



GIG
CYMRU
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WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Date **2026-04-14**
Time **09:30 - 13:00**
Location **Microsoft Teams Meeting; HDD Picton - Dolau Cothi**

Audit & Risk Assurance Committee Meeting

HDD_Audit and Risk Committee

NHS Wales

Agenda - 14 April 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 Meeting held on 10 February 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)

2.5 **Annual Review of Standing Orders and Standing Financial Instructions**

09:50, 5 min

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

3	Audit Wales 09:55, 0 min
3.1	Audit Wales Update Report 09:55, 5 min <i>Anne Beegan, Urvisha Perez, David Williams</i>
3.2	Audit Wales Audit Plan 2026/27 10:00, 5 min <i>Anne Beegan, Urvisha Perez, David Williams</i>
3.3	Structured Assessment - Progress Update on Recommendations 10:05, 10 min <i>Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)</i>
3.4	Review of the Management of Outpatients 10:15, 15 min <i>Anne Beegan, Urvisha Perez, Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care), Lisa Humphrey (Hywel Dda UHB - General Manager)</i>
3.5	Review of Radiology Services 10:30, 0 min <i>Anne Beegan, Urvisha Perez</i>
3.6	Review of Investment in Digital Systems 10:30, 0 min <i>Anne Beegan, Urvisha Perez</i>
4	NWSSP – Audit and Assurance Services - Internal Audit 10:30, 0 min
4.1	Internal Audit Plan Progress Report 10:30, 5 min <i>James Johns (NWSSP - Internal Audit)</i>
4.2	Internal Audit Plan 2026/27

10:35, 5 min
James Johns (NWSSP - Internal Audit)

4.3 BREAK

10:40, 10 min

4.4 Operational Governance Arrangements (Limited Assurance)

10:50, 20 min
James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

4.5 Internal Escalation: Level 3 & 4 Functions (Limited Assurance)

11:10, 20 min
James Johns (NWSSP - Internal Audit), Huw Thomas (Hywel Dda UHB - Director of Finance)

4.6 Estates Assurance – Space Utilisation (Advisory Report)

11:30, 10 min
James Johns (NWSSP - Internal Audit), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Paul Williams (Hywel Dda UHB - Head of Property Performance), Sharon Hughes (Hywel Dda UHB - Principal Programme Manager Transformation)

4.7 Human Tissue Authority Follow-up (Review)

11:40, 10 min
James Johns (NWSSP - 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)

4.8 Infection Prevention & Control

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

4.9 GP Out of Hours

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

4.10 Major Infrastructure Investment Plan

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

4.11 Decision Making for High Cost Drugs

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

4.12 Wellsky System

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

4.13 Joint Committee with SBUHB

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

4.14 Medical Workforce Stabilisation

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

4.15 Theatre Stock System Implementation

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

5 Clinical Audit

11:50, 0 min

5.1 Clinical Audit Update

11:50, 10 min
Mark Henwood (Hywel Dda UHB - Executive Medical Director), Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience), Ian Bebb (Hywel Dda UHB - Clinical Audit Manager)

6 Financial Focus

12:00, 0 min

6.1 Financial Assurance Report

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

6.2 Financial Grip and Control

12:05, 0 min
Huw Thomas (Hywel Dda UHB - Director of Finance)

6.3	Counter Fraud Annual Report 2025/26 12:05, 5 min <i>Benjamin Rees (Hywel Dda UHB - Local Counter Fraud Specialist)</i>
6.4	Counter Fraud Work Plan 2026/27 12:10, 5 min <i>Benjamin Rees (Hywel Dda UHB - Local Counter Fraud Specialist)</i>
6.5	NHS Counter Fraud Authority Draft SRT Return 12:15, 0 min <i>Benjamin Rees (Hywel Dda UHB - Local Counter Fraud Specialist)</i>
7	Assurance and Risk 12:15, 0 min
7.1	Risk Assurance Report 12:15, 5 min <i>Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)</i>
8	Post Payment Verification 12:20, 0 min
8.1	Post Payment Verification (PPV) Report 12:20, 5 min <i>Huw Thomas (Hywel Dda UHB - Director of Finance), Amanda Legge (NWSSP - PCS), Sue Tillman (NWSSP - PCS)</i>
8.2	Primary Care PPV Report 12:25, 5 min <i>Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Rhian Bond (Hywel Dda UHB - Assistant Director of Primary Care)</i>
9	For Information 12:30, 0 min
9.1	ARAC Workplan 2026/27 12:30, 0 min

10 Any Other Business

12:30, 0 min

11 Review of Meeting

12:30, 0 min

11.1 Matters and Risks for Escalation to the Board

12:30, 0 min

12 Date and Time of Next Meeting

12:30, 0 min

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1 - 1 Introductions

1.1

09:30, 0 Mins

1.1 - Apologies

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

| For information

1.2

09:30, 0 Mins

1.2 - Declaration of Interests

All

hduhb.nhs.wales/about-us/governance-arrangements/register-of-interests-gifts-sponsorship-and-hospitality/register-of-igsh-documents/register-of-board-members-interests-2025-2026/

| For information

2 - Governance

2.1

09:30, 0 Mins

2.1 - Minutes of the Meeting held on 10
February 2026

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

| For approval

Attachments

2.1 Unapproved ARAC Minutes 10 February 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: 9:00 AM, Tuesday 10 February 2026

VENUE: Virtual via Microsoft Teams

PRESENT: Cllr Rhodri Evans, Independent Member (Chair) (VC)
Mr Winston Weir, Independent Member (Vice Chair) (VC) (part)
Mr Maynard Davies, Independent Member (VC)
Mrs Eleanor Marks, Independent Member (VC)

IN ATTENDANCE: Mr Shaun Ayres, Director of Delivery (VC) (part)
Mr Andrew Carruthers, Chief Operating Officer (VC) (part)
Ms Sophie Corbett, Deputy Head of Internal Audit (VC)
Mrs Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience (VC) (part)
Dr Ardiana Gjini, Director of Public Health (VC) (part)
Mr James Johns, Head of Internal Audit, NWSSP (VC)
Professor Philip Kloer, Chief Executive (VC) (part)
Ms Louise O'Connor, Assistant Director (Legal and Patient Support) (VC) (part)
Ms Urvisha Perez, Audit Wales (VC)
Mr Benjamin Rees, Head of Counter Fraud (VC)
Mr Huw Thomas, Executive Director of Finance (VC)
Mr David Williams, Audit Wales (VC)
Ms Charlotte Wilmshurst, Assistant Director of Assurance and Risk (VC)
Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary (VC)
Mr John Jenkins, Committee Services Officer (Secretariat) (VC)

MINUTES REF.	ITEM	ACTION

AC(26)1	INTRODUCTIONS AND APOLOGIES	

Cllr Rhodri Evans, Audit and Risk Assurance Committee (ARAC)
Chair welcomed all present to the meeting.

No apologies for absence had been received.

AC(26)2	DECLARATION OF INTERESTS	

No declarations of interests were made.

AC(26)3	MINUTES OF THE MEETING HELD ON 9 DECEMBER 2025	

The minutes of the ARAC meeting held on 9 December 2025 were reviewed and were approved as a correct record of proceedings.

Decision: It was **RESOLVED** that the minutes from the Audit and Risk Assurance Committee meeting on 9 December 2025 were approved as an accurate record.

AC(26)4

TABLE OF ACTIONS

The Table of Actions arising from the ARAC meeting held on 9 December 2025 was reviewed and the following updates were provided:

AC(25)171 ('Validation of Emergency Department Waiting Time Data'): Mrs Joanne Wilson advised that due to the on-going operational pressures, it had not been possible for the Community and Integrated Medicine (CIM) Clinical Care Group (CCG) to take the revised Standard Operating Procedures (SOP) through the governance process and advised of the revised delivery date of 31 March 2026.

AC(25)179 ('Internal and External Recommendations and WHC Tracking Assurance Report'): Mrs Wilson advised that due to the on-going operational pressures, at the request of the Chief Operating Officer, that the meetings arranged to review recommendations overdue by 6 months or more had been stood down and would be re-arranged for Summer 2026. It was agreed to re-open the previously closed action and that an update would be provided to the ARAC meeting on 23 June 2026.

AC(25)204 ('Review of Urgent and Emergency Care - Patient Flow (Regional Report)'): Mrs Wilson advised that due to the on-going operational pressures the timescale for completion would be revised to April 2026.

Decision: The Audit and Risk Assurance Committee **REVIEWED**, **NOTED** and **UPDATED** the Table of Actions from the Audit and Risk Assurance Committee meeting held on 9 December 2025.

AC(26)5

MATTERS ARISING NOT ON AGENDA

There were no matters arising not on the meeting agenda.

