themes



Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: Contracts for goods and services are subject to competitive procurement and supported with sufficient evidence to demonstrate compliance with the requirements of relevant policies and procedures, Procurement Act 2023, Standing Orders and Standing Financial Instructions.	Limited

The Capital Equipping Team is responsible for ensuring that capital projects and service developments are appropriately equipped by planning, coordinating, procuring and monitoring the required equipment. The team works closely with service leads, clinical specialists and other stakeholders to identify equipment needs, develop and manage equipment schedules, obtain quotations, and oversee the procurement of medical and non-medical equipment to support the successful delivery of capital schemes.

The Health Board 2025/26 received a capital allocation of £42.436m in 2025/26. During the period April 2025 to June 2026, ten capital equipping schemes were active with a cumulative value of just over £3 million. For a sample of four schemes with a total value of £2.55m, the supporting paperwork was verified to Welsh Government funding approval letters with no issues identified. One scheme had exceeded the approved budget by 4% (£7k) due to ongoing equipment storage costs associated with project delays outside of the control of the Capital Equipping Team. The overspend is due to be discussed at the next project meeting in July 2026.

There is no agreed process on when to engage NWSSP Procurement Services on equipping schemes and purchases. Our review identified a mixture of procurement routes, including blanket call-offs, framework purchases and quotations, with NWSSP Procurement Services involved in some but not all cases. Testing identified instances where the correct procurement route had not been applied as it was determined based on the value of a single purchase rather than the total anticipated value of expenditure per supplier per scheme. In some cases, these exceeded the threshold for competitive procurement and required reporting to the Non-Pay Group for approval, which was not done as they did not go through NWSSP Procurement Services. This inconsistent approach limits NWSSP Procurement Services' oversight of procurement activity and their ability to appropriately advise and ensure that procurement requirements are met and that value for money is achieved, particularly when considering aggregate spend. **[Finding 1]**

There are no formal operating procedures for the capital equipping process. We were advised that the team utilises the 'Capital Team Manual' - an informal guidance document - which requires the establishment of Capital Equipping Forums, submission of monthly highlight reports to the Project Design Lead, and evidence of key stakeholder approval to proceed with purchases. Our testing identified that this is not consistently complied with. **[Finding 2]**

NWSSP Procurement Services is responsible for ensuring compliance with declaration of interest (DOI) requirements for procurements within its remit. Our testing identified that DOIs had not been completed by the Capital Equipping Team and relevant stakeholders for procurements where NWSSP Procurement Services had not been engaged, increasing the risk that potential conflicts of interest are not appropriately identified and managed. **[Finding 1 & 2]**

Key Findings		Risk & Impact	Agreed Management Action
1	**Appropriateness of Procurement Route** The Capital Equipping Team are not consistently engaging with NWSSP Procurement Services for all equipping schemes and purchases to ensure that procurement routes are compliant and offer value for money. Testing identified four instances where, based on aggregate spend with the supplier, sufficient quotations had not been obtained in accordance with thresholds set out within Standing Financial Instructions; and a further two cases which should have been procured via competitive process or framework. All procurements exceeding £25k require scrutiny and approval by the Health Board's Non-Pay Group – these are routinely reported by the NWSSP Deputy Head of Procurement. The two instances above have not been reported as they were completed by the Capital Equipping Team without engaging NWSSP Procurement Services. Declarations of interest had also not been completed where NWSSP Procurement Services had not been engaged.	Inconsistent engagement with NWSSP Procurement Services in procurement exercises potentially resulting in inappropriate procurement routes, non-compliant procurement activity and value for money not achieved.	**Agreed Action:** A workshop with NWSSP Procurement Services has been arranged for 14 September 2026 to review the capital equipping process. The agreed process will be reflected in the new formal operating procedures (see finding 2). NWSSP Procurement Services advise will be sought for all capital equipping procurement activity to ensure that procurement is compliant and value for money is achieved. **Expected Evidence of Implementation:** Capital equipping process document.
		High Priority	**Officer:** Eldeg Rosser, Head of Capital Planning **Target Implementation Date:** 30 October 2026
	Theme: Finance Management & Control	Control Operation	
2	**Operating Procedures** In the absence of formal operating procedures for the capital equipping process the team utilise the Capital Team Manual - an informal guidance document – although the requirements of this are not consistently complied with. The manual requires the establishment of Capital Equipping Forums and submission of monthly highlight reports to the Project Design Lead, and evidence of key stakeholder approval to proceed with purchases. Evidence of forums was available for only two of ten schemes reviewed, and we were advised that monthly highlight reports are not produced for any schemes. However, all schemes demonstrated ongoing engagement with stakeholders, and we were advised that the Capital Equipping Team feed into wider capital project group meetings.	Inconsistent procurement activity potentially resulting in inappropriate procurement routes, non-compliant procurement activity and value for money not achieved.	**Agreed Action:** Capital equipping processes and requirements will be determined, with appropriate input from NWSSP Procurement Services and documented in formal operating procedures. A workshop with NWSSP Procurement Services has been arranged for 14 September 2026 to review the capital equipping process.

	The manual also requires a signed approval sheet, or documented approval evidenced through signatures on quotations, to confirm authorisation to proceed with purchases by key stakeholders. No evidence was available for 11 of the 20 sampled purchases and there is lack of clarity regarding the circumstances where approval is required. The Health Board's *Standards of Behaviour Policy* assumes that procurement activity is undertaken through NWSSP Procurement Services and places responsibility on NWSSP for ensuring DOIs are completed. However, testing identified that not all procurement activity was routed through NWSSP Procurement Services, resulting in the DOI process not being applied.		
			Expected Evidence of Implementation: Capital equipping process document.
		High Priority	**Officer:** Eldeg Rosser, Head of Capital Planning **Target Implementation Date:** 30 October 2026
	Theme: Policies & Procedures	Control Design	

Appendix A

Assurance Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Unsatisfactory

Action is required to address the whole control framework in this area.

High impact on residual risk exposure until resolved.

Advisory

Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.

These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

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

Disclaimer

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

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Hywel Dda University Health Board, and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Hywel Dda University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the Institute of Internal Auditors (IIA's) professional standards and to the Global Internal Audit Standards in the UK Public sector through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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

5.4

10:45, 15 Mins

5.4 - Progress Update on Major Infrastructure Investment Programme Internal Audit

Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Rob Elliott (Hywel Dda UHB - Programme Director Major Infrastructure Projects)

For assurance

Attachments

5.4 Progress Update MIIP IA ARAC August 2026.pdf

5.4 Appendix 1 - MIIP Audit Update August 2026.pdf

Pwyllgor Archwilio a Sicrwydd Risg/ Audit and Risk Assurance Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	**13 AUGUST 2026**
TEITL YR ADRODDIAD: TITLE OF REPORT:	Progress Update on Major Infrastructure Investment Programme (MIIP) Internal Audit
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Lee Davies, Executive Director of Strategy and Planning
SWYDDOG ADRODD: REPORTING OFFICER:	Rob Elliott, Programme Director Major Infrastructure Projects

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 Major Infrastructure Investment Programme Internal Audit Report was presented to the Audit and Risk Assurance Committee (ARAC) meeting on 7 May 2026. An update report on the progress of actions from the Audit was requested to be presented to this ARAC meeting.

Cefndir / Background

The Audit was rated at a Reasonable Assurance level and contained 10 recommendations, noting the status of each.

Following consideration of the Audit findings, the Major Capital Projects team has worked closely with the Hywel Dda University Health Board (HDdUHB) Assurance and Risk team and NHS Wales Shared Services Partnership (NWSSP) Internal Audit team. This has provided assurance by independent validation that actions taken by the Major Capital Projects team fully satisfy the requirements of each recommendation.

In addition, we have worked closely with the Assurance and Risk and Internal Audit teams to specify completion dates for recommendations listed for future actions. These dates will be recorded in the Audit Management and Tracking (AMaT) system, so that assurance can be given that they are completed against timelines now set.

Asesiad / Assessment

At Appendix 1 to this report, a summary is attached from the AMaT system confirming the status of the 10 recommendations listed.

In summary, of the 10 recommendations:

- 6 have now been "*Fully Completed and Approved*"

- 4 are noted as *"In Progress"* as future actions, but now have specific dates set so that these recommendations can be tracked for Assurance. The dates now established have been agreed with the HDdUHB Assurance and Risk and NWSSP Internal Audit teams as appropriate to when these issues will need to be addressed in future stages of the Project.

Argymhelliad / Recommendation

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

- On the current status of completed recommendations
- That specific completion dates are now established for all future actions.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	Not Applicable
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	2. Timely 3. Effective
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	8. Fit for Purpose, Modern Facilities and Services
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	10. Not Applicable

Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Major Infrastructure Investment Programme Audit Report
Rhestr Termau: Glossary of Terms:	Within the body of text
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	None

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Capital requirements linked to Welsh Government funding
Ansawdd / Gofal Claf: Quality / Patient Care:	Infrastructure /environmental improvements
Gweithlu: Workforce:	Not Applicable
Tegwch Iechyd: Health Equity:	Not Applicable
Risg: Risk:	Infrastructure risks identified in HDdUHB operational team systems. Mitigation plans set out to manage these risks.
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

Update inspection - Internal Audit - Major Infrastructure Investment Programme Final Internal Audit Report 2025/26 (Reasonable) - Actions

Reference	Action	Site	Service	Responsibility	Date raised	Due date	Approval board	Progress status	Manage
Internal Audit/2026/790/MD1/1	MD A Programme Execution Plan is now in place, reviewed at Project Group level and signed off by the Executive Director (SRO).	No Site Specific	Strategy & Planning	Mr Rob Elliott	01/05/2026	30/06/2026	N/A	**Fully complete (Approved)**	Manage
Internal Audit/2026/790/MD2/1	MD • Actioned since fieldwork - the ToR has been reviewed and updated, with the comments received from Internal Audit reflected in the updated version. • Members will be reminded of the importance of regular attendance and ongoing attendance monitored. • Meetings will be recorded, ensuring a record is maintained where support staff are not available to take minutes during the meeting.	No Site Specific	Strategy & Planning	Mr Rob Elliott	01/05/2026	30/06/2026	N/A	**Fully complete (Approved)**	Manage
Internal Audit/2026/790/MD3/1	MD Agreed Action: With the external Project Manager now in post (Feb 2026), this will support more detailed reporting against the areas highlighted by Internal Audit, including risks and programme status. The Progress Report template will be fully populated for each Programme Group meeting to ensure information is fully conveyed.	No Site Specific	Strategy & Planning	Mr Rob Elliott	01/05/2026	30/06/2026	N/A	**Fully complete (Approved)**	Manage

Internal Audit/2026/790/MD4/1	MD	As above, the recently appointed (Feb 2026) external Project Manager will support the project in developing project management tools, including a risk register and detailed programme for BJC1 development. These tools will be used to inform the Progress Report to Programme Board and elsewhere.	No Site Specific	Strategy & Planning	Mr Rob Elliott	01/05/2026	30/06/2026	N/A	**Fully complete (Approved)**	Manage
Internal Audit/2026/790/MD5/1	MD	We confirm that evidence of insurances was included within the tender documents. We will ensure at future procurements that evidence of insurances is documented within the tender evaluation. We will ensure that these are updated each year for the duration of the appointment. We will ensure that signed copies are held for all key approval documents.	Trust wide	Trust wide	Mr Rob Elliott	02/07/2026	31/01/2027	N/A	**In progress**	Manage

Internal Audit/2026/790/MD6/1	MD	We have issued JCT Consultancy contracts to all advisers and a number have already been signed and returned. We will pursue the outstanding contracts to ensure this is resolved as soon as possible	Trust wide	Trust wide	Mr Rob Elliott	02/07/2026	30/06/2026	N/A	**Fully complete (Approved)**	Manage
Internal Audit/2026/790/MD7/1	MD	A decision has been made to maintain the intended JCT Consultancy contract approach for the work being undertaken to develop BJC1. Further consideration will be given to switching to NEC Professional Services Contracts, thereafter, should this be determined to better align with the works-contracting approach.Appropriate advice will be obtained to inform the decision.Any potential cost impacts (to the advisers quoted fees) will be appropriately considered and reported.	Trust wide	Trust wide	Mr Rob Elliott	02/07/2026	31/12/2026	N/A	**In progress**	Manage

Internal Audit/2026/790/MD8/1	MD	With formal contracts in place, any future contractual changes will be managed via the appropriate contractual route. Cost information reported to Programme Group will be checked for accuracy and updated if required.	Trust wide	Trust wide	Mr Rob Elliott	02/07/2026	31/12/2026	N/A	**In progress**	Manage
Internal Audit/2026/790/MD9/1	MD	We will review the intended KPI approach as outlined in the tender specification and determine an appropriate level of application for the current stage.	Trust wide	Trust wide	Mr Rob Elliott	02/07/2026	31/12/2026	N/A	**In progress**	Manage
Internal Audit/2026/790/MD10/1	MD	We will require advisers to provide more detailed information about activities completed, and this will be reviewed against the defined cash flow for the lump-sum appointment before payments are made.	Trust wide	Trust wide	Mr Rob Elliott	02/07/2026	31/07/2026	N/A	**Fully complete (Approved)**	Manage

5.5 **11:00, 10 Mins**

5.5 - BREAK

5.6

11:10, 15 Mins

5.6 - Progress Update on Human Tissue Authority Internal Audit

James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science), Jonathan Arthur (Hywel Dda UHB - Deputy Director of Health Sciences), Craig Baker (Hywel Dda UHB - Cellular Pathology Service Manager)

For assurance

Attachments

5.6 Progress Update HTA IA ARAC August 2026.pdf

Pwyllgor Archwilio a Sicrwydd Risg/ Audit and Risk Assurance Committee

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	**13 AUGUST 2026**
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Progress Update on Human Tissue Authority Internal Audit
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	James Severs, Executive Director of Allied Health Professions and Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	Craig Baker, Cellular Pathology and Mortuary Service Delivery 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

An internal audit of Human Tissue Authority (HTA) governance, compliance and operational arrangements within the Health Board's licensed mortuary facility was undertaken between August and September 2025, as part of the Internal Audit Programme.

The audit focused on compliance with HTA standards, governance arrangements, documentation, security, consent processes and operational controls within the licensed service.

The audit findings and recommendations have been reported through the appropriate governance structures and oversight has been maintained via the HTA Assurance Group.

Cefndir / Background

The audit was commissioned to provide independent assurance regarding compliance with the Human Tissue Act 2004 and associated HTA licensing requirements.

Following receipt of the finalised audit report in September 2025, a comprehensive gap analysis was undertaken and an improvement action plan developed to address identified findings.

The action plan was monitored through the HTA Operational and HTA Assurance Groups.

Asesiad / Assessment

Internal Audit concluded their review in September 2025 and presented their final report at the Audit and Risk Assurance Committee (ARAC) meeting in October 2025.

An action plan was developed to address the audit findings and recommendations, with oversight provided through the HTA Operational and HTA Assurance Groups in an effort to strengthen existing processes and procedures where improvement opportunities had been identified. Subsequently:

- All audit findings and recommendations were actioned and implemented by the Mortuary team on 12 December 2025.
- Evidence demonstrating completion was uploaded onto the Audit Management and Tracking (AMaT) system.
- Assurance monitoring was undertaken through the established HTA governance groups.
- All actions and recommendations have been completed in relation to the internal HTA audit.
- A follow-up review was undertaken on 5 February 2026 and confirmed that all actions had been implemented (Appendix 1), and no further action tracking was required.
- The follow up report was released on 2 April 2026 and presented to ARAC on 14 April 2026
- Internal Audit formally closed the audit on 19 June 2026.