AC(26)6

ESCALATION STATUS UPDATE REPORT

Professor Philip Kloer presented the Escalation Status Update Report to the Committee and advised that the Health Board had been de-escalated to Level 1 for Leadership and Governance and that the Health Board had reviewed the approach to reporting escalation status to Board Committees to reflect the confidence expressed in the reporting process. Professor Kloer advised that updated guidance on accountability and escalation arrangements had been received from Welsh Government (WG).

Mr Shaun Ayres believed that the reason for the Health Board being placed in Health Board-wide escalation was due to concerns relating to Planning and Finance with a need for the whole organisation to contribute to the solutions required to enable de-escalation. Mr Ayres expressed concern on the capability and capacity with the organisation to progress the actions to enable wider de-escalation with operational pressures hindering the timely progress of the development of the 2026/27 Annual Plan.

In response to question from Cllr Evans on whether the Committee could be assured that there were robust operational governance arrangements in place, Mrs Wilson advised that there were good processes in place however there were inconsistencies within operational governance processes in respect of how this had been implemented. Furthermore, feedback from CCG colleagues was that there are too many meetings given the limited capacity to service the meetings, alongside undertaking other operational duties. A review has been undertaken by internal audit to ascertain how assurance can be provided that the required operational governance arrangements were in place are robust.

Mr Huw Thomas believed that further progress was required from the CCGs on the development of the required savings plans. Furthermore, work is required on the escalation processes at Level 3 and Level 4 of internal escalation and the role of the Chief Executive within the process to improve the interface between corporate and operational governance.

Mrs Elenor Marks commended the work undertaken to enable the Health Board to be de-escalated for Leadership and Governance and believed that the development of an integrated plan was a positive development.

In response to a question from Mrs Marks on the timescale for the development of an integrated plan, Mr Ayres believed that a significant area for the Health Board to address was within cancer performance and diagnostics and meeting the 8-week target for diagnostic services and the demand-related pressures within urgent and emergency care (UEC) and the impact of both on performance and finance.

Professor Kloer advised that the significant challenge was the Health Board's financial allocation for 2026/27 was only a 1.1%

increase compared to a 1.7% increase in 2025/26 and that the choice facing the Health Board would be in making the choice of where to prioritise investment for targeted improvement in performance and ensuring that the Health Board was as efficient and productive as possible.

In response to a question from Mr Maynard Davies on how the individual Board Committees scrutinised individual elements of the development of the Annual Plan and how ARAC oversaw the overall delivery of the plan whether there was a need for a process that incorporated inter-committee escalation of alerting, Mrs Wilson advised that the role of Board Committees in providing assurance on the individual elements of the Annual Plan and the role of ARAC in providing overall assurance on the delivery of the plan would be reviewed to enable assurance to be given.

JW/SA

Mrs Wilson advised that the financial pressure of needing to determine within which areas would be prioritised for investment would result in the level of risk in the de-prioritised areas not being addressed or adversely affected and that the Health Board needed to be transparent in addressing the risk and how the risks would either be tolerated or mitigated.

Decision: The Audit and Risk Assurance Committee:

- **NOTED** the de-escalation to Level 1 for Leadership and Governance and confirm BAU reporting route;
- **ENDORSED** the shift in assurance focus to plan credibility, controls and evidence across remaining Level 4/3 domains;
- **AGREED** a standing “escalation readiness” pack to the Audit and Risk Assurance Committee (monthly/meeting cycle) until Annual Plan submission;
- **AGREED** to review how the Audit and Risk Assurance Committee will receive assurance on the process and progress of developing the Annual Plan aligned to revised Welsh Government escalation framework;
- **AGREED** 2–3 targeted deep dives where assurance is highest risk avoiding duplication to work undertaken by other Board Committees; and
- **CONFIRMED** how the Audit and Risk Assurance Committee will monitor new risks emerging from CCG delivery plans and interdependencies (workforce, estates, infection).

AC(26)7

ALL WALES NHS AUDIT COMMITTEE CHAIRS' MEETING UPDATE

Cllr Evans provided an update from the All-Wales NHS Audit Committee Chairs' meeting held on 26 January 2026 and advised that a view had been expressed at the meeting by several of the Health Board Audit Committee chairs that serving on a multitude

of Board Committees raised questions on the independence of Audit Committee chairs. Cllr Evans believed that serving on other Board Committees provided a wider perspective on the challenges facing the Health Board.

Mrs Wilson advised that there was all-Wales guidance on the role of Audit Committee chairs and model standing orders that recommended that the Audit Committee chair should be a member of the Quality and Safety Committee and serve as Vice Chair of the Remuneration Committee of the Health Board.

In response to a question from Mr Davies on training for aspiring Independent Members (IMs), Mrs Wilson confirmed that a training programme was provided by the Aspiring Board Members Team and that Health Education and Improvement Wales (HEIW) provided a module-based induction programme for Board Members.

Professor Philip Kloer left the meeting

Decision: The Audit and Risk Assurance Committee **NOTED** the All-Wales NHS Audit Committee Chairs' meeting update.

AC(26)8

SCHEME OF DELEGATION

Mrs Wilson presented the revised and updated Scheme of Delegation following the revised portfolio changes within the Health Board and that the revised Scheme of Delegation had been approved by Executive Team on 21 January 2026 and would be presented to Board on 26 March 2026.

Mrs Wilson advised that there were a small number of items outstanding to be determined such as the residential scheme of delegation and a few revisions between the Director of Strategy and Planning and the Director of Public Health and within Estates and Facilities arising following the Remuneration and Terms of Service Committee (RTSC) meeting on 5 February 2026.

Mrs Wilson advised that Chair's Action may be necessary to approve any further changes following any approval at the Committee ahead of ratification at Board.

In response to a question from Mrs Marks on the linkage between the separate strategies of the Health Board, Mrs Wilson advised that the Director of Strategy and Planning was and remains responsible for the A Healthier Mid and West Wales Strategy and all the strategic plans that fed into the overarching strategy and that following the RTSC meeting on 5 February 2026 it was resolved that responsibility for estates would be the responsibility of the Director of Strategy and Planning with facilities being the

responsibility of the Director of Allied Health Professions and Health Science.

Decision: The Audit and Risk Assurance Committee **REVIEWED** and **RECOMMEND** the revised version of Hywel Dda University Health Board's Scheme of Delegation for onward approval to the Board on 26 March 2026.

AC(26)9

AUDIT WALES UPDATE REPORT

Mr David Williams presented the Audit Wales Update Report to the Committee and advised that Audit Wales had completed its 2024/25 audit of Hywel Dda Health Charity (HDdHC) with the planning work commenced for the HDdUHB accounts in progress.

Mr Williams advised the timeline for the audit of the Health Board accounts was similar to previous years with the accounts submitted by the Health Board to WG in early May 2026 with the audit undertaken and completed by the end of June 2026.

Ms Urvisha Perez presented the performance audit update to the Committee and advised that the review into outpatient management would be presented to the ARAC meeting on 14 April 2026 alongside the review into digital investment and the radiology review. Ms Wilson advised that the review of digital investments would be presented to the ARAC meeting on 7 May 2026 and the radiology review would be presented to the ARAC meeting on 23 June 2026.

Ms Rhian Bond joined the meeting

Ms Perez advised that the fieldwork for a deep dive into estates management was in the initial stages with a project brief for the local cancer review would be issued before the end of February 2026.

Ms Perez advised that the planning work for 2026/27 had commenced and an audit plan would be presented to ARAC on 14 April 2026.

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

AC(26)10

REVIEW OF INVESTMENT IN DIGITAL SYSTEMS

This agenda item was deferred to the 7 May 2026 meeting.

AC(26)11

REVIEW OF THE MANAGEMENT OF OUTPATIENTS

This agenda item was deferred to the 14 April 2026 meeting.

AC(26)12

REVIEW OF RADIOLOGY SERVICES

This agenda item was deferred to the 23 June 2026 meeting.

AC(26)13

INTERNAL AUDIT PLAN PROGRESS REPORT

Mr James Johns presented the Internal Audit Plan Progress Report to the Committee and advised of the 5 reports that had been finalised since the last ARAC meeting on 9 December 2025 and were presented to the Committee for consideration:

- Escalation Governance – Substantial Assurance
- Cyber Security – Substantial Assurance
- Patient Experience – Reasonable Assurance
- Managed Practices – Reasonable Assurance
- Vaccination and Immunisation – Limited Assurance

Mr Johns provided an update to the plan delivery and advised that following the update provided at the ARAC meeting on 9 December 2025, a request had been received to defer the audit of Ionising Radiation (Medical Exposure) Regulations (IRMER) due to operational pressures.

Mr Johns advised that the planning process for the development of the 2026/27 Internal Audit Plan had commenced and would be presented to the ARAC meeting on 14 April 2026 for consideration.