The audit process has contributed to strengthening the Health Board's assurance arrangements relating to HTA compliance and has supported continued regulatory readiness across licensed activities.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to **TAKE ASSURANCE** that all internal audit recommendations and findings have been actioned and fully implemented within the defined timelines, resulting in the audit being formally closed.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.1 The Committee shall review the adequacy of the Health Board'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, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality	7. All apply

Quality and Engagement Act (sharepoint.com)	
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Striving teams 3. Great care 4. Positive futures 2. Healthier communities
Nodau Cynllunio 2026/27 Planning Goals 2026/27	1. Healthy, Thriving Teams 2. Customer Service Excellence 6. Safe, Timely, High Quality Care 7. Future Orientated 8. Fit for Purpose, Modern Facilities and Services
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	3. Create people-centred employment and development opportunities that support workforce transformation, reflect the changing needs of
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	7. All Apply
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	HTA Regulations
Rhestr Termau: Glossary of Terms:	HTA – Human Tissue Authority AMaT - Audit Management and Tracking system. ARAC - Audit and Risk Assurance Committee
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	HTA Operational Group HTA Assurance Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	Positive: Compliance with HTA regulations mitigates the potential risk of receiving a financial penalty for non-compliance following a HTA Inspection.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Positive: Continued compliance with the HTA regulations, demonstrates that the service is meeting the required standards and expectations to deliver the most effective and dignified care to our deceased patients.
Gweithlu: **Workforce:**	Positive: Compliance with the HTA regulations provides the workforce with a service that is operationally complaint with HTA regulations and standards.
Tegwch Iechyd: **Health Equity:**	Neutral: No service change is being deployed and therefore no potential impacts on health equity.
Risg: **Risk:**	Positive: Compliance with HTA regulations and standards minimises the risk of an adverse event occurring within the service. No risk on the risk register regarding HTA compliance.
Cyfreithiol: **Legal:**	Positive: Compliance with the HTA regulations provides the organisation minimal risk of legal impact as the services is fully complaint with HTA regulations and standards.
Enw Da: **Reputational:**	Positive: Compliance with the HTA regulations provides the organisation assurance that there is a minimal risk of reputational damage due to the services being compliant with the HTA standards and regulations.
Gyfrinachedd: **Privacy:**	Positive: Compliance with the HTA regulations reduces the potential impact on individual's privacy rights or confidentiality and/or the potential for an information security risk due to the way in which information is being used.
Cydraddoldeb: **Equality:**	Neutral: No service change is being deployed and therefore no protected personal characteristics will be impacted.

6

11:25, 0 Mins

6 - Assurance and Risk

6.1

11:25, 20 Mins

6.1 - Scrutiny of Outstanding Improvement Plans - Update on Status of Risks and Audits: Community and Integrated Medicine

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Peter Skitt (Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine), Anna Chiffi (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality)

For assurance

Attachments

6.1 CIM CCG - Update on Status of Risks and Audits ARAC August 2026.pdf

Pwyllgor Archwilio a Sicrwydd Risg/ Audit and Risk Assurance Committee

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	**13 AUGUST 2026**
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Community and Integrated Medicine: Scrutiny of Outstanding Improvement Plans - Update on Status of Risks and Audits
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Peter Skitt, Clinical Care Group Service Director Anna Chiffi, Assistant Director of Nursing, Patient Safety, Quality

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 assessment of the effectiveness of governance arrangements within the Community and Integrated Medicine (CIM) Clinical Care Group in relation to:

- External audit and inspection recommendations
- Management responses and improvement plans
- Risk register management
- Delivery of mitigating actions
- Governance oversight arrangements

Cefndir / Background

The Community and Integrated Medicine Clinical Care Group (CCG) was established on 1 April 2025 and was assessed as being at escalation Level 2 for Governance until it was escalated to Level 3 in August 2025, at which level it has remained. The principal reasons for the increased escalation level in this domain were:

- Number of overdue inspection plans and recommendations
- Delay in preparing management responses to the above
- Number of overdue risks and actions

CIM CCG delivers against a significant number of national priority areas, which have been the subject of a number of audits/inspections. This has seen an increasing number of resultant reports and recommendations allocated to the CCG for action.

Since its formation, the CCG has seen an increase in the both the number of inspections/audits and the resulting recommendations, including recommendations relating to revisits and follow-up inspections. There have also been multiple reviews of the same service areas by different inspection bodies and duplication of recommendations has arisen as a result. It is also highly likely that many of these matters already exist as risks on the CCG's risk register.

As reported to this Committee, CIM CCG staff have spent dedicated time with the Assurance and Risk team and Internal Audit team reviewing risks and the Audit Management and Tracking (AMaT) position at a system level. This has helped ensure greater alignment between audit findings, improvement plans and risk management arrangements. As part of this work, we have confirmed that Risk 1027 remains the overarching corporate risk, providing oversight across the associated service and directorate risks. Arrangements have been put in place for the CIM CCG Assurance and Risk Business Partner to support the CCG, the first such meeting took place in in June 2026, with regular future follow-up meetings scheduled. This process supports the closure of recommendations and actions to enable closure, which will ensure that the systems are updated and provide an accurate position for the CCG.

Alongside the direct action, the appointment to the System General Managers and Heads of Nursing under OCP1, has enabled the implementation of robust governance assurance processes:

1) Monthly System level performance and quality meetings with 3A reports being presented to:
2) Monthly CCG Integrated Performance and Quality meetings.

The monthly meeting is an important point of grip and control within the directorate, ensuring that delivery against existing actions and recommendations is on track and that there is an appropriate level of check and challenge of new reports and recommendations; to ensure that they are clear and (where possible) consolidated within existing workstreams, to reduce duplication and promote delivery.

The Health Board is currently in the second phase of its Operational Organisation Change Process (OCP2), which sets out a considerable revision of the CCG's structure. This proposal sets out both service/specialty clinical and administration management arrangements, together with a formalised a business support function as a keystone to delivery of the CCG's planning, audit, education and governance responsibilities.

Although service/cluster/locality level arrangements are still evolving as OCP2 progresses, the System Triumvirates are ensuring governance matters are identified to lead nurses and managers as part of 'business as usual', with the development of data driven dashboards to identify and address areas for improvement. This grip will strengthen as OCP2 progresses over the next 3-4 months.

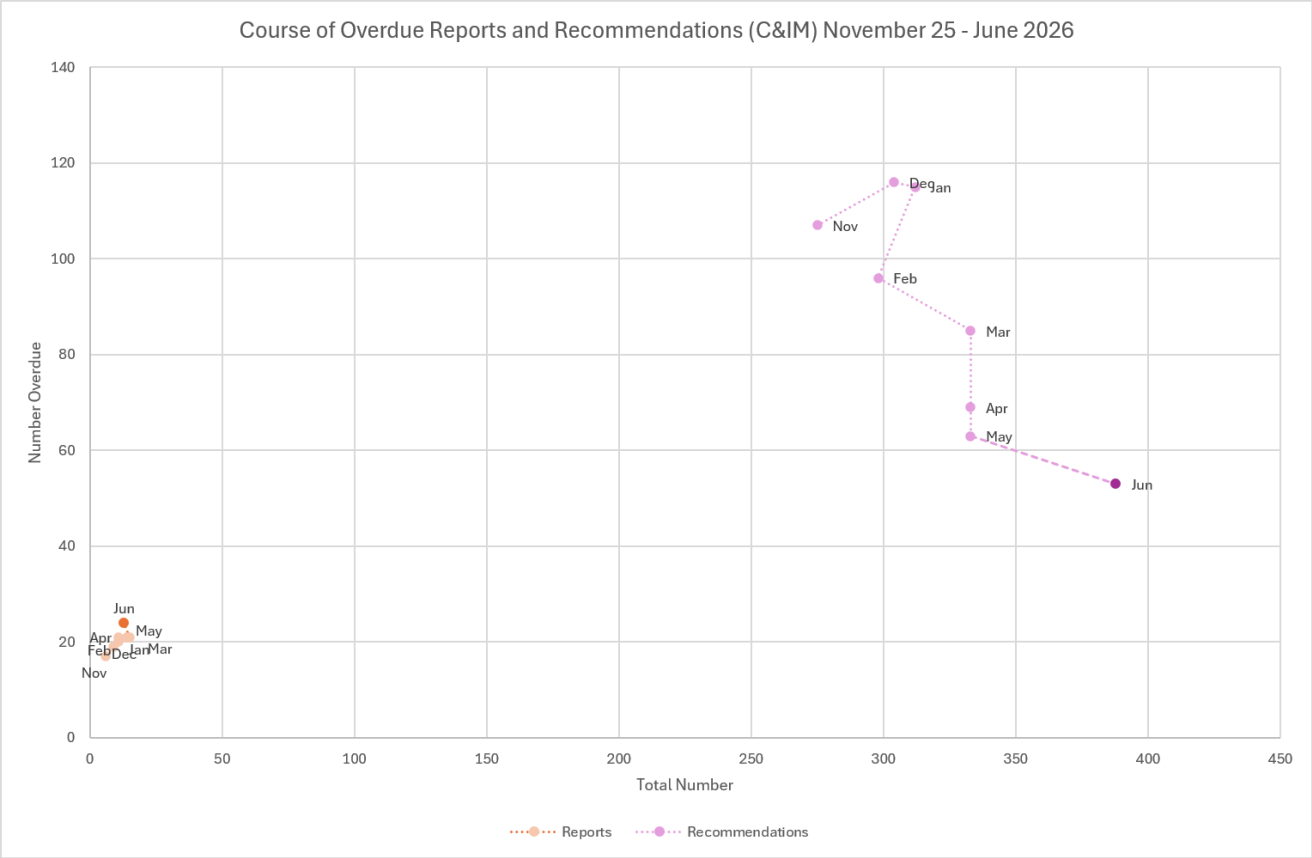
Asesiad / Assessment

External Audit and Inspection Reports and Recommendations

As illustrated below, whilst the overall number of reports shown as overdue has increased, the total number of recommendations classified as overdue has demonstrated consistent improvement since December 2025, despite the total number of recommendations increasing by almost 50%. Within the current monitoring system (AMaT) a report cannot be closed until all recommendations relating to it are complete and there is no way of this being clearly identified in the reporting mechanisms. There are some reports where recommendations are applicable across a number of CCGs/directorates and, where outstanding actions sit outside of the CIM

CCG, the closure of reports can be delayed even if all the recommendations assigned to the CCG have been completed.

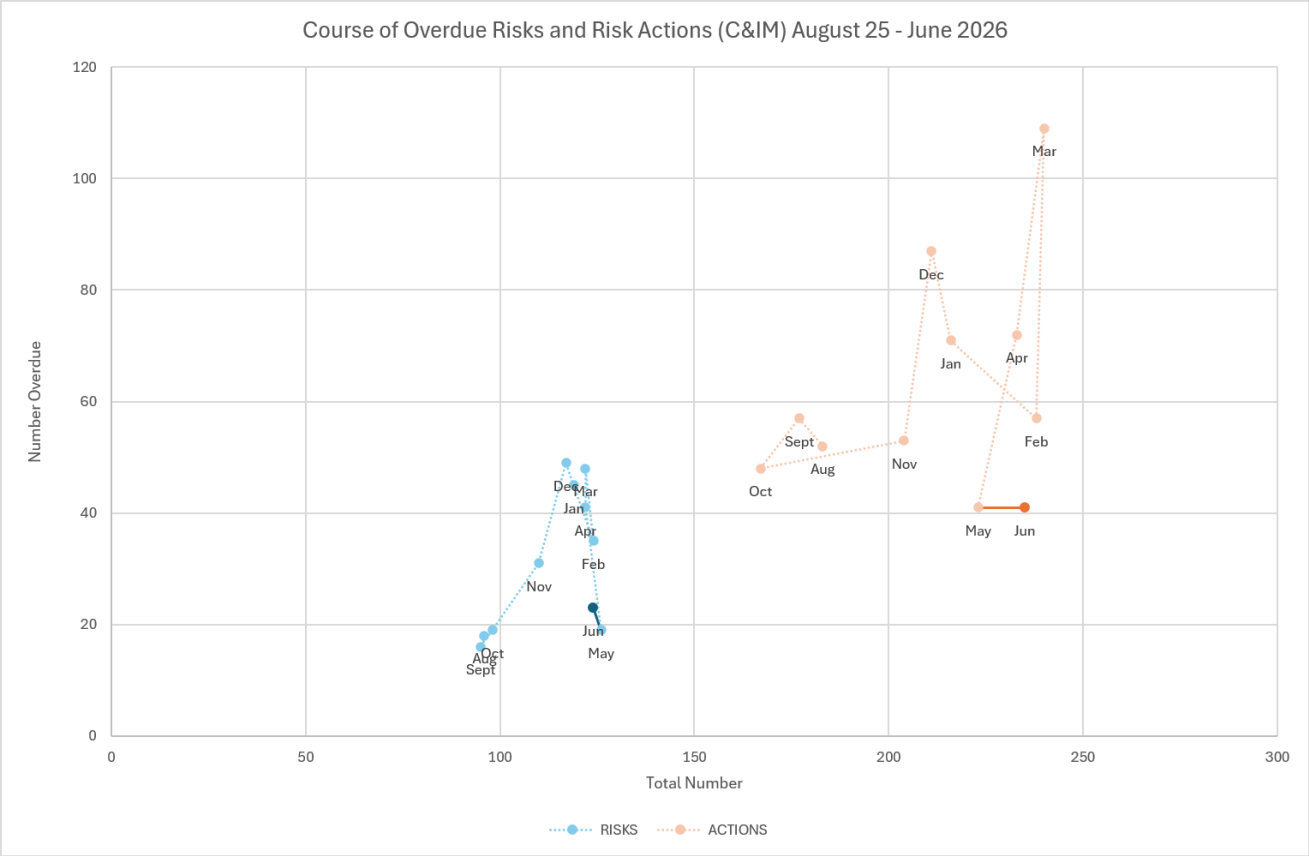
Of the total number of overdue recommendations at the end of June (53), 39 were overdue by more than 6 months.



Risks and Actions

Over the past year, the CCG has seen an increase in the number of risks identified and continues to ensure all risks are identified and managed within all service areas, hence the number of corresponding actions.

As shown below, the CCG has experienced two surges in overdue risks, one in December 2025 and one in March 20206; however, the actions of the CCG have addressed these areas and improved the overall position relating to overdue actions.



The CIM CCG has identified 12 risks rated at 20, the majority of which are also identified in the Audit and Inspection reports. Action to address these risks and recommendations is being taken forward by the CCG, primarily through the 6-Goals Programmes and the recently approved Urgent and Emergency Care business case (to deliver 7-day Same Day Emergency Care and 7-day clinical streaming hubs), which are fundamental to these risks being mitigated.

1992	Risk to patient safety due to insufficient medical staffing to volume of medical patients severe & inpatient acuity.
1943	Risk of harm to patients and staff due to the fragility of the Bladder and Bowel service.
2378	Risk of being unable to consistently deliver safe, sustainable and timely ED services across all hospital sites.
2396	Risk to patients waiting for pacemaker procedure due to the implant procedure capacity not meeting the Health Board demand
750	Risk of delays at Emergency Department due to lack of substantive middle grade doctors
1027	Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity
1115	Risk of increased time in ED due to lack of inpatient beds, GGH.
2113	Risk of patient harm in Emergency department WGH due to demand exceeding capacity,
2141	Risk of harm to patients, staff and public due to insufficient physical security measures in place BGH
2156	Risk of patient harm within the bone health service due to lack of clinical capacity across the Hywel dda University HB
2264	Risk to patient safety, quality & experience due inconsistent delivery of urgent and emergency care due to system fragility
2350	Risk of avoidable patient harm due to delayed analysis and reporting of ambulatory cardiac monitoring

A significant number of risks and actions identified within the CCG require additional resources, workforce capacity and broader system transformation, including that being delivered through programmes such as Community by Design (CbD) and Integrated Urgent and Emergency Care (IUEC), to achieve sustainable mitigation.

Whilst financial investment remains an important enabler, funding alone will not resolve many of the underlying challenges. The successful reduction of a number of the CCG's highest-rated risks is dependent upon the availability of appropriately skilled staff, the delivery of sustainable service models, and the resolution of system-wide capacity constraints across the Health Board.

Consideration should, therefore, be given to the extent to which these risks can be mitigated locally by the CCG and whether continued corporate ownership is required until the necessary strategic, workforce and service transformation programmes have been delivered.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to **TAKE ASSURANCE** from the progress made in strengthening governance arrangements within the Community and Integrated Medicine Clinical Care Group and **NOTE** the continuing risks associated with overdue recommendations, high-rated risks and resource-dependent mitigating actions.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	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, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	As indicated
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 3. Effective
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	1. Leadership 4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	5. People First, Digital Always

Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	10. Not Applicable
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Contained within the body of the report
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Not applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impact.
Ansawdd / Gofal Claf: Quality / Patient Care:	Report describes improvements to the CCG's governance arrangements, which will impact upon management of patient safety.
Gweithlu: Workforce:	No direct impact
Tegwch Iechyd: Health Equity:	No direct impact
Risg: Risk:	Report describes improvements to the CCG's governance arrangements, which will impact upon management of risks.
Cyfreithiol: Legal:	No direct impact
Enw Da: Reputational:	No direct impact
Gyfrinachedd: Privacy:	No direct impact
Cydraddoldeb: Equality:	No direct impact

6.2

11:45, 10 Mins

6.2 - Risk Assurance Report

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

For assurance

Attachments

6.2 Risk Assurance Report ARAC August 2026.pdf

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Risk Assurance Report

Audit and Risk Assurance Committee

18 August 2026

Situation and Background

The report aims 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. This is in line with the requirements as noted in the Committee's Terms of Reference which state:

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.

The report aims to provide assurance by outlining the risk management activity that has taken place since the previous report presented to ARAC in December 2025 on the effectiveness of the Risk Management Framework, and the implementation of the Risk Management Strategy. The revised Risk Management Framework and Risk Management Strategy were approved by the Board in September 2025.

New risk management objectives for the next 12 months, which are aimed to further embed risk management and improve our risk maturity, are outlined in the report.

This report also 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.

Progress Since the Previous Report to ARAC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

A summary is provided below of the progress made against the next steps which were identified in the previous Risk Assurance report provided to ARAC in April 2026:

Next Steps	Progress Made
To continue to work towards achieving our objectives over the next 12 months following the approval of the Risk Management Strategy (the Strategy), including identifying a suitable risk management system ahead of 30 November 2027	Progress against the current **Risk Management Strategy** is reported within this paper. Historically, the Health Board's risk management objectives have been set out within a standalone Risk Management Strategy and agreed on an annual basis. Following discussions with Audit Wales, a separate Risk Management Strategy will not be developed for 2026/27. Instead, risk management objectives for the period to September 2027 will be agreed by the Executive Team and reported to the Board through the Chief Executive's Report, removing the need for a standalone strategy document. Progress against these objectives will continue to be monitored through the Risk Assurance Report and reported to the Audit and Risk Assurance Committee three times per year
To review the outcomes of the Risk Maturity Assessment which will inform the revised Risk Management Strategy and supporting implementation plan. Focus will be on those areas that have returned the lowest level of maturity. The revised Risk Management Strategy is due to be presented to ARAC in August 2026.	Outcomes of the assessment as presented to ARAC in April 2026 have been considered when developing risk management objectives for the next 12 months, however, the priority next year will be to procure and implement a new risk management system.

Risk Management Framework

Risk Management Framework (the Framework)
Risk Management is the process which 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 Health Board's Framework is currently made up of the **risk architecture**, **strategy** and **protocols** (RASP), sets out the roles and responsibilities of individuals and committees, and wraps around the Health Board's risk management process. The Framework provides the mandate for embedding risk reporting in the Health Board, and includes the process for the escalation of risk, and acceptance of risks which exceed the Health Board's risk appetite.

The Framework was refreshed during Q2 of 2025/26, endorsed by ARAC in August 2025 ahead of approval by Board at its meeting in September 2025, and details the process for the escalation of risks and their acceptance when they exceed the Health Board's risk appetite.

Risk Management Strategy 2025/26

The **Health Board's current Risk Management Strategy** (the 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.

The Strategy, approved by Board in September 2025, set out the Health Board's risk management policy statement and objectives in respect of strengthening risk management for the period up to September 2026. The Strategy needs to be read in conjunction with the Risk Management Framework, also approved by the Board in September 2025.

Progress made on these objectives are included on slides 6-9.

Progress Update on the Implementation of the Risk Management Strategy 2025/26

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Objective 1 - Support operational risk management arrangements to ensure consistent approach to the ownership and oversight of risks	Progress Update
Supporting Functions via local quality and performance governance meetings and Executive Improving Together sessions to identify, assess and manage risks and improve outcomes	**Complete** – Assurance and Risk Officers **continue to regularly produce assurance and risk reports** and attend local governance meetings of CCGs/Executive Functions, provide training and support, and undertake monthly analysis of key risk metrics as part of Executive Improving Together Framework.
Providing practical support to services with operational risk management arrangements via partnering arrangements to ensure risk management outcomes inform and prioritise organisational decision making	**Complete** - Dedicated meetings with risk leads continue to be held as required to support services identifying and articulating risks. Escalation of key risks discussed at local governance meetings, with appropriate support and challenge provided by Assurance and Risk Officers in attendance. Monthly analysis undertaken of key risk metrics as part of Executive Improving Together sessions identified areas who may require additional support. Following the submission of the Annual Plan 2026/27, the Assurance and Risk Team will schedule risk workshops with leads from Clinical Care Groups and Executive Functions to refresh risk registers during Q2 and Q3 of 2026/27.
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	**Complete** - Training Needs Analysis (TNA) form has been included within the revised Risk Management Framework for use at local inductions, and available on the Assurance and Risk Sharepoint site. The Head of Assurance and Risk met with colleagues in Learning and Development in July 2026, identifying available routes to advertise and encourage the utilisation of the TNA at local inductions. Relevant on-boarding and training materials have been updated. The Assurance and Risk Team continue to deliver the Risk Management New Managers Training Package as part of the Health Board-wide managers training programme. This highlights the importance of identifying the risk management training needs of staff and further inform development of training materials based on feedback received.
Further develop risk management training materials to ensure alignment with the Health Board's objectives following the Strategy Refresh	**Complete** - The Strategy Refresh was presented to Board in January 2026 for approval, and training materials have been updated accordingly.

Progress Update on the Implementation of the Risk Management Strategy 2025/26

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Objective 1 - Support operational risk management arrangements to ensure consistent approach to the ownership and oversight of risks	Progress Update
Developing a communications plan in order to further promote awareness of risk management arrangements	**Complete** - A documented communications plan has been developed, which: • links with key business processes such as Annual Planning; • Promotes the revised Risk Management Strategy; • Advertises risk management training; • Promotes completion of Risk Maturity Assessment for 2027; • Details timescales and requirements for the new Risk Management System, due for implementation by November 2027; and • Updates the organisation on the Principal and Corporate risks in line with Board reporting. The communications plan will be regularly reviewed and updated in line with developments such as the roll out of the new risk management system, and delivered using a range of communication tools including Viva Engage, the Assurance and Risk Sharepoint site and e-mail as appropriate.
Developing a detailed scope and procure a new risk register system	**In progress** - A specification document for a risk management system has been developed with Swansea Bay University Health Board as part of a regional procurement approach. A pre-market engagement exercise was undertaken in July 2026, with tender expected to be advertised in August 2026 and contract award in January 2027. This action will be carried forward as an objective for 2026/2027.

Progress Update on the Implementation of the Risk Management Strategy 2025/26

Objective 2 - Support the strengthening of operational risk management arrangements	Our plan to achieve the objective
Continue to implement the current risk appetite across the Health Board, ensuring that risks are aligned with the UHB's risk appetite	**In Progress** - The Assurance and Risk Team continue to deliver risk training on risk appetite as outlined in Objective 1. Support is provided functions to ensure escalation of risks which exceed risk appetite as per guidance in the Risk Management Framework. Feedback obtained via the risk maturity assessment has highlighted the need to further develop risk management training material on risk appetite to support its embedding across the organisation. This will be developed and communicated during Q2 of 2026/27, coinciding with the Board Assurance Framework refresh and the updating of risk registers based on the outcomes of the Annual Plan.
Reviewing the risk appetite following the Strategy Refresh	**Complete** - The risk appetite statements were reviewed by the Executive Team, with minor adjustments made, and are reflected in the risk training materials.
Reviewing and updating strategic risks and Board Assurance Framework as part of Strategy Refresh	**Complete** - A focussed session with the Executive Team was held in February 2026 to undertake a high-level review of the risk principal risks following the Strategy Refresh, approved by the Board in January 2026. The principal risks, as part of the refreshed Board Assurance Framework were presented to Board in July 2026, following which, regular reporting of principal risks to the Board and its Committees will resume.

Progress Update on the Implementation of the Risk Management Strategy 2025/26

Objective 3 - Improving the risk maturity of the UHB	Our plan to achieve the objective
Continued engagement with relevant teams across the Health Board 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	**Complete** – The Assurance and Risk Team promoted the completion of a feedback form in relation to the Health Board's risk management arrangements which informed the completion of the Risk Maturity Assessment in accordance with the Orange Book (a recognised risk management standard for the public sector). Responses highlighted that while some felt that risks are considered when setting and changing strategy and priorities, others expressed concerns that operational issues rather than true risks were being identified, leading to overcrowded registers, reduced clarity, and difficulties in prioritising risks. Observations also included the need to identify dependencies across risks and other areas within the Health Board to support and enhance planning processes. The feedback form has been reviewed and updated, taking in to account the outcomes of this years' Risk Maturity Assessment so that progress and further areas of improvement can be identified. This will be shared with staff during Q3 of 2027.
Further development of risk management training material, with more focus on the identification of opportunities	**Complete**- The Assurance and Risk Team continue to deliver and develop risk training including communication, as outlined in Objective 1. Material continues to be developed to provide support on the identification and articulation of opportunity risks.
Engaging with service leads across the Health Board 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	**Complete** – feedback obtained from a focussed workshop held with the Executive Team in February 2026 and from leads across the organisation via a feedback form on risk management arrangements for this years' risk maturity assessment. The feedback form has been reviewed and updated, taking in to account the outcomes of this years' Risk Maturity Assessment so that progress and further areas of improvement can be identified, with the form to include questions with more focus on the interdependencies of link to encourage a more system-wide and holistic view of risks.
Develop guidance for appropriate risk management arrangements with key partners of the Health Board to support its ability to achieve organisational objectives	**In Progress** - On review of the principal risks in February 2026, along with feedback obtained via the risk maturity assessment, it is acknowledged that further work is required to strengthen risk management arrangements with key partners, however this will be progressed following the implementation of the new risk management system subject to capacity and organisational priorities.

Risk Management Objectives 2026/27

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Historically, the Health Board's risk management objectives have been set out in a standalone Risk Management Strategy, and approved annually by the Board.

To streamline governance arrangements, future risk management objectives (the Objectives) will be approved by the Executive Team and reported to Board via the Chief Executive's Report, removing the need for a separate strategy document. This approach has been discussed with Audit Wales.

The Objectives for the period to September 2027 have been informed by the outcomes of the risk maturity assessment undertaken in December 2025 in line with the Orange Book (a recognised risk management standard for the public sector). The objectives and underpinning actions are outlined on slides 11-14. Progress against the objectives will be report to the Audit and Risk Assurance Committee at alternating meetings via the Risk Assurance Report.

The Objectives aim to:

1. **Improve decision-making**
   Use risk management as a tool to inform better, evidence-based decisions.
2. **Drive continuous improvement**
   Identify risks and opportunities to improve services and processes.
3. **Link to planning and performance**
   Embed risk management in organisational planning, performance reporting and learning.
4. **Foster a blame-free, open culture**
   Promote openness, learning and constructive challenge in a supportive culture.
5. **Adopt a dynamic and systematic approach**
   Use a structured, flexible and responsive approach to manage risk in a changing environment.
6. **Identify, assess and manage risks promptly**
   Ensure risks to strategic objectives and day-to-day operations are identified, assessed and managed.

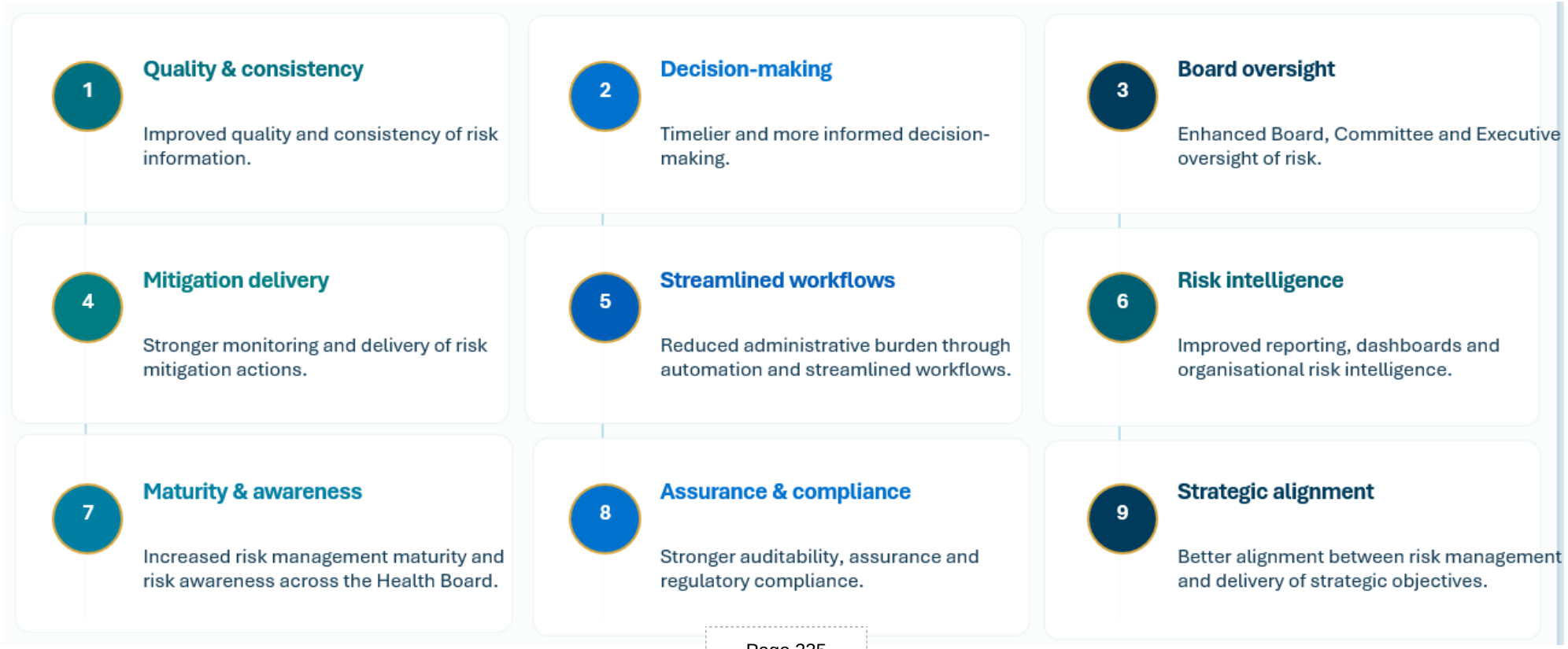
Objective 1 – Implementation of a new risk management system by 30 November 2027

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Why are we doing this?:

To ensure the availability of a robust risk management system across the Health Board once current contract with Datix ends in November 2027. This will address the needs of the Health Board including supporting decision making, the achievement of organisational objectives, embedding good governance and continuous improvement.

Expected Outcomes:



Objective 1 – Implementation of a new risk management system by 30 November 2027

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

How will we do this?

Actions to achieve objective	By when	By who	Outcome measures
Finalise a detailed scope for the procurement of a new risk register system	31/08/2026	Assistant Director of Assurance and Risk / Head of Assurance and Risk	Agreed joint specification document with Swansea Bay UHB
Publish tender notice for minimum of 2 months	30/09/2026	Procurement	Tender Responses
Evaluation of tender submission with stakeholders against system specification (Scheduled for 5 and 6 November 2026)	30/11/2026	Assistant Director of Assurance and Risk / Head of Assurance and Risk	Preferred Supplier for new system
Develop a project plan, ensuring key milestones in place to facilitate full roll out and the de-commissioning of Datix by November 2027	31/12/2026	Head of Assurance and Risk	Project Plan
Develop a communications plan to inform the organisation of key milestones, including any system downtime and testing	31/12/2026	Head of Assurance and Risk	Communications Plan
Award/sign off Contract with successful supplier 5 years and 6 months to account for the implementation period with an option to extend for a further 5 years	31/01/2027	Assistant Director of Assurance and Risk / Head of Assurance and Risk	Agreed contract in place
Implementation of new risk management system	30/11/2027	Assistant Director of Assurance and Risk / Head of Assurance and Risk	New risk management system in use and fully operational

Objective 2 – Risk maturity, culture and operational risk management

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Why are we doing this?:

To strengthen local ownership of risk, improve consistency of risk management practice, and support the successful embedding of new ways of working across the Health Board, which will support the improvement of the organisation's risk culture, risk maturity and operational risk management, and the embedding of risk management into organisational-wide processes. This will address the needs of the Health Board including supporting decision making, supporting the achievement of organisational objectives, embedding good governance, and continuous improvement.