In response to a question from Mrs Marks on whether Internal Audit were receiving information in a timely manner from the Health Board, Mr Johns advised that discussions had been held with Mrs Wilson regarding a number of internal audits where there had been some specific difficulties in accessing the required information due to operational pressures, with it noted this had been raised directly with the Chief Operating Officer.

Decision: The Audit and Risk Assurance Committee:

- **NOTED** the Internal Audit Plan Progress Report; and
- **APPROVED** the amendment to the Internal Audit Plan 2025/26 to defer the Ionising Radiation (Medical Exposure) Regulations internal audit.

Mr Johns presented the Escalation Governance Final Internal Audit Report that examined the governance arrangements around the management of the escalation process and the processes for the monitoring and review of the actions associated with the escalation arrangements.

Mr Johns commended the positive outcome of the audit that had found substantial assurance with no actions or findings identified through the audit.

Mr Andrew Carruthers and Mrs Sharon Daniel joined the meeting

Decision: The Audit and Risk Assurance Committee **NOTED** the Escalation Governance Final Internal Audit Report and the substantial assurance opinion received.

This agenda item was deferred to the 14 April 2026 meeting.

Ms Sophie Corbett presented the Managed Practices Final Internal Audit Report that was a high-level review of the arrangements in place for the management of key systems and risk areas in relation to managed practices and advised that reasonable assurance was given with two high-priority findings identified within the audit.

Ms Corbett advised that the audit identified that managed practice budgets were based on historic General Medical Service (GMS) allocations from the point at which the practice had transferred to Health Board management and had not been subsequently updated to reflect any changes to patient capitation or actual running costs given that the cost of Health Board managed practices were potentially higher than those of a contracted practice.

Ms Corbett highlighted that at the time of the audit being undertaken, the forecasted end-of-year financial position for managed practices within the Health Board was a £1m overspend.

Ms Corbett stated that the second high priority finding related to the strategic vision for managed practices and advised that despite a report setting out the vision being presented to Board in March 2023 there had been no further updates considered since

resulting in a lack of clarity in the strategic intent into which managed practices were integrated into the Health Board operational arrangements and the consequential arrangements for financial and service planning.

Ms Corbett informed that other issues identified by the audit related to inconsistent risk management practices and inconsistent complaint recording and monitoring.

Ms Rhian Bond noted that work in relation to financial planning had been undertaken in 2024 and following the internal audit findings the recommendations had been progressed with work undertaken with Finance Business Partners to reset the managed practices budget from April 2026 that would require individual managed practices to develop savings plans and believed that some managed practices were significantly over-resources whereas others were under-resourced.

Ms Bond remarked that the mitigating factor for the apparent lack of update since the March 2024 Board meeting was due to the development of the Primary and Community Services Strategic Plan that would incorporate the approach to managed practices within the Health Board.

Ms Bond advised that an annual review process had been established to determine whether a managed practice would be retained as a Health Board managed practice or whether options to test the market for potential contracting arrangements or a dispersal of patients through the Vacant Practice Panel would be undertaken.

Mr Shaun Ayres left the meeting

In response to a question from Mr Davies on the managed practice overspend, Ms Bond stated that profiling work was being undertaken to rebalance the practice budgets to ensure that managed practices are allocated budgets consistent with independent contractor practices with a similar patient cohort with allowances made for staffing costs with an aim of staying within budget. Ms Corbett believed that the budget setting was linked to the strategic vision with any intention to maintain practices within Health Board management would require the practices to be integrated with Health Board operational arrangements.

Dr Ardiana Gjini and Ms Louise O'Connor joined the meeting

In response to a question from Mr Winston Weir on the need to ensure that regular finance meetings were undertaken, Ms Bond advised that regular meetings had now been arranged and were being undertaken between Finance Business Partners and the Primary Care Team on resetting the managed practice budget and the development of the required savings plans.

In response to a question from Mrs Marks on how investment is made in managed practices, Ms Bond believed that managed practices were typically more resource-heavy than independent contracted practices with higher rates of staff sickness and that the management structure of managed practices were less efficient than independent contracted practices that raised further strategic questions for the Health Board's continued operation of managed practices.

Mr Andrew Carruthers stated that the Health Board's strategic vision on managed practices was a priority within the development of the Primary and Community Services Strategic Plan and believed that there was a tension between how often the Health Board reviewed the market for the return of managed practices to the independent contracting arrangements and the impact on the stability of the staff within the affected practice with the need to develop a clear policy for the management of the process involving the Vacant Practice Panel.

Mr Carruthers advised that there was no all-Wales standardised approach for the management of managed practices and the process for progressing a managed practice's return to independent contracting and that had been raised with WG for the need for national consistency.

Mr Thomas believed that it would be unacceptable for managed practices to have a planned overspend and that the financial constraints required a rebalancing of the existing budgets with any non-recurrent additional resources needing to be considered within the wider Health Board financial position.

Mr Andrew Carruthers and Ms Rhian Bond left the meeting

Decision: The Audit and Risk Assurance Committee **NOTED** the Managed Practices Final Internal Audit Report and the reasonable assurance opinion received.

AC(26)17

THEATRE STOCK SYSTEM IMPLEMENTATION

This agenda item was deferred to the 14 April 2026 meeting.

AC(26)18

VACCINATION AND IMMUNISATION (LIMITED ASSURANCE)

Ms Sophie Corbett presented the Vaccination and Immunisation Final Internal Audit Report to the Committee that assessed the arrangements in place to monitor and promote the uptake of vaccinations and immunisation programmes within the eligible population of the Health Board.

Ms Corbett advised that prior to the commencement of the audit, the Health Board did not have an overarching strategic immunisation plan and while to have such a plan was not a WG requirement Ms Corbett observed that other Health Boards in Wales did have such a plan and it was considered beneficial for the Health Board to have such a plan. Ms Corbett advised that a regional plan was currently being developed.

Ms Corbett informed the Committee that while the Health Board had published a Immunisation Equity Strategic Plan it was considered that the implementation plan to support the strategic plan was not sufficiently 'SMART' (Specific, Measurable, Achievable, Relevant and Timely).

Ms Corbett highlighted that the audit identified that there were two versions of the implementation plan that were inconsistent with each other and that there was no evidence of progress monitoring identified due to the delays in establishing the Vaccine Equity Steering Group that was responsible for undertaking the required monitoring.

Ms Corbett added that 80% of vaccinations were delivered by GP practices and that while the Health Board had annual delivery plans in place for COVID-19 and influenza vaccinations there were no equivalent delivery programmes for other routine vaccinations.

Ms Corbett advised that the audit had identified that there was an operational governance structure in place it was not fully implemented, meetings were infrequent, engagement was limited and a number of groups had not been established as planned. The audit concluded that engagement between the immunisation teams and primary care contractors could be improved and roles and responsibilities could be clarified further.

Ms Corbett stated that while the audit had identified evidence of community outreach activity it was felt that this was not derived from any data-driven or coordinated programme of activity that linked to the equity strategic plan with little evidence that any outcomes would be monitored to assess the impact of engagement to inform future activity.

Ms Corbett summarised that as a result of the issues identified within the audit only a limited assurance option could be provided.

Dr Ardiana Gjini thanked Internal Audit for their support in undertaking the audit and advised that several of the recommendations arising from the audit and associated action plans had been initiated in response to the audit and that appointments had been made to within the Health Board's Vaccination and Immunisation Team.

Dr Gjini advised that she was confident that all the recommendations made by Internal Audit would be undertaken and within the agreed timescales.

Mrs Marks expressed disappointment with the audit findings and emphasised the need for the Primary Care Strategic Plan to link to the various related programmes to drive improvements to service delivery. Mrs Marks highlighted the importance of transparency and accountability and the need for clear roles and responsibilities.

In response to a question from Mrs Marks on what were the contributory factors to the issues identified within the audit, Dr Gjini believed that the manner of vaccination and immunisation programmes has changed so significantly within the past 12 months with the transition from mass vaccination centres for COVID-19 vaccinations to the establishment of Health Board vaccination teams and community vaccination clinics had resulted in the confusion of roles and responsibilities that had been identified in the audit.

Dr Ardiana Gjini and Mr Winston Weir left the meeting

Decision: The Audit and Risk Assurance Committee **NOTED** the Vaccination and Immunisation Final Internal Audit Report and the limited assurance opinion received.

AC(26)19 LEVEL 3 AND 4 DIRECTORATES

This agenda item was deferred to the 14 April 2026 meeting.

AC(26)20 DECISION MAKING FOR HIGH COST DRUGS

This agenda item was deferred to the 14 April 2026 meeting.

AC(26)21 DEPARTMENTAL / LOCAL IT SYSTEMS MANAGEMENT

This agenda item was deferred to the 14 April 2026 meeting.

AC(26)22 PATIENT EXPERIENCE (REASONABLE ASSURANCE)

Ms Corbett presented the Patient Experience Final Internal Audit Report to the Committee that had reviewed the arrangements that the Health Board had in place for capturing and utilising patient experience data. Furthermore, it was noted that the audit had

been undertaken during a transitional period for the service recognising some processes were currently being undertaken manually and were slightly fragmented, strategic improvements were planned in accordance with the revised People Experience framework.

Ms Corbett advised that reasonable assurance was provided by the audit with one high priority finding identified relating to the need to clarify responsibilities and expectations within the service in relation to interpreting and acting upon patient feedback and utilising the Civica patient experience software system.

Ms Corbett added that the audit had identified the need to update the Improving People and Community Experience Charter to reflect the new People Experience framework and to address variation in Civica system engagement at service level with action logging not being fully utilised that resulted in action not being consistently being taken in response to feedback.

Furthermore, there was demonstrable evidence of analysis of patient feedback and triangulation of this data being undertaken at corporate level for reporting to Board, there was limited evidence to indicate that this analysis was being undertaken at CCG and Clinical Service Group (CSG) level.

Mrs Sharon Daniel believed that work to provide further consistency and alignment with the People Experience Framework and strengthened governance arrangements would enhance the Health Board's approach to capturing and utilising patient experience data and that the actions in response to the audit findings had been agreed.

Ms Louise O'Connor advised that the transition period was while the revised all-Wales patient experience framework was being implemented and advised that the all-Wales work was being undertaken by NHS Wales Performance and Improvement who had yet to establish an implementation group due to the focus on the implementation on the new Listening to People's Concerns regulations. The Health Board progressing its own work in relation to addressing the local response to the People Experience Framework.

Ms O'Connor advised that work to address the recommendations was being progressed with a report being presented to the Executive Team on 4 March 2026. Ms O'Connor advised that work was being undertaken with the Informatics Team to develop an integrated dashboard for use by CCGs to provide service-level data in a digestible format that integrates with other patient feedback data such as compliments received to provide a fully balanced level of patient experience data. Ms O'Connor advised that the timescale for all the actions proposed in response to the audit were on target to be completed within the proscribed timescales.

In replying to a question from Cllr Evans on the responses received from the CCGs, Ms O'Connor believed that the response from the various CCGs on how patient experience data was embedded into the governance arrangements had been varied and anticipated that the implementation of a self-assessment tool would assist strengthen the governance arrangements at CCG level.

In answering a question from Mr Davies on the development of the self-assessment tool and comparisons to other similar tools developed by other Health Boards, Ms O'Connor advised that the revised People Experience Framework provides the self-assessment framework and believed that the HDdUHB self-assessment process was already robust and would be adapted to an electronic self-assessment format to enable maximum completion with further work required to assist CCGs embed the self-assessment process within their day-to-day work.

In response to a question from Mr Davies on what difficulties were experiences in data analysis, Mrs Daniel believed that the Health Board had a deficit in data analytical support and that work was being undertaken with the Data Informatics Team to explore how additional support could be received.

Mrs Sharon Daniel and Ms Louise O'Connor left the meeting

Decision: The Audit and Risk Assurance Committee **NOTED** the Patient Experience Internal Audit Report and the reasonable assurance opinion received.

AC(26)23

ESTATES ASSURANCE – SPACE UTILISATION

This agenda item was deferred to the 14 April 2026 meeting.

AC(26)24

FINANCIAL ASSURANCE REPORT

Mr Benjamin Rees joined the meeting

Mr Thomas presented the Financial Assurance Report to the Committee and advised that the level of staff overpayments had decreased, that the average recovery period has increased from 5 to 14 months as a result of a number of individual cases having concluded their repayment period that had resulted in a spike that was anticipated to reduce in future months.

Mr Thomas highlighted one individual loss exceeding £5,000 in November and December 2025 through drugs wastage due to a specific product ordered into the Intensive Therapy Unit (ITU) at WGH that was not required and with no alternative use.

In replying to a question from Cllr Evans on the breach of Standing Financial Instructions (SFIs), Mr Thomas advised that there had been six breaches reported in November and December 2025 with one breach of £96k relating to security services at WGH within Estates and Facilities. Furthermore, the Procurement Team had been involved too late in proceedings to prevent the occurrence from being a breach of SFIs and that the matter had been raised with the relevant Director for awareness and action.

In relation to a question from Mr Davies on Public Sector Payment Policy (PSPP) compliance, Mr Thomas advised that a dip in PSPP compliance performance was a result in a small number of high-value invoice payments that had been subject to further discussion between the Health Board and the payees.

In answering a question from Mr Davies on the effectiveness of project bank accounts, Mr Thomas advised that no review of their effectiveness had been undertaken and advised that he would discuss with WG whether any review of the effectiveness of Project Bank Accounts could be undertaken and to discuss with Internal Audit whether any work needs to be undertaken by the Health Board into the continued use and effectiveness of Project Bank Accounts.

HT

Mr Thomas advised that he would establish the precise number of project bank accounts established by the Health Board and feedback to the Committee via the table of actions.

HT

Decision: The Audit and Risk Assurance Committee:

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

AC(26)25

ANNUAL STATEMENT OF FINANCIAL PROCEDURES

Mr Thomas presented the Annual Statement of Financial Procedures to the Committee for review.

In response to a query from Mr Davies on the precise number of financial procedures contained within the annual statement, Mr Thomas advised that he would confirm the correct number of financial procedures that would be reviewed in 2026/27.

HT

Decision: The Audit and Risk Assurance Committee **NOTED** the Annual Statement of Financial Procedures

AC(26)26

COUNTER FRAUD UPDATE

Mr Winston Weir joined the meeting

Mr Benjamin Rees presented the Counter Fraud Update to the Committee and advised that a number of engagement events had been undertaken in December 2025 and January 2026 to raise awareness of the risk of working while sick and general NHS fraud with a New Year's Counter Fraud message being circulated to staff and further communications circulated on Viva Engage highlighting emerging fraud trends.

Mr Rees advised that a proactive local exercise into procurement-based activity had been undertaken to highlight the need to undertake good procurement governance and adherence to procedures.

Mr Rees advised that a review of counter fraud risk management processes and strategy had been undertaken within the Counter Fraud Team with a course of action identified to be commenced within Q1 2026/27 to review all previously identified risks to enable a review to be completed by the end of 2026/27 that would be presented to ARAC for assurance.

Mrs Wilson thanked Mr Rees for the work undertaken by the Counter Fraud Team as part of the counter fraud peer review. In response to a question from Cllr Evans on the timescale for the publication of the outcome report of the review, Mr Rees advised that the report was not anticipated before the end of Q4 2025/26.

Decision: The Audit and Risk Assurance Committee **NOTED** the Counter Fraud Update report.

AC(26)27

EXTERNAL RECOMMENDATIONS AND WELSH HEALTH CIRCULARS ASSURANCE REPORT

Ms Wilmshurst presented the External Recommendations and Welsh Health Circular Assurance Report to the Committee that outlined the process for tracking the progress of implementing external recommendations.

Ms Wilmshurst highlighted the number of open reports from 123 to 134 however advised that there had been a reduction in the number of overdue reports from 56 to 49 with half of those being overdue by six months or more, an improvement from October 2025 driven by improvements within Estates and Facilities who have reduced the number of overdue reports within their CCG from 29 to 13 however the number of overdue reports within the Community and Integrated Medicine had increased from 1 to 11.

Ms Wilmshurst advised that the number of open recommendations had been reduced from 557 to 435 with the number of overdue recommendations reduced from 236 to 196 with the number of recommendations overdue by over six months having also reduced from 82 to 36.

Furthermore, the number of recommendations with revised timescales had been significantly reduced down to 133, driven by improvements within Estates and Facilities that was reflected by the Estates and Facilities CCG having been de-escalated to Level 1 for governance within the internal escalation process.

Ms Wilmshurst advised that the Community and Integrated Medicine CCG performance had deteriorated since October 2025 with the number of overdue recommendations with revised timescales having increased with the CCG remaining within Level 3 of internal escalation for governance. Ms Wilmshurst advised that the Community and Integrated Medicine CCG also had an outstanding action in relation to overdue compliance with Welsh Health Circulars (WHCs).

Cllr Evans believed that no improvement had been displayed by the Community and Integrated Medicines CCG by the April 2026 report then a formal response from the Chief Operating Officer would be requested at the June 2026 ARAC meeting.

AC

Mr Davies questioned the number of open recommendations from the Mid and West Wales Fire and Rescue Service (MWWFRS) in relation to Estates and Facilities. Mrs Wilson advised that a review had been undertaken with the Estates and Facilities Team of those recommendations open for longer than six months. As part of this review assurance was sought that that actions were documented as opposed to verbal agreements with MWWFRS, requesting the Health Board follow up the actions from each meeting in writing. Ms Wilmshurst advised that the Health and Safety Committee oversaw the recommendations through their Risk and Assurance Report.