Expected Outcomes:

1. **Escalation Levels**
   Improved escalation levels awarded to Functions relating to risk management arrangements
2. **Consistency**
   Greater consistency in the application of risk management arrangements across Functions
3. **Oversight & Assurance**
   Enhanced oversight and assurance of risks to the delivery of the Annual Plan and strategic objectives.
4. **Risk Ownership & Quality**
   Stronger ownership and improved articulation and management of risks leading to better quality risk information to support operational and strategic decision-making and to support the annual planning process
5. **Risk Alignment**
   Improved alignment between operational, corporate and principal risks.
6. **Risk Culture**
   Stronger risk culture
7. **Maturity Assessment**
   Improvement in risk maturity assessment outcomes
8. **Organisational Resilience**
   Increased organisational resilience through proactive management of emerging risks.
9. **Ways of Working**
   Increased assurance that new Ways of Working are implemented safely, sustainably and effectively
10. **Risk Appetite**
    Embedding of risk appetite across the organisation

Objective 2 – Risk maturity, culture and operational risk management

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

How will we do this?

Actions to achieve objective	By when	By who	Outcome measures
Complete Risk Maturity Assessment	31/12/2026	Assurance and Risk Team	Feedback forms / presentation of findings to ARAC February 2027
Update guidance on escalation of risks to be tolerated, reflecting revised governance arrangements	31/12/2026	Assurance and Risk Team	Clear guidance and materials on escalation of risks to be tolerated
Update training materials to reflect revised risk appetite statements and the identification of opportunities	31/12/2026	Assurance and Risk Team	Updated training material and SOPs
Provision of technical risk support to operational leads ensuring that risks are appropriately articulated and considered as part of the annual planning process for 2027/28 to ensure risk management outcomes inform and prioritise organisational decision making.	31/03/2027	Assurance and Risk Team	Annual Plan 2027/28 Risk Workshops with functions
Providing practical support to services with operational risk management arrangements via partnering arrangements: * training sessions * provision of reports to governance meetings * one-to-one support with risk leads	31/09/2027	Assurance and Risk Team	Improvement in key metrics such as timely risk reviews / improvement in completion of risk actions

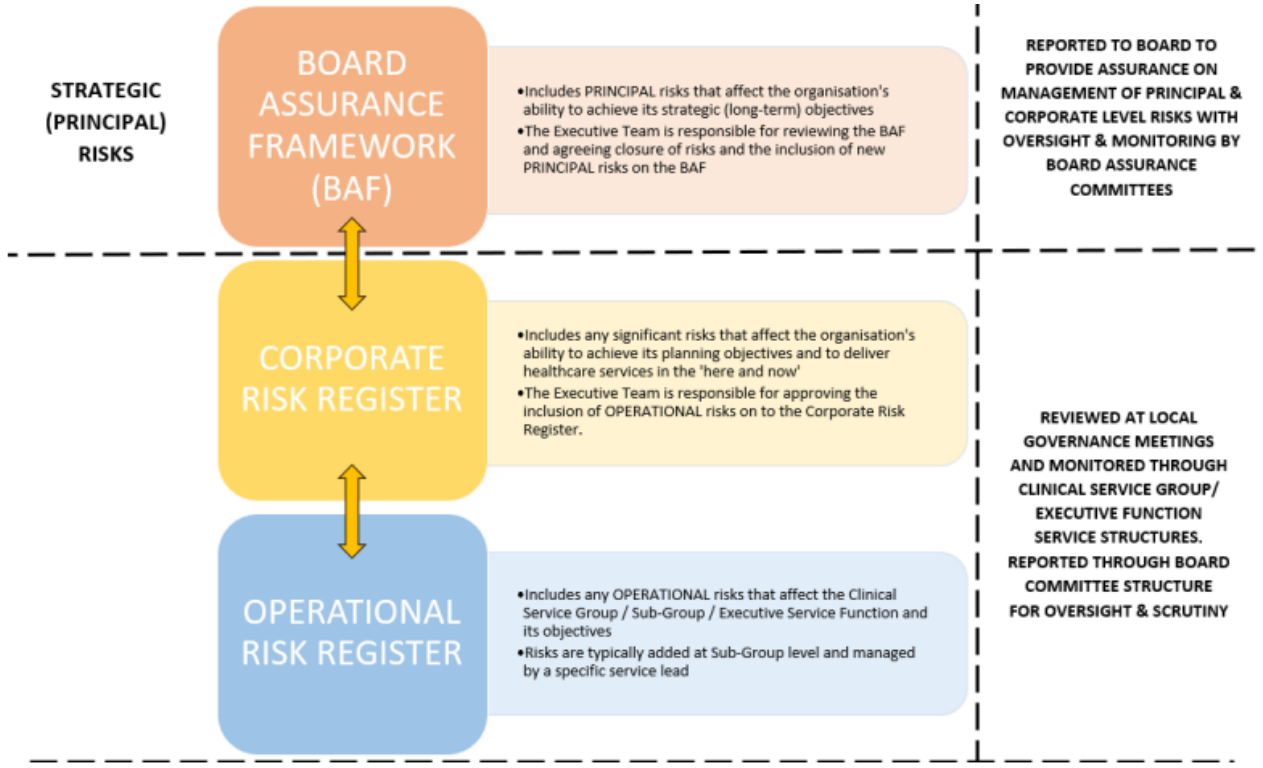
Risk Management Process

Risk Management Process

The Health Board's risk management process is recorded via the Datix Risk Register Module (Datix), with risk register reports provided to both assurance and operational management meetings. Datix enables risks to be recorded at one of three risk levels, ensuring that risks are reported to and scrutinised at the most suitable forums:

- **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 goals, to deliver healthcare services in the 'here and now' and compliance with legislations/Standards
- **Operational** – Risks that affect the Function's abilities to achieve its objectives, delivery of healthcare services and compliance with legislation/standards.

Risk management processes are in place to ensure ownership by appropriate service leads in line with revised management hierarchies and support the effective oversight and escalation through updated operational and executive governance arrangements within Functions.



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. These are detailed in the Risk Management Framework which was approved by Board in September 2025.

Organisational Context

As at 30 June 2026, the Health Board has **672 open risks** (**Feb 26: 679**) across principal, corporate and operational risk levels.

Risk exposure continues to be concentrated in a small number of Clinical Care Groups (CCGs) and Executive Functions, particularly **Estates and Facilities, Community and Integrated Medicine, Planned and Specialist Care** and **Operational Allied Health Professions and Health Sciences**. These risks are primarily driven by ageing estate and infrastructure, demand and capacity pressures, workforce and service fragility, financial constraints, equipment issues and digital limitations. These themes are reflected in the narrative across the first-line risk management slides within this report.

The risk register highlights the need for continued focus on risk review discipline, the delivery of mitigating actions, realistic target risk score dates, and active use of risk information to support decision-making, planning and assurance.

The following slides provide a more detailed analysis of the Health Board's risk registers per the three lines of defence model.

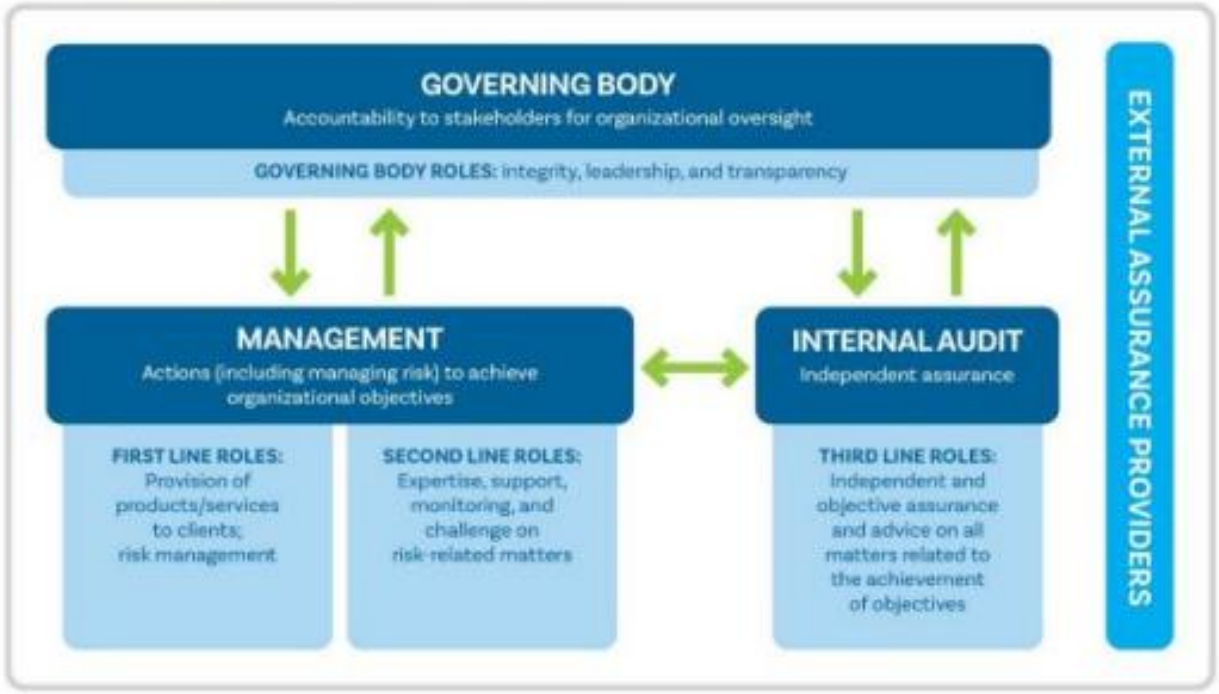
Three Lines of Defence

The Health Board operates within the widely accepted "Three Lines of Defence Model" which provides a simple and effective way to delegate and coordinate risk management roles and responsibilities within an organisation, to ensure the appropriate responsibility is allocated for the management, reporting and escalation of risk.

Operational Management (1st line)
First line are functions which own and manage risk, with operational staff responsible for maintaining internal controls such as processes, procedures and identifying risks, addressing as required. The first line also provides assurance that controls are in place and working.

Progress on the management of risks are discussed at the Clinical Service Groups' (CSG) Integrated Governance Group meetings for operational areas in the first instance, and then escalated if required to their CCG Integrated Governance Group meetings. For Executive Functions (EF), risks are discussed within the Executive Function Services' local management meetings, and escalated as appropriate to Senior Leadership Team meetings/relevant Lead Executive as appropriate. CCG and EF governance arrangements are considered when assessing the escalation status for Governance.

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

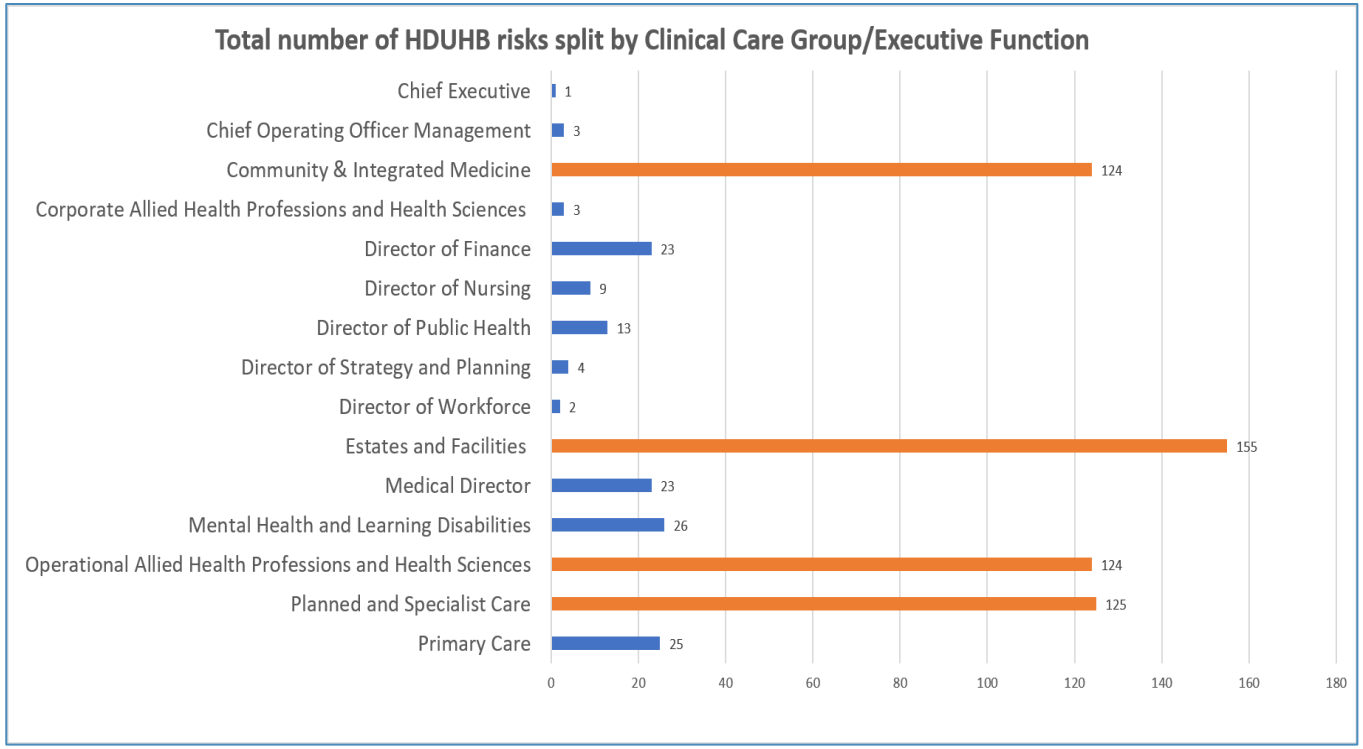


1st Line of Defence
Risks by Function– June 2026

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Estates and Facilities hold the largest number of risks at 155, **a 6% increase since the previous report** (February 2026: 146), primarily relating to the condition of the Health Board's ageing estate and infrastructure (including fire safety devices and equipment); with 65% of the risks reliant on capital funding to resolve. This is reflected in corporate risk 1745: *Risk of not being able to safely deliver services due to ageing estate and infrastructure across the Health Board* (June 2026: Current Risk Score - 15).

Community and Integrated Medicine hold 124 risks, (February 2026: 124) a reflection of the risks associated with operational challenges within unscheduled care and the fragility across the urgent and emergency care system related to workforce compromise and increasing levels of demand and acuity. This is reflected in the corporate risks 1027: *Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity* (June 2026: Current Risk Score - 20) and 2378: *Risk of being unable to consistently deliver safe, sustainable and timely ED services across all hospital sites* (June 2026: Current Risk Score - 20).



Planned & Specialist Care hold 125 risks, a **7% increase since the previous report** (February 2026: 117), reflecting the ongoing challenges associated with workforce shortages, service fragility, demand consistently exceeding capacity, reliance on ageing or inadequate equipment, and the continued lack of fully developed digital systems within the Clinical Care Group.

Operational Allied Health Professions & Health Sciences hold 124 risks, a **3% increase since the previous report** (February 2026: 120), with financial risks, service fragility, demand exceeding capacity, and infrastructure constraints cited as main drivers.