Decision: The Audit and Risk Assurance Committee:

- **NOTED** the External Recommendations and Welsh Health Circular Assurance Report;
- **RECEIVED ASSURANCE** that the Health Board was:

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

AC(26)28 POST PAYMENT VERIFICATION (PPV) ANNUAL REPORT

This agenda item was deferred to the 14 April 2026 meeting.

AC(26)29 PRIMARY CARE PPV REPORT

This agenda item was deferred to the 14 April 2026 meeting.

AC(26)30 ARAC WORKPLAN 2025/26

The ARAC Workplan 2025/26 was presented to the Committee for information.

Decision: The Audit and Risk Assurance Committee **NOTED** the Committee Workplan 2025/26.

AC(26)31 ANY OTHER BUSINESS

There was no other business transacted at the meeting.

AC(26)32 DATE AND TIME OF NEXT MEETING

The next ARAC meeting is scheduled for 9.30am on 14 April 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 10 February 2026.pdf](#)

AUDIT AND RISK ASSURANCE COMMITTEE (ARAC)/ PWYLLGOR ARCHWILIO A SICRWYDD RISG
10/02/2026

TABLE OF ACTIONS/TABL GWEITHREDOEDD

Key: AC-Andrew Carruthers; HT-Huw Thomas; JW-Joanne Wilson; PS-Peter Skitt; RW-Rachel Williams

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	10/02/2026	In progress Due to operational pressures, it has not been possible to take the revised SOP through the governance process. Revised delivery date of end of March 2026 proposed.
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	10/02/2026	In progress See AC(25)171

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
09/12/2025	AC(25)204	Review of Urgent and Emergency Care - Patient Flow (Regional Report) • To discuss outside the meeting whether the contents of the management response can be revisited	AC	10/02/2026	Complete Head of Assurance & Risk and Assurance & Risk Officer met with leads at the Regional Partnership Board on 18 March 2026 to review management responses, and obtain clarification on progress made in their implementation to date. Outcomes of this meeting have been communicated to relevant leads within the Health Board to ensure appropriate ongoing monitoring of the implementation of these recommendations on AMAT. Progress will be reviewed monthly within the Governance domain via the Health Board's internal escalation framework.
09/12/2025	AC(25)205	Risk Assurance Report • To examine prior to the next report the escalation level for the CIM CCG	RW	14/04/2026	Complete Monthly analysis continues for all CCGs and Functions as part of the internal escalation framework, with progress to be provided to ARAC on the performance of CIM within the Governance domain in April 2026, via the next Risk Assurance Report.
10/02/2026	AC(26)6	Escalation Status Update Report • To review the role of Board Committees in providing assurance on the individual elements of the Annual Plan and the role of ARAC in providing assurance to Board on the overall delivery of the Annual Plan.	JW	14/04/2026	Complete Audit Committee will retain an overarching governance role on behalf of the Board in relation to the Health Board's ongoing escalation status.

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
10/02/2026	AC(26)27	External Recommendations and Welsh Health Circulars Assurance Report • To consider requesting a formal response at ARAC from Chief Operating Officer if no improvement in Community and Integrated Medicine CCG performance.	AC	23/06/2026	In progress In progress. To be considered in June 2026 should no improvement in CIM CCG performance exhibited.
10/02/2026	AC(26)25	Annual Statement of Financial Procedures • To confirm the number of financial procedures to be reviewed in 2026/27 (six or ten)	HT	14/04/2026	Complete Confirmed that the appendix was correct with six.
10/02/2026	AC(26)24	Financial Assurance Report • To discuss with Welsh Government any review of the effectiveness of Project Bank Accounts and discuss with Internal Audit whether any work needs to be undertaken by the Health Board into the continued use and effectiveness of Project Bank Accounts.	HT	14/04/2026	Complete Welsh Government have updated their Project Bank Account (PBA) guidance which has been simplified, aiming to reduce confusion around PBAs and therefore prevent mistakes when setting up accounts. Internal Audit are reviewing the operation of our existing PBA as a part of their current review into Withybush Fire Project (Phase 2).
10/02/2026	AC(26)24	Financial Assurance Report • To confirm the number of Project Bank Accounts established by the Health Board.	HT	14/04/2026	Complete Three Project Bank Accounts have been established.

2.3

09:35, 0 Mins

2.3 - Matters Arising not on Agenda

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

| For discussion

2.4 - Escalation Status Update Report

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

| For assurance

Attachments

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

[2.4 20260220 - Ietr OS to PK HDUHB - revised escalation framework.pdf](#)

[2.4 Hywel Dda University Health Board Escalation Framework - February 2026 - final version.pdf](#)

[2.4 20260312 - SE to PK - HDUHB Scrutiny Session Letter.pdf](#)

[2.4 CEO.20064 - Hywel Dda University Health Board Scrutiny Session.pdf](#)

[2.4 Annual Plan Letter 2026.pdf](#)



Discussion paper for the Audit, Risk and Assurance Committee

The revised targeted intervention framework, what has changed,
and the implications for overarching assurance

April 2026



Since the whole organisation was placed into level 4 in January 2024, we have progressively de-escalated across multiple domains:

Jan 2024 Whole organisation escalated to level 4 across all domains **Level 4**

Mar 2025 Planned care, CAMHS, and leadership and governance de-escalated → **Level 3**

Jul 2025 Cancer de-escalated to level 3; CAMHS to level 1 → **Level 3 / 1**

Dec 2025 Leadership and governance de-escalated → **Level 1**

Feb 2026 Cancer de-escalated. Revised framework issued. → **Level 1**

Current position as at February 2026:

Finance, strategy and planning **Level 4**

Urgent and emergency care **Level 4**

HCAIs and fragile services **Level 4**

Planned care **Level 3**

Cancer, CAMHS, leadership and governance **Level 1 (Routine Arrangements)**



The February 2026 framework is the fourth iteration since April 2025. Comparing it against the June 2025 version reveals significant movements: three domains have been de-escalated out entirely, new de-escalation criteria have been introduced, and existing expectations have been sharpened.

Domains de-escalated to level 1 (no longer in the framework)

- ~~Cancer~~ level 4 → level 3 (July 2025) → level 1 (February 2026)
- ~~CAMHS~~ level 3 → level 1 (July 2025)
- ~~Leadership and governance~~ level 3 → level 1 (December 2025)

New de-escalation criteria (not in June 2025 framework)

- **Finance:** Deliver milestone target control totals on an ongoing basis; deliver a financial improvement trajectory towards in-year balance over two financial years
- **Strategy:** Planning maturity self-assessment against an agreed matrix; regional working now requires demonstrated joint plans and increased activity across five specialties
- **UEC:** New enabling metrics for emergency admissions over 21 days and pathways of care assessment delays

Criteria tightened or revised

- **Finance:** June 2025 required “annual plan demonstrating trajectory to deliver TCT”; February 2026 now requires ongoing milestone delivery and a two-year trajectory to in-year balance
- **Planned care:** follow-up reduction now requires continuous monthly improvement maintained for three months
- **UEC and planned care:** assessment of BCIs and complaints removed as de-escalation criteria but retained as action requirements



Although three domains have been de-escalated, the revised framework has introduced new and more exacting criteria. Alongside the annual plan for 2026/27, the total set of commitments the health board must deliver against includes:

- **Level 4** Quantified de-escalation criteria across finance (4 criteria), strategy and planning (5 criteria), UEC (4 criteria plus 2 enabling metrics), HCAs (3 criteria), and clinical services (6 criteria)
- **Level 3** Planned care de-escalation criteria across outpatients, RTT, diagnostics, endoscopy, NOUS/MRI, therapies, and follow-ups (9 criteria)
- Submit an acceptable annual plan for 2026/27 and demonstrate progress towards an approvable IMTP
- Progress regional service planning with Swansea Bay across orthopaedics, ophthalmology, stroke, urology, and upper GI with demonstrated joint plans and activity
- Deliver a credible financial improvement trajectory towards in-year balance over two financial years
- Maintain and sustain improvements in cancer, CAMHS, and leadership and governance to avoid re-escalation
- Respond to external reviews, inspections, royal college recommendations, and national programme requirements across all domains

This is being delivered alongside operational pressures and the normal business of running the health board. The question for the committee is whether we have sufficient organisational bandwidth to deliver the totality of what is required, and how any shortfall in one area may cascade into others.



No single board committee currently asks the systemic question: given everything the framework and plan require, is this deliverable?

Individual committees scrutinise their domains. But the interdependencies between those domains mean that pressure in one area can affect delivery in another:

- Financial recovery depends on service change, which depends on planning capacity and regional collaboration
- UEC performance depends on flow, which depends on delayed pathways of care, which depends on community capacity and planning capacity
- Fragile services require workforce stability, which competes with the same recruitment challenges affecting planned care delivery and consultation and engagement
- Meeting the expanded planned care criteria while also delivering the UEC and HCAI targets draws on the same clinical and operational leadership whilst balancing theatres

If a domain that has been de-escalated deteriorates, it could re-enter the framework and further stretch the organisation's capacity to deliver across the remaining commitments.



At a previous meeting, Mr Maynard Davies asked how ARAC provides overarching assurance on the annual plan when no de-escalation criteria are directly assigned to the committee.

The revised framework provides a basis for defining that role. We suggest ARAC's contribution is not to duplicate what other committees scrutinise, but to ask:

- Given the revised criteria and the breadth of what is required, is the overall position deliverable?
- Are there interdependencies or capacity constraints that could affect delivery across domains?
- Are all criteria allocated to a board committee with appropriate scrutiny arrangements?
- Are de-escalated domains being monitored to avoid re-escalation?

This gives ARAC a defined role that is distinct from other committees: overseeing the coherence and deliverability of the whole, rather than scrutinising individual parts.



We ask the committee to consider this approach and, if content, agree the following:

- **Note** the changes in the revised February 2026 escalation framework and the cumulative de-escalation progress since January 2024
- **Agree** that ARAC's role in relation to the annual plan is to provide overarching assurance on the deliverability and coherence of the totality of commitments, including organisational capacity to achieve overarching escalation
- **Receive** a consolidated position on delivery against the framework at each meeting, including cross-cutting risks and interdependencies
- **Refer** specific concerns to the relevant board committee for detailed scrutiny and require a response
- **Report** to Board where the committee identifies material concerns about overall deliverability

We will bring a fuller assessment of the revised criteria and their implications for committee assurance arrangements to the next meeting.



Llywodraeth Cymru
Welsh Government

Y Grŵp Iechyd Gofal Cymdeithasol a'r Blynyddoedd Cynnar
Health, Social Care and Early Years Group

Phil Kloer
Chief Executive
Hywel Dda University Health Board

Eich Cyf/Your Ref:
Ein Cyf/Our Ref:

20 February 2026

Dear Phil

Revised Health Board escalation framework

Following the de-escalation of cancer from level 3 to level 1 on 19 February 2026, I enclose the revised version of the health board escalation framework.

Yours sincerely

Olivia Shorrocks
HEAD OF PERFORMANCE, ESCALATION AND INTERVENTION

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

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Introduction

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

- level 4 for finance, strategy and planning, performance and outcomes related to urgent and emergency care, quality of care related to HCAs and fragile services.
- level 3 for performance and outcomes related to planned care.

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

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

Escalation history

September 2022

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

January 2024

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

March 2025

The health board was de-escalated to level 3 for performance and outcomes relating to planned care and CAMHS and for leadership and governance.

July 2025

The health board was de-escalated to level 3 for cancer and to level 1 for CAMHS.

December 2025

The health board was de-escalated to level 1 for leadership and governance.

February 2026

The health board was de-escalated to level 1 for cancer.

NHS Wales oversight and escalation framework

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

During escalation, interventions will be:

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

Whilst the health board is in escalation:

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

De-escalation

This framework sets out the expectations for de-escalation against each area and domain of escalation. Where possible, these de-escalation criteria are consistent with other health organisations in escalation.

De-escalation will be no more than one level at a time with reduced oversight and intervention at each stage of de-escalation. De-escalation from level 3 (enhanced monitoring) will typically be to level 1 (routine arrangements).

To be considered for de-escalation, an organisation must demonstrate that progress towards the de-escalation criteria is being made.

There are two approaches to de-escalation:

1. The Welsh Government will coordinate activity to closely monitor, challenge and review progress made by the NHS organisation. If the NHS organisation can provide evidence of sufficient and timely improvement, then the Welsh Government and external review bodies will share knowledge to enable them each to consider whether de-escalation of the intervention arrangements placed on the NHS organisation is appropriate. For de-escalation to occur, the NHS body may not have achieved all of the de-escalation criteria, but they will need to demonstrate sustained improvements with a credible improvement plan to maintain improvements.
2. De-escalation for those areas with quantifiable outcomes and targets such as performance and outcomes will take place once the de-escalation criteria have been met and sustained for the agreed period of time. If the NHS organisation meets the de-escalation criteria for a specific domain or sub-domain then they will be de-escalated to the next level on the escalation scale. This de-escalation will be automatically triggered outside of the normal escalation cycle and will be confirmed in writing to the organisation.

Roles and responsibilities

The roles and responsibilities of Welsh Government are to:

- support a formal structure for reviewing and reporting progress.
- signpost relevant best practice guidance and frameworks.
- act as a critical friend and sounding board on existing practices and new developments.
- review and provide feedback on action plans.
- undertake and share relevant analysis and deep dives of national data.
- enable shared approaches to key national issues across Welsh organisations and promote shared learning.
- direct the NHS P&I to provide targeted support to areas of concern to help the health board to improve their progress against programme objectives.
- work with the health board on critical enablers relating to regional planning, clinical services redesign, infrastructure (digital and buildings).

The roles and responsibilities of the health board are to:

- appoint an SRO(s) for all areas of escalation.
- ensure Board ownership and oversight with a clear governance structure, ensure that the Board is appraised of the escalation plan and evidence regular progress updates to the Board on progress against de-escalation criteria.
- produce a realistic and achievable level 3 / level 4 plan in response to the areas of concern and in line with the agreed de-escalation criteria.
- provide progress reports and evidence against the escalation plan to Welsh Government.
- give assurance that there are formal review mechanisms in place within the health board to monitor and deliver the required improvements.

Finance, strategy and planning

Finance

The finance intervention and focus whilst in level 4 covers the following areas:

The health board will be required to action and:

- demonstrate financial governance and financial control environment mechanisms that are robust, and sufficient assurance is received on their effectiveness by undertaking a review of the financial management arrangements in place against an appropriate best practice framework(s) and developing and implementing an action plan to address any gaps in approach.
- articulate clearly the drivers of the current deficit to inform a triangulated approach to identify and deliver actions that will improve efficiency, sustainably reduce costs, and maximise the sustainable use of resources.
- evidence clear policies and processes supporting the identification, delivery and monitoring of all savings schemes and opportunities. This should include having a clear and robust opportunities framework (and pipeline) that contains realistic opportunities to support and manage the short-term challenges being faced, as well as driving the larger-scale transformational changes that will support long-term sustainability.
- evidence an integrated planning approach and strategy to deliver a clear roadmap and key milestones for delivery of a breakeven plan in line with the expectations set by Welsh Government. This should include clear and realistic planning assumptions, which triangulates with the organisation's longer-term strategic objectives around service delivery, workforce, infrastructure, etc.
- challenge and stress-test the health board's plan submission for 2026/27 and identifying opportunities for improvement.
- deliver an improving financial trajectory in line with the organisation's Board approved plans, including significant progress towards in-year financial balance over the next two financial years.

The health board will be required to action and demonstrate financial governance and a control environment through:

- the financial governance framework at the health board that is robust in both design and implementation, including a self-assessment against best practice frameworks.
- the financial committee structure; clearly articulated and addresses key risks.
- financial reports and supplementary presentations that include the analysis and narrative explanation required to enable management and the board to discharge their duties.
- financial controls at the health board that are robust in both design and implementation, including a self-assessment against model frameworks, review implementation of the Standing Financial Instructions, internal audit reviews, or other control reviews.
- the finance function that has the necessary capacity and capability to support the needs of the wider organisation.
- holding budget holders and managers to account for delivering their financial plans.

- delivery of its action plan to improve the financial governance and financial control environment.

The health board will be required to action and demonstrate understanding of the existing deficit and key drivers and must:

- demonstrate there is a clear understanding of the cost drivers and investment decisions responsible for the growth in deficit across the organisation, including an explicit breakdown by key service area and cost driver.
- review prior year investments to assess whether the planned benefits have been delivered.
- implement a robust process for challenging underlying deficits reported at local divisional levels.
- understand that the drivers and investment decisions responsible for the growth in workforce are well understood; are reviewed for ongoing value; and are monitored through the integrated performance report.
- ensure integrated performance reports clearly identify and monitor metrics against key activity cost drivers.

As a result of the above, there are triangulated approaches to identify and deliver actions to improve efficiency and maximise the use of resources.