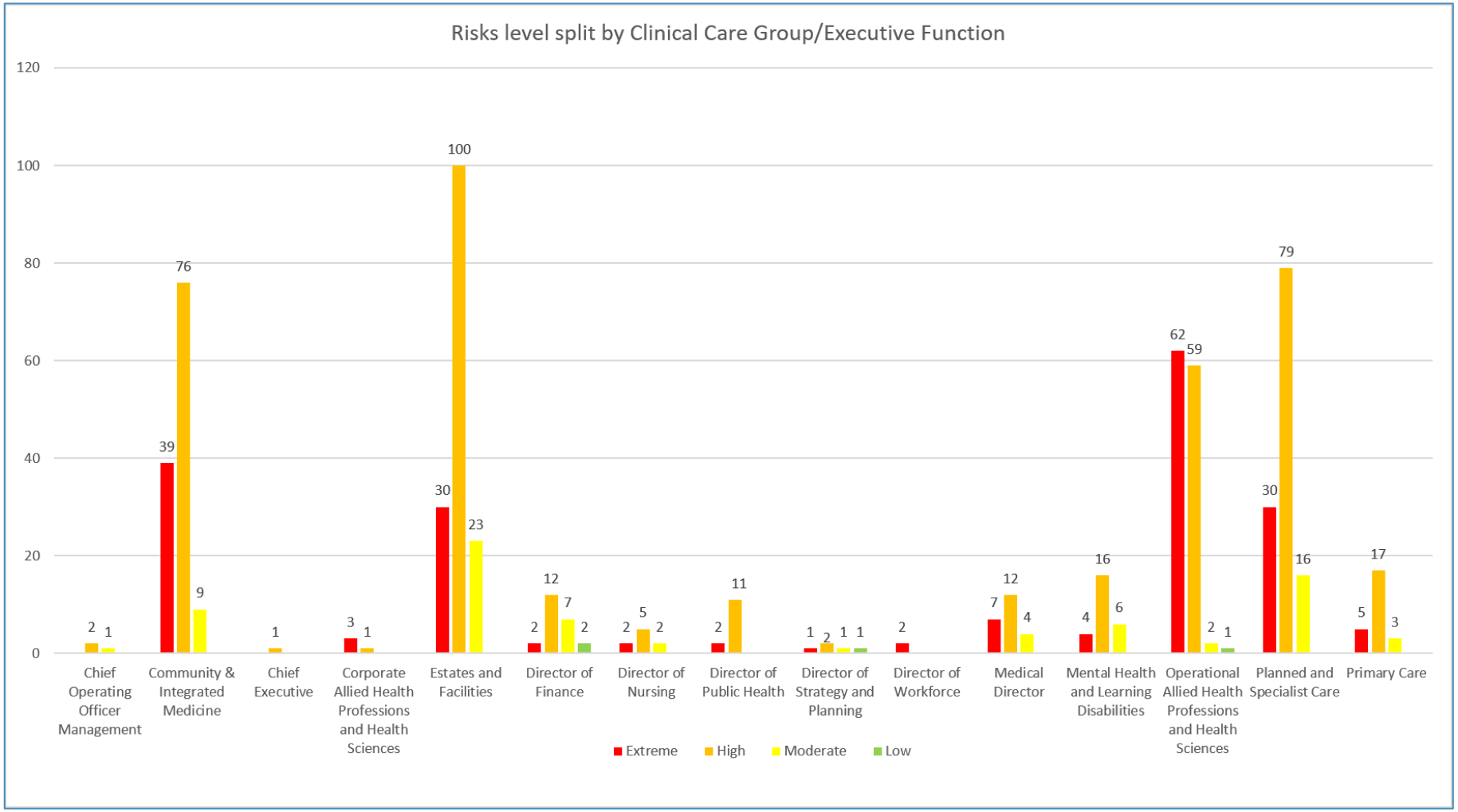
1st Line of Defence
Risk Management:
Level of Risk held by Clinical Care Group/ Executive Function

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The graph demonstrates that a small number of areas carry most of our risks, namely **Estates & Facilities, Operational Allied Health Professions & Health Sciences, Planned & Specialist Care**, **and Community & Integrated Medicine** hold the highest number of risks.

As at 30 June 2026, **Operational Allied Health Professions & Health Sciences continues to hold the highest number of extreme-level risks 62 risks** (February 2026: 62) **accounting for over 50% of their risk register.**

35 of these risks are scored 20 or above and the majority of these are aligned to the Patient Safety, Quality and Finance impact domains.



1st Line of Defence
Risk Management - Overdue Risks and Actions

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The number of overdue risks have remained broadly consistent, with **80 risks overdue for review as at 30 June 2026** (February 2026: 73).

Of those risks noted as overdue at June 2026, **48 have recently lapsed and are not overdue by more than one month** (February 2026: 36) and considered to be within an acceptable timeframe for review.

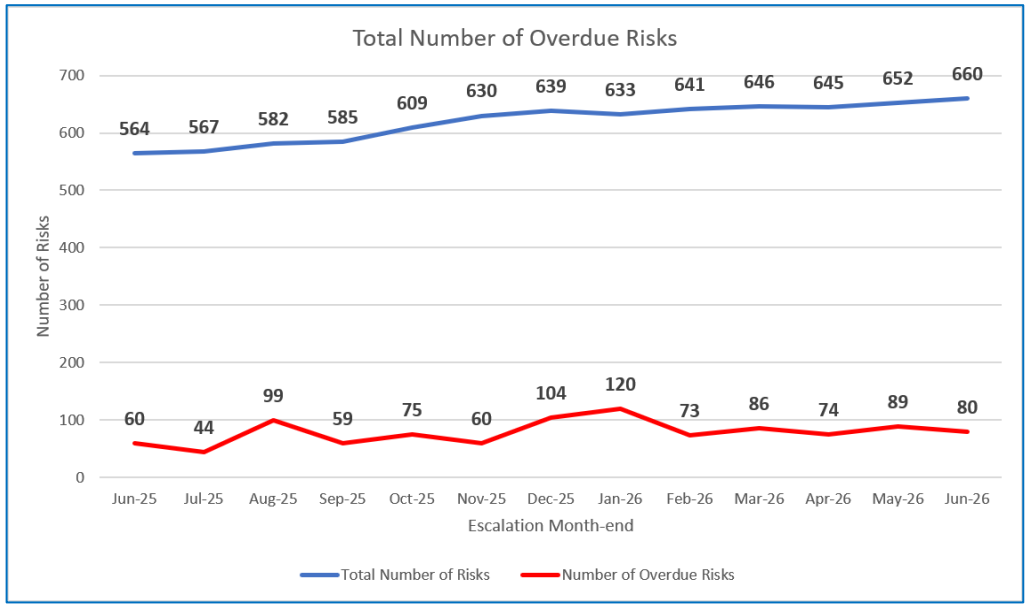
32 risks were overdue by more than one month (February 2026: 37), with **14 of these overdue by more than 2 months** (February 2026: 16), the longest being overdue by 10 months, indicative of the operational pressures faced Clinical Care Groups.

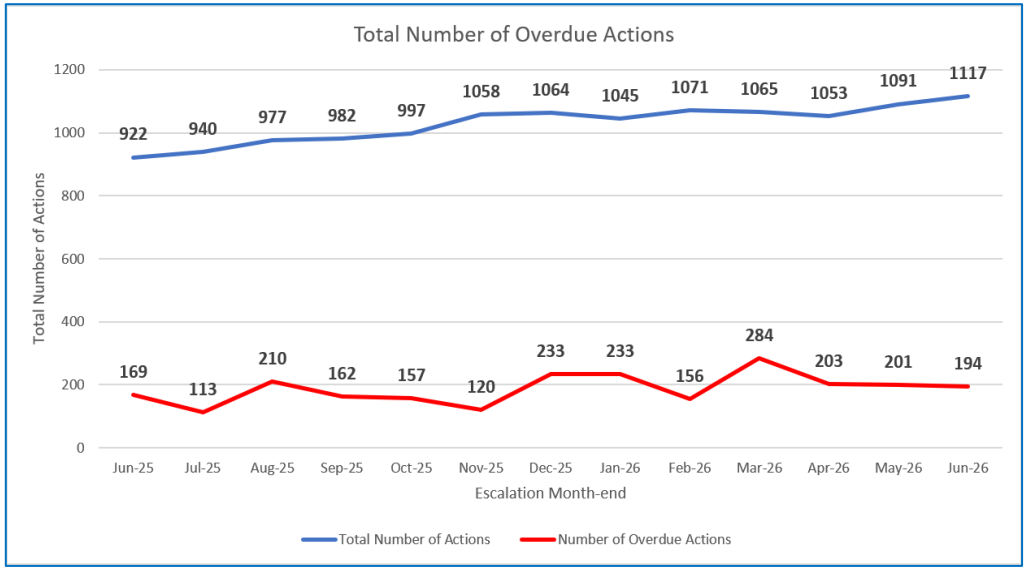
There has been a **notable reduction in the number of overdue risk actions since the implementation of the internal escalation framework,** however further progress is required to ensure that actions are clear, deliverable, reviewed and updated in a timely manner, and implemented within noted timeframes.

194 of risk actions are overdue as at June 2026, compared to 156 at February 2026, and may be a result of being assigned unrealistic or unachievable timescales, or are not being updated fully during risk reviews.

Limiting factors which provide a barrier to the completion of risk action plans should be reflected in the Rationale for Target Risk Scores (TRS) in line with the revised approach to risk tolerance, outlined in the Health Board's Risk Management Framework.

Risk leads are advised to provide realistic revised action dates where original dates have lapsed, with sufficient narrative noting the reasons behind any delays and justification for the new date expected to achieve the TRS. This advise is included in risk training, Sharepoint material and communication, as well as being considered in the scope of the procurement of the new risk register system.

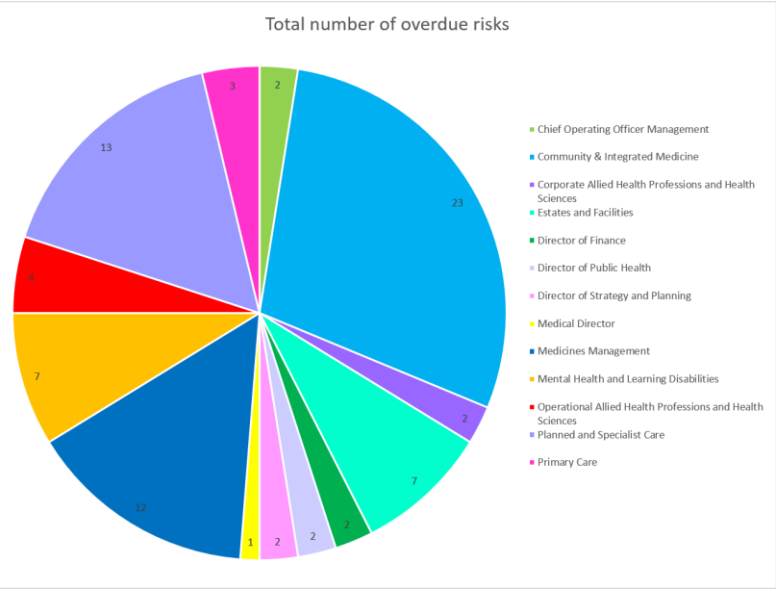




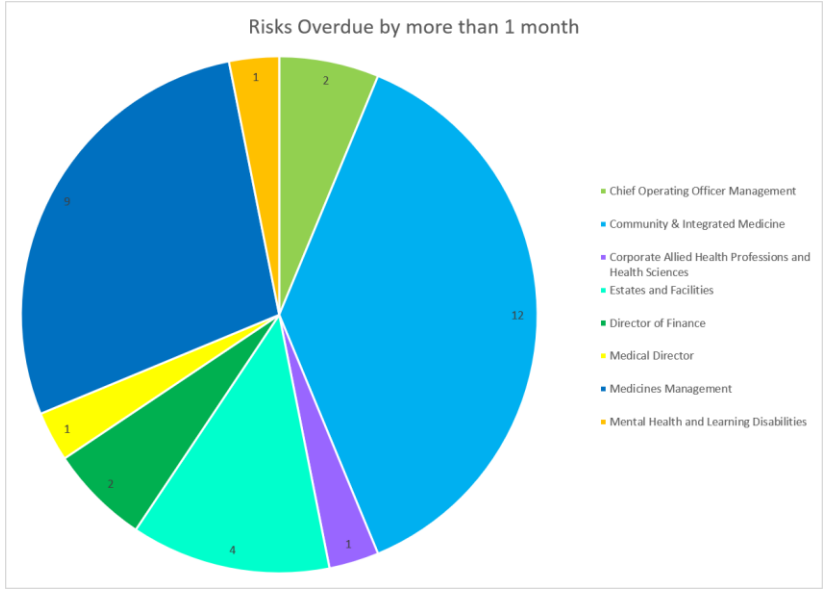
1st Line of Defence
Risk Management - Overdue Risks and Risk Actions

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

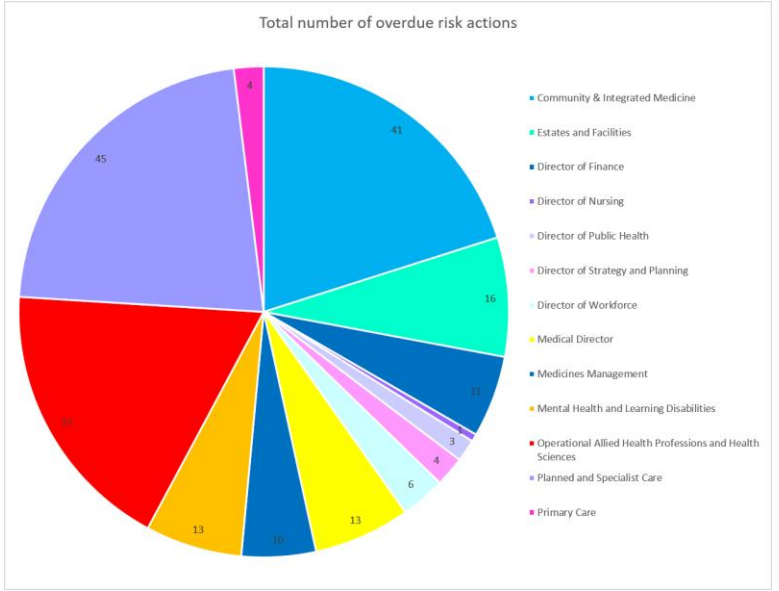
Overdue risks (12%)



Risks overdue >1 month (5%)



Overdue risk actions (29%)



Overdue risk reviews

Community & Integrated Medicine: 23/124 overdue (19%) – highest number.

Planned & Specialist Care: 13/125 overdue (10%).

Medicines Management: 12/17 overdue (71%) – highest proportion.

Overdue actions indicate that risks may not have been reviewed or fully updated.

Assurance and Risk Officers continue to support risk leads to improve timely review and update discipline.

Overdue risk actions

Planned & Specialist Care: 45/187 overdue (24%).

Community & Integrated Medicine: 41/235 overdue (17%).

Operational AHP & Health Sciences: 37/246 overdue (15%).

1st Line of Defence
Risk Management - Risk Treatment

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

4 risks do not currently have an 'Expected Date to Achieve Target Risk Score (TRS)', all of which sit with Community & Integrated Medicine. Whilst the risks have been reviewed, the 'Expected Date to Achieve TRS' section has not been updated.

80 risks have an 'Expected Date to achieve TRS' that has passed (February 2026: 62), of which **12 have a current risk score (CRS) that meets the TRS score** (February 2026: 18)**:**

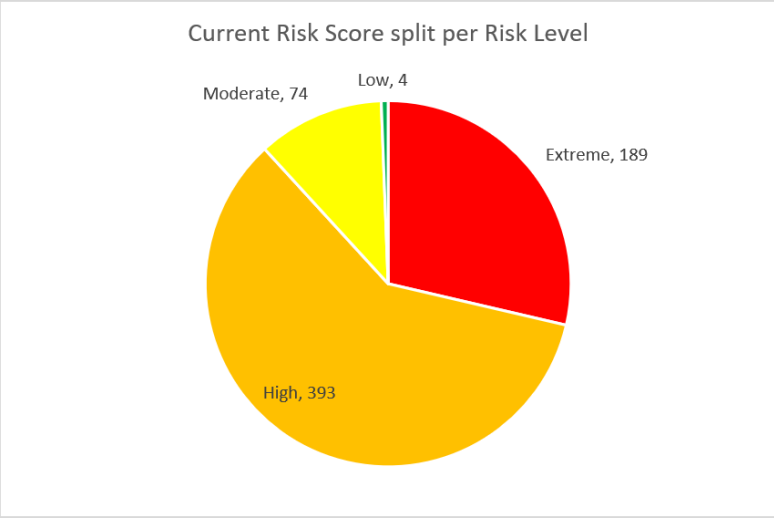
- 20 risks have not been reviewed within timeframe
- 60 have been reviewed within timeframe but the 'Expected Date to achieve TRS' has not been updated, suggesting that risk leads may not be fully updating risks on review.