The health board will be required to action and demonstrate development and realisation of opportunities and must:

- have a clear process and approach across the organisation to support the identification, delivery and monitoring of all savings schemes.
- develop a comprehensive opportunities framework with a constant pipeline of opportunities and establish clear roles and responsibilities for developing opportunities into saving schemes and subsequent delivery of these saving schemes.
- translate national opportunities identified through the Value and Sustainability Board into local savings.
- have clear policies and processes in place to enable budget holders and managers to realise and deliver identified savings schemes.
- demonstrate how the health board uses Value based health care principles across the organisation through specified services and pathways.

The health board will be required to action and demonstrate a clear financial plan and strategy through:

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

The health board will be required to action and demonstrate delivery of a plan through:

- a clear improvement in the planned financial trajectory for 2026/27 including further progress around identification and delivery of recurring opportunities.

De-escalation criteria

In order for the health board to be de-escalated to the next level of intervention, they must meet the criteria set out below:

- demonstrate that there are robust financial governance and robust financial control environment in place with risks minimised.
- make substantial progress in delivering the level 4 action plan, including actions to improve the organisation's understanding of the existing deficit and key drivers and development and realisation of opportunities.
- continue to deliver milestone target control totals on an ongoing basis such as the reset TCT for 2025/26 of a £22.1m deficit.
- continue to demonstrate and deliver a financial improvement trajectory to deliver in-year financial balance in line with Welsh Government expectations.

Strategy and planning

The strategy and planning intervention and focus whilst in level 4 escalation covers the following areas:

The health board will be required to action and demonstrate delivery of milestones within the approved plan and must:

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

The health board will be required to demonstrate how the delivery of a clinical strategy and plan is supporting:

- future planning and investment decisions.
- decision making across the organisation.

The health board will be required to demonstrate how regional planning is supporting the health board to:

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

De-escalation criteria

In order for the health board to be de-escalated to the next level of intervention, they must meet the criteria set out below:

- submit an acceptable annual plan in line with the current planning framework.
- evidence an integrated planning across the organisation which supports the development of a coherent and deliverable annual plan.
- evidence a clear roadmap and implementation of the health board's clinical services plan.
- increase Welsh Government's confidence in delivery based on an assessment against an agreed planning maturity matrix.
- evidence progress made with regional planning in relation to orthopaedics, ophthalmology, stroke services, urology, and upper gastrointestinal services in 2025/26 as demonstrated by joint plans, improved working, and increased activity delivered through regional working.

Clinical services

The fragile services intervention and focus whilst in level 4 will alter over time in response to workforce and estate challenges. The current focus will be on the nine clinical areas identified in the health board's clinical services plan:

1. Critical care
2. Dermatology
3. Elective orthopaedics
4. Ophthalmology
5. Urology
6. Emergency general surgery
7. Stroke
8. Endoscopy
9. Radiology

De-escalation criteria

In order for the health board to be de-escalated to the next level of intervention, they must meet the criteria set out below:

- evidence that the health board has the appropriate mechanism to understand the drivers behind a fragile service through the triangulation of key data points, including staffing levels, staff and patient feedback, concerns, incidents, stakeholder feedback (HIW, Audit Wales, HMC, Royal Colleges, Llais etc), mortality reviews, duty of quality / candour, infection protection control, performance, clinical and medical leadership.
- demonstrate that fragile services are supported by strong clinical leadership, have an effective integrated improvement plan, project management structure and effective transformation support.
- show progress is being made towards key performance metrics.
- evidence that all recommendations from the Royal Colleges, HIW and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the health board's longer-term improvement plan.
- evidence that the Board is sighted on fragile services and has a robust response and action plan for each area.
- 65% R1 ophthalmology patient pathways to be waiting within or no longer than 25% of their target date for an outpatient appointment and maintained for 3 months.

Performance and outcomes

Urgent and emergency care

The performance and outcomes level 4 intervention and focus for urgent and emergency care (UEC) covers the following areas:

The health board will be required to action and demonstrate sustainable services and must:

- ensure that recovery and improvement plans are in place and that agreed priorities are being implemented, in accordance with evidence-based practice and national requirements.
- improve unscheduled care performance to ensure that patients access safe, timely and effective unscheduled care services, reducing waiting times, delays and improving quality.
- deliver activity in line with agreed trajectories and implement any necessary changes where performance falls below trajectory.
- deliver the UEC enabling actions in the 2025/28 planning guidance.
- demonstrate how the health board responds and handles concerns, complaints, incidents and patient experience feedback related to UEC as part of the quarterly escalation meetings.
- assess declared BCIs, including reasons why, actions taken, and lessons learnt.
- ensure that patients are clear where they can and should access support, signposting away from emergency services.

The health board will be required to action and demonstrate working with national programmes and respond to external reviews and must:

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

De-escalation criteria

In order for the health board to be de-escalated to the next level of intervention, they must meet the criteria set out below:

- continuous reduction of ambulance handovers over an hour of at least 11% in three consecutive months and maintained for 3 months (Based on agreed baseline).
- continuous monthly improvement towards achieving no more than 7% of patients waiting over 12 hours at each individual site and across the health board.
- continuous improvement in the median time from arrival at an emergency department to assessment by a clinical decision maker to achieve a maximum of 60 minutes.

- continuous reduction in delayed pathways of care (with a focus on those caused by assessment issues) of 5% for three consecutive months and then maintained (based on agreed baseline).

The enabling metrics for de-escalation are:

- a three-month continuous reduction of at least 5% in each month (from the November 2023 baseline) in the number of people admitted as an emergency who remain in hospital over 21 days since admission.
- a three-month continuous reduction of at least 5% in each month in pathways of care assessments issues (from the November 2023 baseline).

Quality of care related to HCAs

The performance and outcomes level 4 intervention and focus for quality of care related to Healthcare Acquired Infections (HCAs) covers the following areas:

The health board will be required to demonstrate how they are delivering sustainable services through:

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

The health board will be required to demonstrate appropriate governance and leadership through:

- a clear improvement plan based on a root cause analysis to address the issue of hospital onset HCAs.
- having clear and effective response mechanisms in place to respond to outbreaks reporting directly to Board.

De-escalation criteria

In order for the health board to be de-escalated to the next level of intervention, they must meet the criteria set out below:

- reduce the number of hospital onset C-Diff infections by 25% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 (2023/24) of 8 cases to no more than 6 per month).
- reduce the number of hospital onset Staph Aureus infections by 33% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 (2023/24) of 3 cases to no more than 2 per month).
- reduce the number of hospital onset E-Coli infections by 25% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 (2023/24) of 7 cases to no more than 5 per month).

Planned care

The performance and outcomes level 3 intervention and focus for planned care covers the following areas:

The health board must demonstrate how they have sustainable planned care services through:

- a robust improvement plan in accordance with evidence-based practice and national requirements.
- improved access to planned care services with reduced waiting times in line with the de-escalation criteria.
- delivery of the planned care enabling actions in the 2025/28 planning guidance.
- how the health board responds and handles concerns, complaints, incidents and patient experience feedback related to planned care at the quarterly escalation meetings.
- implementation of an outpatient transformation plan in line with the requirements of the planned care programme.
- utilisation of regional working arrangements to improve outcomes and improved access to services.

The health board will be required to action and demonstrate working with national programmes and respond to external reviews and must:

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

The health board must demonstrate improved communications and engagement through:

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

De-escalation criteria

In order for the health board to be de-escalated, they must meet the criteria set out below:

- 100% of open outpatient pathways to be waiting less than 52 weeks and maintained for 3 months.
- continuous improvement towards 75% of all open outpatient pathways waiting less than 26 weeks.
- 100% of open pathways to be waiting less than 104 weeks and maintained for 3 months.
- continuous improvement towards 80% of all open pathways waiting less than 36 weeks.
- continuous monthly improvement towards achieving a 12% reduction in the number of patients delayed by 100% for their follow up appointment in three consecutive months and maintained for 3 months (based on the agreed baseline).
- 85% of patients waiting for a diagnostic test to be waiting less than 8 weeks and maintained for 3 months.
- 85% of patients waiting for a diagnostic endoscopy to be waiting less than 8 weeks and maintained for 3 months.
- 85% of patients waiting for a NOUS and non-cardiac MRI to be waiting less than 8 weeks and maintained for 3 months.
- 90% of patients waiting for therapies to be waiting less than 14 weeks and maintained for 3 months.

Version control

Date	Comments
August 2025	Revised version shared with health board incorporating comments received
September 2025	Final version with accessibility changes incorporated
December 2025	New framework following changes in escalation status in December 2025.
February 2026	Revised framework following de-escalation for cancer.