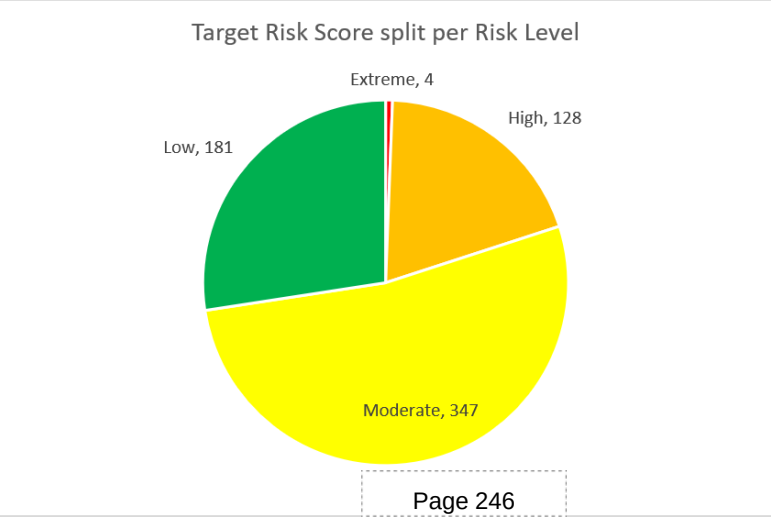
Of risks with a CRS higher than TRS, **7 risks have an 'Expected Date to achieve TRS' which is overdue by more than 6 months, the longest being overdue by 9 months.**

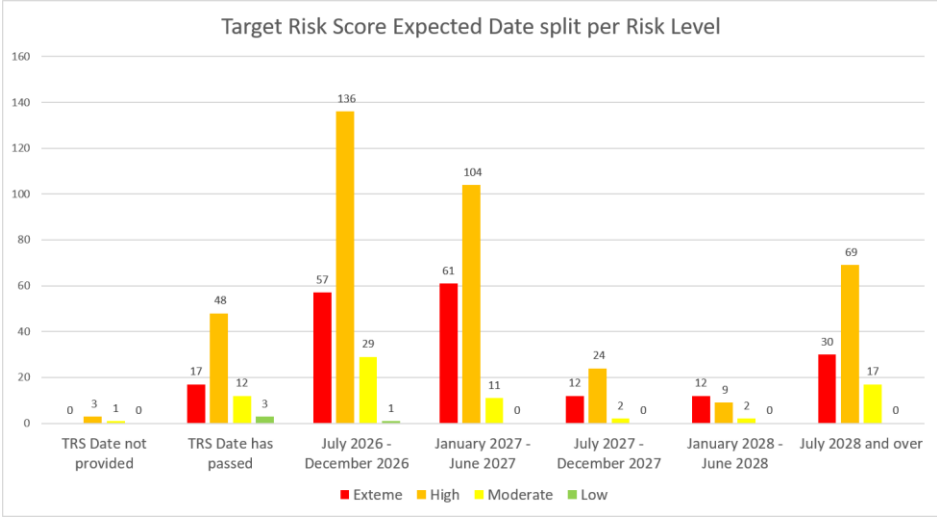
Of the 4 risks with an Extreme TRS, these are held by Operational Allied Health Professions and Health Sciences (3) and Mental Health and Learning Disabilities (1).

39 risks have a CRS equalling the TRS. These risks require review by the risk leads to consider if the risk can be tolerated (do nothing further), treated (further action to be taken) or closed.

The Assurance and Risk Team continue to support Functions by highlighting these risks within governance reports and the expectations around their update, reiterating the escalation via management structures to support decision-making if required, as outlined in the risk management framework. Risk management training material has also been updated to reflect these requirements.







1st Line of Defence
Operational Oversight of Risks

Clinical Care Group and Executive Function Level Monitoring Arrangements

Clinical Care Groups

Risks are discussed at the CCG Integrated Governance Group meetings which occur fortnightly or monthly, alternating the agendas of Quality, Health & Safety, and Business, Planning, Performance & People.

The CCG's remit is to evidence that these risks are being managed and monitored effectively in line with the Health Board's Risk Management Framework or escalated as required. The requirements of the CCG are stipulated within the Operational Scheme of Delegation, and in place since the introduction of the CCG structures as part of the operational Organisational Change Process (OCP).

The Assurance and Risk team prepare risk reports for CCG and Executive Function meetings, presenting at meetings on request and sharing the slides at meetings when not in attendance.

Executive Functions

Executive Functions have local governance arrangements for risk, most notable Senior Leadership Team meetings, with their frequency varying dependant on the Function.

Continuing local governance arrangements, including frequency of stood down meetings, are considered when awarding the escalation status for Governance.

2nd Line of Defence
Oversight of Risk - Internal Escalation

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

- **Risk management**, with relevant risks articulated with appropriate actions in place, evidenced that these are being delivered;
- **Implementation of recommendations** raised in audits / inspections and regulatory activity;
- **Implementation of Welsh Health Circulars and Ministerial Directions**; and
- **Governance arrangements** are in place.

The assessment criteria for the Governance domain has been reviewed to include more qualitative elements to reflect the quality of risks, in addition to statistical criteria and implemented from April 2026.

Level 1: Reasonable assurance that the function can meet prescribed targets in a given domain within the year

Level 2: Limited assurance that the function can meet prescribed targets in a given domain within the year

Level 3: No assurance that the function can meet prescribed targets in a given domain within the year OR insufficient engagement with Targeted Intervention objectives

Level 4: No assurance that the function can meet prescribed targets in a given domain within the year, with insufficient actions or engagement in place to secure recovery

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 risks are escalated via CCG management structures where necessary, demonstrating good engagement and the ability for make informed decisions on prioritisation of resources

2nd Line of Defence
Internal Escalation Framework – Governance Domain

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Function	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26
Chief Operating Management	2	2	2	2	2	1	1	1	1
Community & Integrated Medicine	3	3	3	3	3	3	3	3	3
Estates & Facilities	1	1	1	1	1	1	1	1	1
Executive Director of Allied Health Professions and Health Sciences	1	1	1	1	1	1	1	1	1
Executive Director of Finance	1	1	2	2	2*	2	2	2	2
Executive Director of Nursing, Quality and Patient Experience	2*	2	2	1	1	1	1	1	2*
Executive Director of Public Health	1	1	1	1	1	1	1	1	1
Executive Director of Strategy and Planning	1	1	1	1	1	1	1	1	1
Executive Director of Workforce and Organisational Development	1	1	1	1	1	1	1	1	1
Medical Director	1	1	1	1	1	1	1	1	1
Medicines Management	n/a	n/a	1	1	1	1	1	1	1
Governance and Communication	1	1	1	1	1	1	1	1	1
Mental Health and Learning Disabilities	2	1	1	1	1	1	1	1	1
Operational Allied Health Professions and Health Sciences	1	1	1	1	1	1	1	1	1
Planned and Specialist Care	2	2	2	3	2	2	2	2	2
Primary Care	2*	2	2	2	2*	1	1	1	1

As at 30 June 2026 ,**Community and Integrated Medicine** met the Level 3 escalation criteria for risk management under the Governance domain. A detailed analysis is provided on the next slide.

Two Functions met the Level 2 escalation criteria in relation to risk management, with detail provided on slide 24:

- Planned & Specialist Care; and
- Director of Finance.

The Assurance and Risk Team provide focussed advice and assistance for those Functions at level 3 to aid their de-escalation / recovery, and to support those awarded level 2 status from being escalated. Full detail for the reasons behind their escalation status, and suggested actions to de-escalate (where appropriate) is provided within an Assurance & Risk report that is circulated monthly and presented at Function governance meetings.

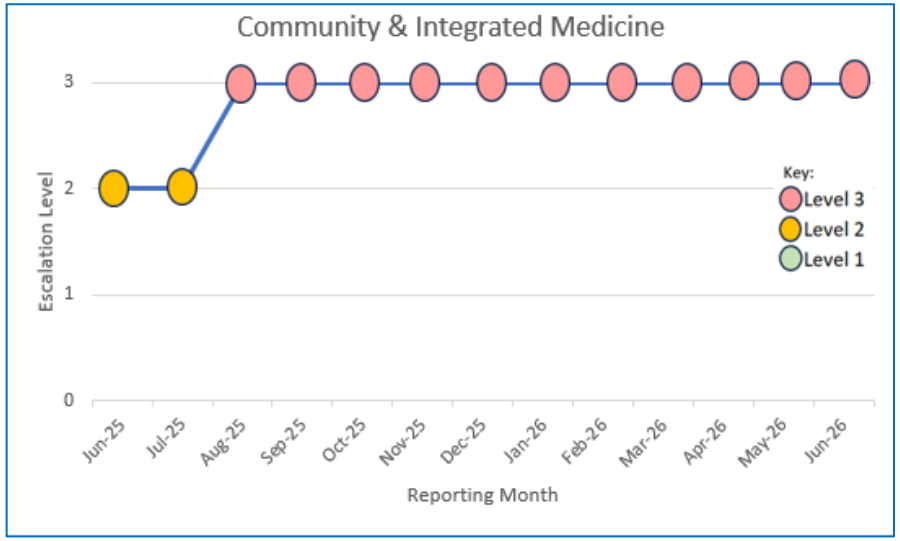
*The escalation status of Level 2 (Executive Director of Nursing, Quality and Patient Experience) was not attributable to risk management but was based on the management of the implementation of audit and inspection recommendations, Welsh Health Circulars, Ministerial Directions or governance arrangements.

2nd Line of Defence
Internal Escalation Framework –Governance Domain:
Level 3 - No Assurance

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Community & Integrated Medicine

As at 30 June 2026, the Clinical Care Group (CCG) had **23 of 124 risks overdue (19%),** an improvement on the February 2026 position (28%). The CCG had 235 open risk actions, of which 41 **were overdue (17%),** an improvement on the February 2026 position (24%) and meets L2 criteria.



Whilst the figures above meet L2 criteria the CCG remains in L3 for risk due to the following:

- **13 risks (5 extreme and 8 high scoring risks) do not have open risk actions**.
- Of the 23 overdue risks, **12 are overdue by more than 1 month** which all sit with the Carmarthenshire Integrated System.
- Of the 41 overdue risk actions, **23 are overdue by more than 1 month.**
- 20 risks where the Current Risk Score is higher Target Risk Score have an 'Expected Date to achieve TRS' which has passed, **17 of which have been reviewed after the 'Expected Date to achieve TRS' and the date has not been revised accordingly, suggesting that risks are not being fully updated during review.**
- **4 of the 124 risks (2%) do not have an 'Expected Date to achieve TRS**'.
- Delays in new / emerging risks being added to Datix.

The Assurance and Risk Officer attended the Speciality Service Review day on 4 March 2026 to provide support to articulate fragility risks sitting across Speciality pathways that are currently overseen by the CCG. The Assurance and Risk Officer continues to offer support to the CCG by meeting when required with risk leads, and provides a summary of their risk position and risk review requirements at the relevant governance meetings. The CCG triumvirate team have scheduled quarterly risk sessions with each integrated system. Operational pressures continue, including the OCP Phase 2 consultation.

2nd Line of Defence
Internal Escalation Framework – Governance Domain
Level 2 – Limited Assurance

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

The following 2 Functions were awarded a Level 2 attributable to risk management performance within the Governance domain, as per the criteria outlined on slide 28 based on data available at 30 June 2026:

Clinical Care Group / Executive Function	Reason for award of L2	De-escalation Criteria
Planned and Specialist Care	An improved position with **13 out of 125 (10%) risks overdue (90% compliance)** and **45 out of 187 (48%) risk actions overdue (less than 80% compliance).** This was primarily due to services not updating their risk actions within the required timeframes.	To achieve Level 1, 90% of risks and risk actions are reviewed within timeframes and evidence of compliance in achieving TRS dates
Director of Finance	An improved position with **2 out of 23 (9%) risks overdue (91% compliance)** for the Function as a whole, with **1 out of 19 (95%) of Digital's operational risks overdue** and 1 Finance Corporate risk overdue**.** However, **11 out of 32 (34%) risk actions overdue** at month-end across the Executive Function.	To achieve Level 1, 90% of risk actions to be reviewed within timeframes and compliance achieving TRS dates.

2nd Line of Defence
Thematic Analysis

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk owners can allocate themes to their risks, which allows the Health Board to share risk information on specific areas with relevant experts as part of the second line of defence. Themes are assigned based on additional impacts or contributory factors 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 theme is aligned to a designated committee to provide assurance that processes are in place to deliver a holistic approach to risk management, further enabling the Health Board to better identify and define its risk appetite, risk capacity and total risk exposure in relation to each risk. It also provides the opportunity to group similar risks or generic type of risk. Thematic risk registers also support the identification of trends, clusters, and potential gaps within the Health Board's control framework. They may be used to determine whether further action is needed to prevent risks from materialising.

Each risk theme has assigned owners based on their subject matter expertise and are provided with the relevant thematic risk register on a bi-monthly basis. Upon receipt, theme owners are expected to:

- Confirm that risks are appropriately assigned to the theme
- Review the risk, associated controls, and planned actions from an expert perspective
- Offer oversight and guidance to the relevant manager on any additional controls required to manage the risk to an acceptable level

To strengthen the effectiveness of this framework, the Assurance and Risk Team have conducted a review of existing risk themes. The review identified duplication across several themes, leading to a decision to streamline and consolidate them into a more manageable and meaningful data set. The progress of the work undertaken to date are noted on the following slides.

Work has now been completed by the team, with input from the Quality Assurance and Safety Team, to review risk themes relating to the appropriate alignment to the relevant groups within the revised governance arrangements underpinning QSEC.

The following slide details the reviews undertaken and risk themes agreed since the previous report presented to ARAC, to ensure these are as effective and meaningful as

2nd Line of Defence
Thematic Analysis

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

Risk theme	Theme Definition	No. of Risks	QSEC Sub Group	Review undertaken
HTA Compliance (NEW)	A risk that involves complying with the regulations and legislation under the Human Tissue Act.	**5**	Human Tissue Authority Assurance Group	Further reviews in June 2026 resulting in 5 new risk themes being added to Datix, aligned to the relevant sub-group of Quality, Safety & Intelligence Group (QSIG). From Q2 2026/27 risk themes will be provided to the Leads and QSIG Reporting Group Chairs on a bi-monthly basis.
Nutrition and Hydration (NEW)	A risk in relation to patient care and treatment relating to nutrition and hydration	**19**	Nutrition & Hydration Group	
Resuscitation (NEW)	A risk in relation to patient care and treatment relating to resuscitation and DNACPR	**3**	RADAR Group	
Medical Exposure / IRMER (NEW)	A risk relating to the guidance and regulations for Health Board staff and patients in the use of Ionising Radiation for or medical equipment for treatment purposes and the deliberate exposure of patients to ionising radiation for diagnostic, therapeutic, or health monitoring purposes, with safety and optimisation	**0**	Medical Exposures Group	
Acute Deterioration / NEWS (NEW)	A risk in relation to patient care and treatment relating to acute deterioration and NEWS scores / lack of escalation	**14**	RADAR Group	
Fragile Services	A fragile service is one where there is a risk or the actual delivery of a diminished service or a service being unable to be delivered due to staffing / or other challenges	**212**	Fragile Services Oversight Group	Further reviews in June 2026, with revised theme definitions agreed and confirmation of the sub-group of the QSIG that these themes will be aligned to. From August 2026, risk themes will be provided to the Leads and QSIG Reporting Group Chairs on a bi-monthly basis.
Infection Control	A risk that may compromise the effectiveness of infection prevention and control measures, leading to staff and/ or patients being exposed to a confirmed or suspected pathogen increasing the likelihood of a transmission event and a healthcare acquired infection (HAI) or outbreak	**32**	Infection Prevention Strategic Steering Group	
Medication	A risk that involves the prescribing, dispensing or supply, administration or monitoring of medicines.	**25**	Medicines Management Oversight Group	
Medical Devices	A risk relating to a medical device, which is any instrument (other than a medicine) that is used to diagnose, monitor, treat or manage a medical condition. The definition covers a wide range of products including syringes, dressings, surgical tools, scanners, software, apparatus, machines and some medical applications.	**37**	Medical Devices Group	

2nd Line of Defence
Thematic Analysis

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk theme	Theme Definition	No. of Risks	QSEC Sub Group	Review undertaken
NICE/National Guidance	Risks related to the Health Board's ability to comply with evidence-based guidance for health and care.	**119**	Effective Clinical Practice	Further reviews in June 2026, with revised theme definitions agreed and confirmation of the sub-group of the QSIG that these themes will be aligned to. From Q2 2026/27 risk themes will be provided to the Leads and QSIG Reporting Group Chairs on a bi-monthly basis.
Safeguarding	Safeguarding in its wider context is everyone's responsibility and we have duty of care to support children and adults. It is expected that services and professionals "own" their concerns and take responsibility for the work that needs to be done to keep individuals safe. This includes taking action before, during and after a safeguarding referral has been made. Should risks arise whereby children and adults may be put at risk due to gaps in service provision, or training compliance for example, then a safeguarding theme may be assigned to the risk.	**31**	Strategic Safeguarding Group	
Consent and Mental Capacity	Risks relating to consent to examination or treatment e.g. missing, illegible, incorrect consent form; failure to obtain consent; mismatch between consent form and list etc. Risks relating to people who may lack mental capacity e.g. failure or concerns relating to: assessment of decision making capacity; acting in the person's best interests; consulting with those close to the person etc.	**0**	Mental Capacity Act and Consent Group	
Deprivation of Liberty Standards (DOLS)	Risks relating to: • a failure to submit DoLS referral when needed • a person being deprived of their liberty when they have capacity to consent to be in hospital • a lack of awareness of what actions can and cannot be taken when a DoLS authorisation is in place (e.g. you can stop someone from absconding • DoLS doesn't give authority for care and treatment decisions • patient with a DoLS authorisation can be discharged).	**1**	Mental Capacity Act and Consent Group	
Patient Safety	N/A- removed as a risk theme	**N/A**	N/A	Removed as themes and replaced by the risk themes above, as well as superseded by the Domains of Quality (STEEP) data captured on Datix.
Quality	N/A- removed as a risk theme	**N/A**	N/A	

2nd Line of Defence: 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.

Principal risks are reported to the Board 3 times a year, with the last report provided in July 2026 as part of the BAF Dashboard. The Health Board has updated the planning objectives, principal risks and outcome measures which support the four strategic objectives as part of the Strategy Refresh. The reporting of principal risks to Committees will re-commence in Q3 of 2026.

The Board is also responsible for oversight of the Health Board's **corporate risks**, which are defined as significant risks which affect the Health Board's ability to deliver its priorities set out in the Annual Plan and healthcare services in the 'here and now'. **Corporate risks are reported to the Board 3 times a year**, with the last report provided in May 2026, with a total of 22 risks on the Corporate Risk Register.

The Formal Executive Team reviews the corporate risk register on a monthly basis, and the principal risk register on a quarterly basis, ahead of Board reporting.

The Executive Team have responsibility to:

- Approve or escalate new risks for addition to corporate/principal risk registers; and
- Approve the closure of, or de-escalation of corporate/principal risks to operational level.

At Formal Executive Team in October 2025, a schedule of "deep dives" of corporate risks was agreed to confirm TRS scores, provide direction on further risk treatment, and consider the acceptance of these risks. These are currently being refreshed following the approval of the Annual Plan.

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

2nd Line of Defence: Committee and Reporting Structures

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

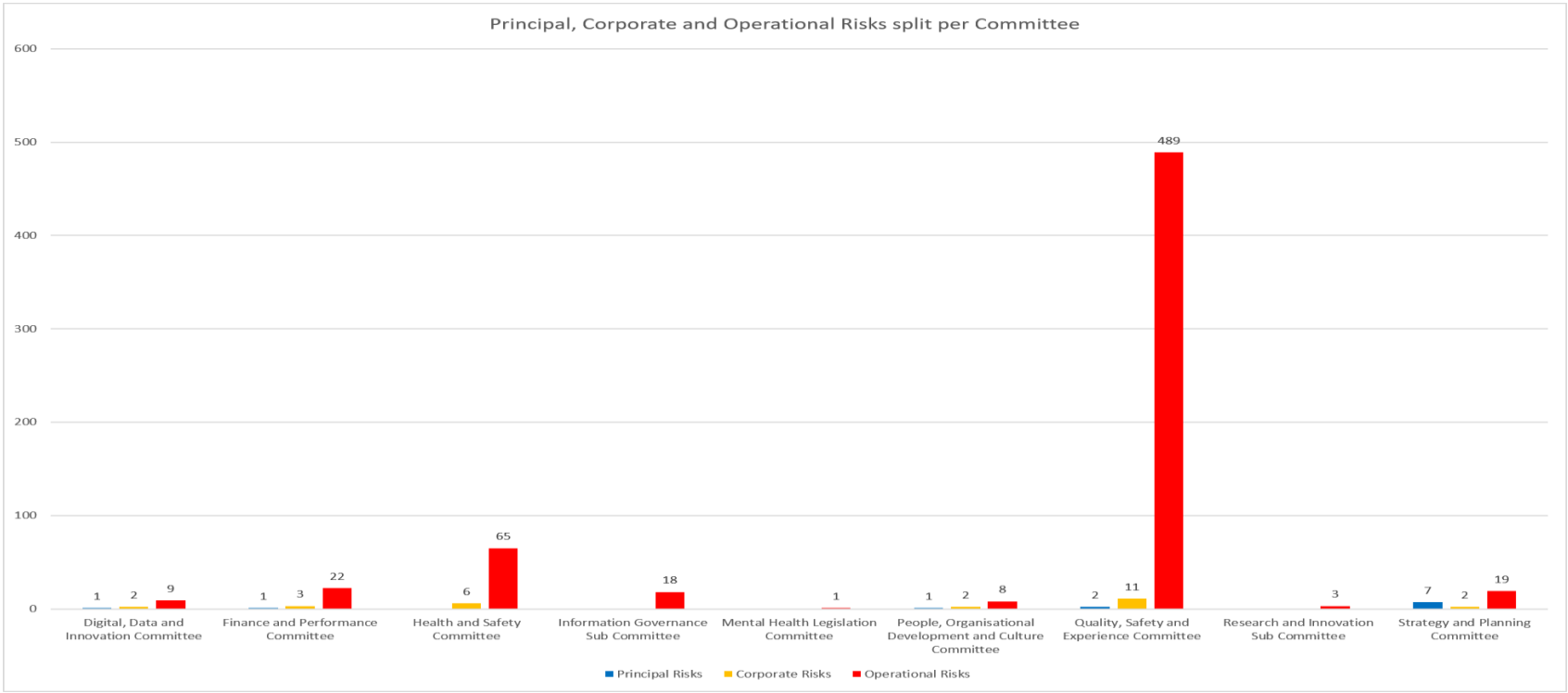
2. Board Committees and Sub-Committees

Terms of References (TORs) are in place for each committee in the Health Board, outlining their responsibility to review and seek assurance that risks aligned to Committees are being effectively managed across the Health Board, and report any areas of significant concern. All risks (principal, corporate and operational) are reported to each Committee meeting via the "Assurance and Risk Report". Principal, corporate and operational risks are reported on an alternate basis to the bi-monthly Committees, with the exception of Digital, Data and Innovation Committee and People, Organisational Development and Culture Committee where all risks are reported to each quarterly meeting.

Where possible, operational risks are also reported to sub-committees, each of whom have delegated authority from the parent committee who receive update reports at each meeting. Operational risks are reported to committees based on the following criteria:

- Current risk score is "extreme" or "high"; and
- Current risk score is either equal to or exceeds the target risk score.

Committees are asked to take assurance from the oversight mechanisms in place, as noted in the 1st line of defence section of the report, to effectively and efficiently manage risks, with escalation as appropriate

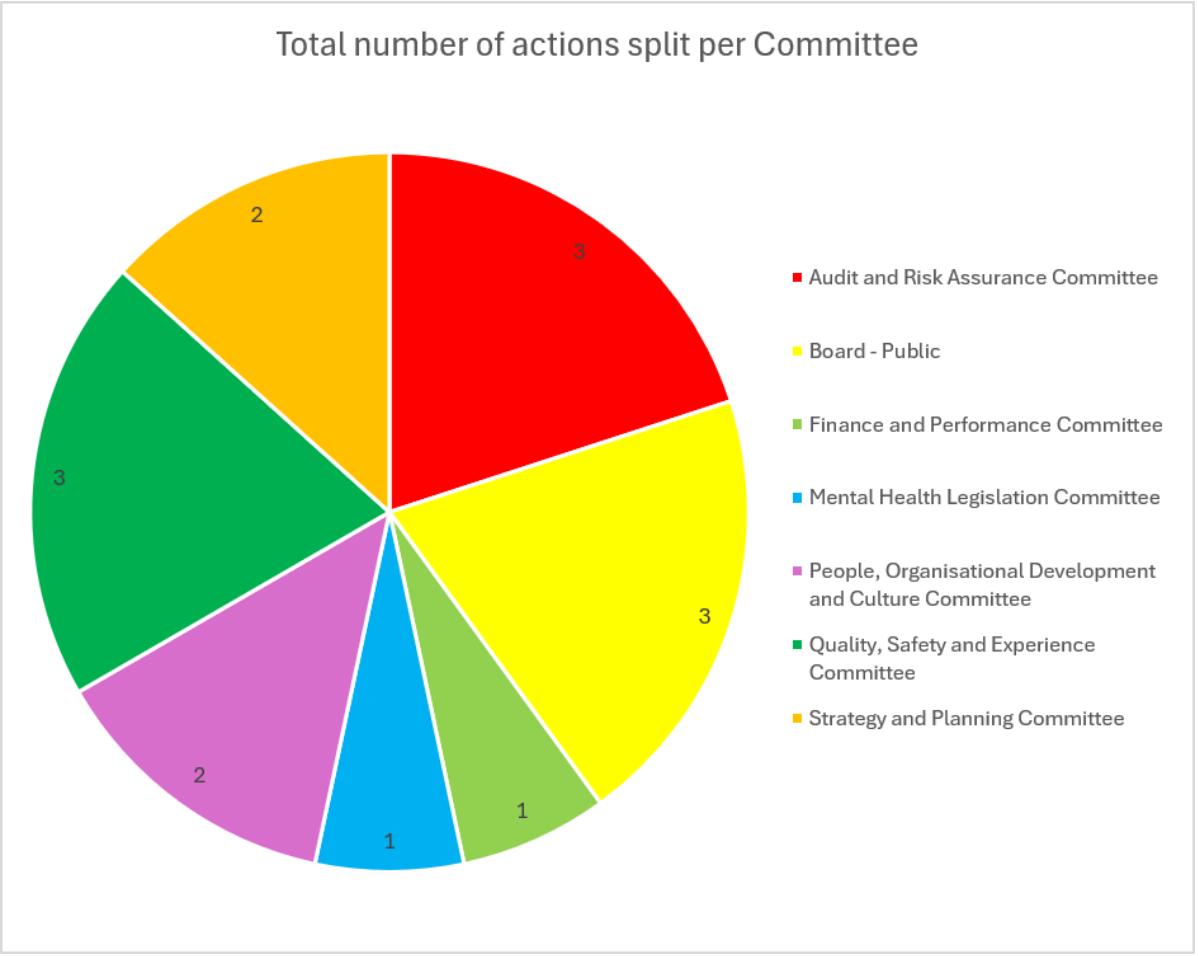


2nd Line of Defence: Committee and Reporting Structures

Tables of Actions (ToAs) are generated following Committee meetings to capture queries, requests for clarification, and actions arising from discussions relating to risk management. These actions are monitored to ensure that required follow-up activity is undertaken and reported as appropriate.

The majority of committee actions relate to strengthening risk governance and assurance arrangements through improved risk reporting, enhanced scrutiny and challenge, and greater visibility of significant operational risks. Committees have sought clearer articulation of risk ownership, scoring and escalation processes, alongside improved assurance regarding the effectiveness of risk management arrangements. A further theme is the development of organisational risk capability and culture, including workforce wellbeing, leadership responsibilities and improved understanding of risk across Board and Committee structures,

Progress against actions continue to be monitored and reported through the relevant Committee Table of Actions.



2nd Line of Defence: Committee and Reporting Structures

Corporate Risk Register

The following slides summarise the changes to the Corporate Risk Register (CRR) since the previous report presented to ARAC in April 2026.
All changes are included in risk reports presented to Board and Committees.

New Risks added or escalated to the Corporate Risk Register

Risk Ref and Title	Clinical Care Group/Executive Function	Lead Committee	Current Risk Score Jun-26	New or escalated Risk	Date of addition to the CRR
2381 - Risk to compliance with Martyn's Law and site safety due to insufficient security infrastructure, capability and preparedness	Estates & Facilities	Health and Safety Committee	15	New Risk	23/06/2026
2380 - Risk to delivery of Single Cancer Pathway performance due to diagnostic capacity gaps, funding uncertainty and pathway fragility	Planned & Specialist Care	Finance and Performance Committee	12	New Risk	19/06/2026
2379 - Risk to effective climate adaptation and compliance due to insufficient resourcing, leadership and system-wide coordination	Public Health	Strategy and Planning Committee	16	New Risk	19/06/2026
2378 - Risk of being unable to consistently deliver safe, sustainable and timely ED services across all hospital sites.	Community & Integrated Medicine	Quality, Safety and Experience Committee	20	New Risk	19/06/2026
2349 - Risk of disruption to services and increased financial pressure arising from fuel supply constraints and rising cost	Public Health	Health and Safety Committee	12	New Risk	22/05/2026
2327 - Risk to planned care and RTT recovery in 2026/27 due to demand–capacity gaps, estate fragility and non-recurrent funding	Planned & Specialist Care	Finance and Performance Committee	12	New Risk	22/04/2026
2326 - Risk to achieving 26/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non recurrent funding	Director of Finance	Finance and Performance Committee	20	New Risk	21/04/2026

2nd Line of Defence: Committee and Reporting Structures

Corporate Risk Register

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risks removed from the Corporate Risk Register

Risk Ref and Title	Clinical Care Group/Executive Function	Lead Committee	Reason for Removal	Date of change on CRR
1861 - Risk of harm to staff, patients public and critical assets due to insufficient physical security measures and systems	Estates & Facilities	Health and Safety Committee	Risk closed and superseded by new risk 2381	23/06/2026
2104 - Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 25/26 due to demand exceeding capacity	Planned & Specialist Care	Finance and Performance Committee	Risk closed and superseded by new risk 2327	22/04/2026
2086 - Risk that the cash consequences of the Health Board deficit cannot be covered by WG should it exceed our Target Control Total	Director of Finance	Finance and Performance Committee	Risk closed and superseded by new risk 2326	21/04/2026
1350 - Risk of not meeting the 80% SCP waiting times target for March 2026 due to diagnostics capacity and delays at tertiary centre	Planned & Specialist Care	Finance and Performance Committee	Risk closed and superseded by new risk 2380	19/06/2026

Changes in Current Risk Score:

Risk Ref and Title	Clinical Care Group/Executive Function	Lead Committee	Current Risk Score Jun-26	Previous Risk Score Mar-26	Date of change on CRR
2079 - Risk of loss of Pathology services across the Health Board due to delayed implementation of LIMS	Operational Allied Health Professions & Health Sciences	Digital, Data and Innovation Committee	25 ↑	20	22/05/2026
1810 - Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with QAAPS.	Medical Director	Quality, Safety and Experience Committee	20 ↑	15	10/03/2026
2212 - Risk the Health Board will not have an approvable Integrated Medium-Term Plan (IMTP) by March 2028.	Director of Strategy and Planning	Strategy and Planning Committee	16 ↑	12	23/03/2026
2190 - Risk of CHC service users experiencing a delay in their choice of care provision via Direct Payments.	Community & Integrated Medicine	Quality, Safety and Experience Committee	9 ↓	16	22/05/2026

2nd Line of Defence: Committee and Reporting Structures
Corporate Risk Register

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Changes in Target Risk Score:

Risk Ref and Title	Clinical Care Group/Executive Function	Lead Committee	Target Risk Score Jun-26	Target Risk Score Mar-26	Date of change on CRR
1860 - Risk of staff harm and service disruption due to violence and aggression within healthcare settings	Estates & Facilities	Health and Safety Committee	12 ↑	8	22/05/2026
2190 - Risk of CHC service users experiencing a delay in their choice of care provision via Direct Payments.	Community & Integrated Medicine	Quality, Safety and Experience Committee	8 ↓	12	10/03/2026

3rd Line of Defence
Independent Assurance

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

In December 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 3 (enhanced monitoring) to level 1 (enhanced monitoring). 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.

The Audit Wales Structured Assessment 2025 found that the Board continues to apply a mature approach to strategic risk, regularly reviewing and updating the BAF in line with its strategic objectives. Committees also maintain robust scrutiny of the Corporate Risk Register and now receive a consolidated Assurance and Risk Report covering key risks and external requirements. The Health Board has further strengthened its governance by approving a revised Risk Management Framework and Strategy, with ARAC receiving regular updates on progress and organisational risk maturity.

The Head of In ternal Audit concluded a **limited assurance** rating for 2025/26. The overall opinion by the Head of Internal Audit on governance, risk management and control results from the risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

Limited assurance		The Board can take **limited** assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention. Moderate impact on residual risk exposure until resolved.

Next Steps and Recommendations

This report highlights

- the progress made against the objectives as set out in the Risk Management Strategy 2025/26; and
- the commencement of delivery on the new risk management objectives.

Recommendation

The Audit and Risk Assurance Committee is asked to:

- **TAKE ASSURANCE** on the work being progressed to implement the objectives set out in our Risk Management Strategy to strengthen the effectiveness of our Risk Management Framework, and our overall risk maturity as an organisation; and
- **ENDORSE** the revised Risk Management Objectives for 2027.

7

11:55, 0 Mins

7 - For Information

7.1

11:55, 0 Mins

7.1 - ARAC Workplan 2026/27

For information

Attachments

7.1 Audit Work Programme 2026-27.pdf

HYWEL DDA UNIVERSITY HEALTH BOARD – AUDIT & RISK ASSURANCE COMMITTEE DRAFT ANNUAL WORK PLAN 2026/27

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	PURPOSE	14 April 2026	7 May 2026	23 June 2026	13 Aug 2026	15 Oct 2026	10 Dec 2026	11 Feb 2027	April 2027
INTRODUCTIONS										
Apologies	**Chair**	Information	✓	✓	✓	✓	✓	✓	✓	✓
Declaration of Interests	**All**	Information	✓	✓	✓	✓	✓	✓	✓	✓
GOVERNANCE										
Minutes from previous meeting	**Chair**	Approval	✓		✓	✓	✓	✓	✓	✓
Matters Arising & Table of Actions	**Chair**	Assurance	✓		✓	✓	✓	✓	✓	✓
Matters Arising not on agenda	**Chair**	Discussion	✓		✓	✓	✓	✓	✓	✓
Self-Assessment of Committee's effectiveness	**JW**	Assurance			✓			✓		
Escalation Status Update	**PK/LD/SA**	Assurance	✓		✓	✓	✓	✓	✓	✓
Review and report upon the adequacy of arrangements for declaring, registering and handling interests	**JW**	Assurance		✓						
Receive full report of all offers of gifts and hospitality	**JW**	Assurance		✓						
Review ARAC Annual Report	**Chair**	Approval		✓						
Review Board Effectiveness Report	**JW**	Assurance		✓						
Review Accountability Report, incl Annual Governance Statement	**JW**	Approval		✓ (Draft)	✓ (Final)					
Review Head of Internal Audit Opinion and Annual Report (incl Capital/PFI)	**JJ**	Assurance		✓ (Draft)	✓ (Final)					
Internal Audit: Annual Governance Statement Review	**JJ**	Assurance		✓	✓					
Review, agree and recommend to the Board the audited accounts & financial statements	**HT**	Approval		✓ (Draft)	✓ (Final)					
Audit Enquiries to those charged with Governance and Management	**HT**	Approval		✓						

AGENDA ITEM/ISSUE	LEAD	PURPOSE	14 April 2026	7 May 2026	23 June 2026	13 Aug 2026	15 Oct 2026	10 Dec 2026	11 Feb 2027	April 2027
Audit Wales ISA 260 incl Letter of Representation	**Audit Wales**	Assurance			✓					
Review the Health Board's Annual Report (Overview & Perf Section)	**HT**	Approval		✓ (Draft)	✓ (Final)					
Review changes to Standing Orders & Standing Financial Instructions*	**JW**	Approval	✓							
Annual Review of Standing Orders and Standing Financial Instructions	**JW**	Approval	✓							✓
Scheme of Delegation	**JW**	Approval								
Annual Review of Terms of Reference	**Chair/JW**	Approval			✓					
All Wales NHS Audit Committee Chairs' Meeting Update	**Chair**	Information			✓		✓	✓	✓	✓
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**	Assurance	✓	✓	✓	✓	✓	✓	✓	✓
Provide assurances where a significant activity is shared with another organisation (eg NWSSP/JCC)	**HT**	Assurance	✓	✓	✓	✓	✓	✓	✓	✓
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**	Assurance	✓	✓	✓	✓	✓	✓	✓	✓
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	**MG**	Assurance	✓	✓	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ISSUE	LEAD	PURPOSE	14 April 2026	7 May 2026	23 June 2026	13 Aug 2026	15 Oct 2026	10 Dec 2026	11 Feb 2027	April 2027
AUDIT WALES										
Review External Audit Plan via update reports	**Audit Wales**	Assurance	✓	✓	✓	✓	✓	✓	✓	✓
Approve External Audit Strategy & Annual Audit Plan (designed to implement the strategy) & assoc fees	**Audit Wales**	Approval	✓							✓
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**	Assurance	✓		✓	✓	✓	✓	✓	✓
Consider any Audit Wales National Value for Money Examinations & Performance Reports	**Audit Wales**	Assurance	✓		✓	✓	✓	✓	✓	✓
Receive the Auditor's General report to those charged with governance (Year-end)	**Audit Wales**	Assurance		✓						
Structured Assessment 2024 Management Response Update	**Audit Wales/JW**	Assurance	✓							
Structured Assessment 2025	**Audit Wales**	Assurance	✓							
Structured Assessment 2026	**Audit Wales**	Assurance						✓		✓
Review of the Management of Outpatients	**Audit Wales/AC**	Assurance	✓							
Digital Transformation Review (also IC)	**Audit Wales/HT**	Assurance	D	✓						
Review of Radiology Services	**Audit Wales/AC**	Assurance	D		✓					
Deep Dive - Review of the Arrangements to Manage Estates	**Audit Wales/JS**	Assurance	D			D	✓			
Review of Cancer Services	**Audit Wales/AC**	Assurance	D			D	✓			
Review of Eye Care Services	**Audit Wales/AC**	Assurance							✓	

AGENDA ITEM/ISSUE	LEAD	PURPOSE	14 April 2026	7 May 2026	23 June 2026	13 Aug 2026	15 Oct 2026	10 Dec 2026	11 Feb 2027	April 2027
Review of Management & Prevention of Diabetes	**Audit Wales/AG**	Assurance								✓
Progress Update: Audit Wales Radiology Review	**AC**	Assurance						✓		
INTERNAL AUDIT										
Internal Audit: Audit Plan Progress Report	**JJ**	Assurance	✓	✓	✓	✓	✓	✓	✓	✓
Review and approve Annual Internal Audit Plan	**JJ**	Approval	✓							✓
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**	Assurance	✓	✓	✓	✓	✓	✓	✓	✓
Review and approve Internal Audit terms of reference (charter) and the effectiveness of internal audit	**JJ**	Approval	✓							✓
Correspondence Regarding Audit Participation and Implementation of Recommendations	**Chair/EM/ JW**	Discussion				✓				
Operational Governance Arrangements (Limited Assurance)	**JJ/AC**	Assurance	✓							
Level 3 / 4 Directorates (Limited Assurance)	**JJ/HT**	Assurance	✓							
Estates Assurance – Space Utilisation (Advisory Report)	**JJ/LD**	Assurance	✓							
Human Tissue Authority Follow-up (Review)	**JJ/JS**	Assurance	✓							
Shadow IT (Reasonable Assur) (IC)	**JJ/HT**	Assurance	✓							
Sickness Management Follow-up (Review)	**JJ/LG**	Assurance		✓						
Major Infrastructure Investment Plan (Reasonable Assurance)	**JJ/LD**	Assurance	D	✓						
WGH Fire Precaution Works Phase 2 (Reasonable Assurance)	**MG/LD**	Assurance		✓						

AGENDA ITEM/ISSUE	LEAD	PURPOSE	14 April 2026	7 May 2026	23 June 2026	13 Aug 2026	15 Oct 2026	10 Dec 2026	11 Feb 2027	April 2027
GP Out of Hours (Limited Assurance)	**JJ/AC**	Assurance	D		✓					
Commissioning – Third Sector (Reasonable Assurance)	**JJ/AC**	Assurance			✓					
Regional Joint Cttee Governance Arrangements (Advisory Report)	**JJ/JW**	Assurance	D		✓					
Infection Prevention & Control (Limited Assurance)	**JJ/SD**	Assurance	D		✓					
Medical Workforce Stabilisation (Reasonable Assurance)	**JJ/MH**	Assurance	D		✓					
High Cost Drugs (Limited Assurance)	**JJ/MH/HT**	Assurance	D		✓					
WellSky System (Advisory Report)	**JJ/HT**	Assurance	D		✓					
Follow-up and Action Implementation Review (Reasonable Assurance)	**JJ/JW**	Assurance			✓					
Capital Equipping (Limited Assurance)	**JJ/LD**	Assurance				✓				
Organisational Change Process - Operational Structure (Advisory)	**JJ/AC**	Assurance					✓			
Pathways of Care Delays	**JJ/AC**	Assurance					✓			
Workforce Planning	**JJ/LG**	Assurance					✓			
Staff Experience and Wellbeing	**JJ/LG**	Assurance					✓			
Financial Management - Grip and Control	**JJ/HT**	Assurance					✓			
Radiology Informatics System Programme	**JJ/HT**	Assurance					✓			
Primary Care Prescribing	**JJ/AC**	Assurance						✓		
Rostering	**JJ/LG**	Assurance						✓		
Quality Management System	**JJ/SD**	Assurance						✓		
Integrated Audit and Assurance Plans - Aseptic Scheme	**JJ/LD**	Assurance						✓		
Health and Safety	**JJ/JS**	Assurance						✓		
Cost Management and Savings Schemes	**JJ/HT**	Assurance						✓		
Patient Demographic Information	**JJ/HT**	Assurance						✓		
Digital Partner Contract	**JJ/HT**	Assurance						✓		

AGENDA ITEM/ISSUE	LEAD	PURPOSE	14 April 2026	7 May 2026	23 June 2026	13 Aug 2026	15 Oct 2026	10 Dec 2026	11 Feb 2027	April 2027
Operational Governance Arrangements Follow-up	**JJ/AC**	Assurance							✓	
Management of Service Change	**JJ/AC**	Assurance							✓	
Complaints	**JJ/SD**	Assurance							✓	
Estates Assurance - Control of Contractors	**JJ/LD**	Assurance							✓	
Capital Systems - Targeted Estates Funding	**JJ/LD**	Assurance							✓	
Follow-up and agreed Action Implementation Tracking	**JJ/JW**	Assurance							✓	
Artificial Intelligence and Robotic Process Automation	**JJ/HT**	Assurance							✓	
Heath Records Management	**JJ/HT**	Assurance							✓	
Regional Joint Committee: Work Programme Delivery	**JJ/PK**	Assurance								✓
Validation of Emergency Departments Performance and Waiting Time Data Follow-up	**JJ/AC**	Assurance								✓
Business Continuity - Emergency Escalation	**JJ/AC**	Assurance								✓
Theatre Stock System Implementation	**JJ/AC**	Assurance								✓
Primary Care Community by Design (CbD)	**JJ/AC**	Assurance								✓
Cleanliness Standards Follow-up	**JJ/JS**	Assurance								✓
Vaccination and Immunisation Follow-up	**JJ/AG**	Assurance								✓
Progress Update: Operational Governance Internal Audit	**AC**	Assurance			✓					
Progress Update: Major Infrastructure Investment Programme Internal Audit	**LD**	Assurance				✓				
Progress Update: Human Tissue Authority Internal Audit	**JS**	Assurance				✓				
Progress Update: High Cost Drugs Internal Audit	**MH**	Assurance						✓		

AGENDA ITEM/ISSUE	LEAD	PURPOSE	14 April 2026	7 May 2026	23 June 2026	13 Aug 2026	15 Oct 2026	10 Dec 2026	11 Feb 2027	April 2027
CLINICAL AUDIT										
Review annual forward clinical audit plan and terms of reference	**MH/IB**	Assurance	✓				✓			✓
Review the effectiveness of clinical audit – consider recs from the ECPG on suggested areas of activity for review by internal audit	**MH/IB**	Assurance	✓				✓			✓
FINANCIAL FOCUS										
Review risks and controls around financial management (via Financial Assurance Report)	**HT**	Assurance	✓		✓	✓	✓	✓	✓	✓
Review Annual Summary of Single Tender Actions (STAs)	**HT**	Assurance			✓					
Financial Grip and Control	**HT**	Assurance	D	✓						
Annual statement of financial procedures	**HT**	Assurance							✓	
Receive Post Payment Verification (PPV) report	**HT**	Assurance	✓				✓			✓
Receive PPV annual report	**HT**	Assurance	✓							✓
Receive Primary Care PPV report	**AC**	Assurance	✓				✓			✓
Review of Schedule of Losses & Compensation*	**HT**	Assurance								
Receive reports which record the basis of decisions where the HB awards additional funding to contractors outside the terms of the contract *	**HT**	Assurance								
COUNTER FRAUD										
Review work plan & results from Counter Fraud activities, including anti fraud policies, etc.	**CFO**	Information	✓		✓	✓	✓	✓	✓	✓
To provide an update on the cases highlighted as part of the counter fraud update report (In-Committee)	**CFO**	Information	✓		✓	✓	✓	✓	✓	✓

AGENDA ITEM/ISSUE	LEAD	PURPOSE	14 April 2026	7 May 2026	23 June 2026	13 Aug 2026	15 Oct 2026	10 Dec 2026	11 Feb 2027	April 2027
Review and approve Counter Fraud Annual Report	**CFO**	Approval	✓							✓
Review and approve annual forward work plan for Counter Fraud activities	**CFO**	Approval	✓							✓
NHS CF Authority SRT Return	**CFO**	Approval	✓							✓
Annual Review of Requisitions (as part of main Counter Fraud update)	**CFO**	Information							✓	
Review the Health Board's assessment against NHS Protect Qualitative Assessment Reviews*	**CFO**	Information								
ASSURANCE AND RISK										
External Recommendations and WHC Assurance Report	**JW/CW**	Assurance			✓		✓		✓	
Risk Assurance Report	**JW/CW**	Assurance	✓			✓		✓		✓
Scrutiny of Outstanding Improvement Plans - Update on Status of Risks and Audits: • Community and Integrated Medicine CCG	**JW/CW** **AC**	Assurance				✓				
DEEP DIVE										
TBC *		Assurance								
FOR INFORMATION										
ARAC Work Programme	**Chair**	Information	✓		✓	✓	✓	✓	✓	✓
National Internal Audit Reports *		Information								
REVIEW OF THE MEETING										
Matters & Risks for Escalation to the Board	**Chair/JW**	Discussion	✓		✓	✓	✓	✓	✓	✓

* To be included on agenda as applicable

Initials

AC – Andrew Carruthers	**HT – Huw Thomas**	**LG – Lisa Gostling**
AG – Ardiana Gjini	**IB – Ian Bebb**	**MG – Murray Gard**
CW – Charlotte Wilmshurst	**IMs – Independent Board Members**	**MH – Mark Henwood**
CFO – Counter Fraud Officer	**JJ – James Johns**	**PK – Philip Kloer**
CSO – Committee Services Officer	**JS – James Severs**	**SA – Shaun Ayres**
EDs – Executive Directors	**JW – Joanne Wilson**	**SD – Sharon Daniel**
HIW – Healthcare Inspectorate Wales	**LD – Lee Davies**	

Audit Committee Tasks		14 April 2026	7 May 2026	23 June 2026	13 Aug 2026	15 Oct 2026	10 Dec 2026	11 Feb 2027	April 2027
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

8

11:55, 5 Mins

8 - Any Other Business

9

12:00, 0 Mins

9 - Review of Meeting

9.1

12:00, 0 Mins

9.1 - Matters and Risks for Escalation to the Board

For discussion

10

12:00, 0 Mins

10 - Date and Time of Next Meeting

9.30am, 15 October 2026