Philip Kloer
philip.kloer@wales.nhs.uk

Our Ref: SSE/HDUHB

31 March 2026

Dear Philip,

Hywel Dda University Health Board – Scrutiny Session

Thank you to your team for attending the health board's scrutiny session on the 12th March. The purpose of the meeting was to gain assurance from the executive team based on the issues raised in your Accountable Officer letter that was submitted on 13th of February. Prior to the scrutiny session, you and your team were advised that we would be seeking assurance against:

- Performance ambitions, including the organisation's assessment against the delivery expectations, enabling actions and MAG recommendations
- Actions to address and reduce the underlying deficit
- The total opportunity pipeline available to the organisation
- Detailed actions and savings plan with confidence assessment
- Ownership of risks and mitigations – with clear next steps
- Options and choices to take the organisation to financial balance

I opened the meeting by reflecting that the health board's scrutiny session was triggered because the organisation had signalled that it could not submit a Board approved financially balanced plan. I reiterated that the requirement remains the same – the organisation is expected to submit a balanced plan that delivers against the expectations of the Planning Framework. Furthermore, a deterioration of the financial position would be unacceptable and unsupportable. It is expected that as a minimum, the organisation will balance against and improve upon this year's outturn position.

I acknowledged that the health board had shown progress over the past two years, specifically in relation to

- Strengthened organisational capability
- De-escalation in cancer
- Improvements in data quality, planning, and grip of delivery.



Your team set out the detail of the status of your current financial assessment, which at the time of meeting was an underlying deficit of £58.4m, which is not acceptable. It is Welsh Government's view that choices can be taken to reduce this figure, such as improving on the £28.9m of savings the health board describes as being non-recurrent. You also described an initial forecast deficit as things stand of £41m. We were clear that Welsh Government cannot support or accept a £41m in-year deficit plan. The health board delivered 2025 / 26 forecast outturn deficit of £22.1m against a revised control total.

We acknowledged the incremental progress the organisation has made in recent years. However, Welsh Government has been clear on numerous occasions, and the health board has delivery conditions associated with funding provided on a conditionally recurrent basis in 2024/25, on setting out a clear route-map to deliver in-year financial balance. This has not been provided and must be the focus of the health board.

Your current savings was at £17.6m against a £47m total, leaving a £30m gap. You advised me that the health board was updating its governance process to accelerate conversion of value opportunities into deliverable savings. We reiterated to you that the Welsh Government expects to see improvement in all aspects of the plan including the underlying deficit, actions being taken to mitigate new projected costs, and confidence in plans to realise savings delivery.

On urgent and emergency care, you have genuine ambitions to further improve the one-hour delay metric for ambulance handover to achieve the targeted intervention threshold, improve on the 45-minute ambulance handover time, overall average handover times and the total hours lost over the next 12 months which is heavily dependent on the investment received.

Performance across cancer, planned care and diagnostics has remained stable over the past year, which was supported by targeted investment and prioritisation of diagnostic capacity. However, progressing further towards the 75% cancer ambition will require additional step-up improvements and continued delivery of your productivity and optimisation framework, alongside the structural and enabling actions already underway. You mention that mental health and learning disability services remain key areas of focus.

Most specialties are now operating in sustainable balance, but a small number continue to drive significant delivery gaps. Dermatology accounts for around half of the outpatient shortfall, with an expected gap of just over 9,000 patients against the 26-week standard. For 104-week pathways, the gap is approximately 5,500 patients, two-thirds of which sits within ophthalmology. These specialties have longstanding reliance on external capacity and are part of ongoing Clinical Service Planning and Regional Planning work.

You mention the productivity gains achieved in outpatients, reduced follow-ups, and improved DNA rates, and further improvement will be dependent on additional resource, particularly to expand diagnostic capacity in endoscopy, radiology, and cellular pathology. These areas face genuine demand-capacity pressures that must be addressed to support continued performance improvement.

In relation to planned care you have access to viable solutions to close the gaps identified, but these come with a significant financial cost, which remains the central

challenge to delivery. Therapy provision continues to be an area of difficulty, with limited progress against the 14-week measure and you remain at Level 3. Current breach levels sit at approximately 2,300, with the potential to exceed 3,000 next year due to sustained demand pressures.

To reiterate, there is no available funding to support additional delivery requirements. You must therefore proceed on the basis that no additional financial support will be provided by the Welsh Government. If enabling actions are fully delivered and remaining opportunities maximised, the level of investment required should be significantly lower. The cited requirement of £12.5m does not align with this understanding. There is a need to rapidly reconcile these differing interpretations to ensure a shared and accurate view of what is genuinely required to deliver the plan.

Whilst I understand that the organisation is in a challenging position, Welsh Government's position remains the same. More must be done to improve the current position which is, at present unacceptable. A deficit plan cannot be supported. Should you wish to speak with me or any of the senior officials prior to the submission of your plan, we would be happy to do so.

From a Welsh Government perspective, in summary, clear actions must be taken at pace by the health board to:

- Deliver recurrently savings and mitigations from 2025/26 to not deteriorate the underlying position.
- Undertake a follow-up performance discussion with Jeremy Griffith.
- Strengthen the plan's ambition and clarity.
- Welsh Government to share the assessment for the opportunities relating to enabling actions.

Yours sincerely



Samia Edmonds MBE
Director of Strategic Planning

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Dear Samia

Thank you for your letter of 31 March 2026 and the discussions at our scrutiny session. We welcome the ongoing dialogue and recognise the seriousness of the Board's position as we head into 2026/27.

In line with Welsh Government requirements, we submitted our Annual Plan yesterday, supported by a covering Accountable Officer letter, following extensive discussion at our Board meeting on 26 March 2026. The Accountable Officer letter provides further context and the Annual Plan sets out detail on the financial position, performance expectations and delivery of the enabling actions.

It was acknowledged at Public Board, as discussed in our Scrutiny session, that the scale of the financial deficit means our Plan will understandably be deemed unacceptable and unsupportable by Government. The Plan also carries significant risks. Our immediate intention is therefore to de-risk the Plan through quarter one of 2026/27. In addition, in my Accountable Officer letter, I reference the request of our Board to assess what would be required to meet the revised Target Control Total of £22.1m.

In response to the four specific actions outlined in your letter:

Deliver recurrently savings and mitigations from 2025/26 to not deteriorate the underlying position

Our Plan describes the current position and work will continue through quarter one as part of our intention to de-risk the Plan. As we presented in the scrutiny session, the £28.5m non-recurrent saving delivered during 2025/26 falls into four categories:

- One-off benefits not to be repeated in 2026/27: £9.0m
- Ongoing recurrent savings already supporting the underlying position: £9.0m
- Policy driven: £4.8m
- Health Board choices: £6.1m

Within the Health Board choices, the most significant areas relate to Workforce and Organisational Development (e.g. Apprenticeship recruitment), Planned Care (predominantly theatres) and Public Health (Health Protection Strategy and Health Coaches).

While some of these underspends can be continued non-recurrently into 2026/27, making them permanent would have implications for longer-term sustainability and performance delivery.

Undertake a follow-up performance discussion with Jeremy Griffith

An initial meeting with Jeremy took place prior to the scrutiny session, focused on enabling actions and performance trajectories and I have asked Andrew Carruthers to arrange a follow-up. Productivity and efficiency will be a central focus for 2026/27 and we welcome the continued support of Jeremy and NHS Performance and Improvement.

Strengthen the plan's ambition and clarity

At the scrutiny session we were able to provide a high-level overview of our Plan. The full Annual Plan has now been submitted and I hope this provides the additional clarity sought. If there are any aspects that you would like to discuss further, we would be very happy to do that, perhaps initially through the regular touchpoints. I have asked Lee Davies to discuss this with you at your next meeting.

With regard ambition, we recognise that our Plan does not meet the expectations of Welsh Government. We as a Health Board are also not satisfied with it and have some significant concerns, in particular regarding the financial position and the projected deterioration in planned care performance. Ultimately, this is an unsustainable position and is the focus of our attention heading into 2026/27.

While the Plan does not meet Government expectations it provides a comprehensive and transparent baseline of our position and the actions underway. It assumes delivery of £42.8m of savings in 2026/27 and progress against the enabling actions, with associated risks set out in my Accountable Officer letter. We remain committed to strengthening ambition and pace while ensuring plans remain credible and deliverable.

Our immediate focus through quarter one is to de-risk the financial plan, clarify what would be required to deliver the revised £22.1m Target Control Total and strengthen delivery confidence in the highest risk areas, particularly planned care and urgent and emergency care. This will inform further discussions with Welsh Government ahead of quarter two.

Welsh Government to share the assessment for the opportunities relating to enabling actions

We welcome Welsh Government insight into further opportunities to improve our position. This will be a key focus of follow-up discussions with Jeremy Griffith and ongoing touchpoint meetings, reflecting our Targeted Intervention status. The Plan includes a detailed assessment of progress against the enabling actions and quantifies further opportunities, which we anticipate will mitigate some of the financial and performance challenges facing the Health Board.

Thank you again Samia for you and your colleagues' continued engagement and support. We have made progress over the past 12 months and remain determined to build on this, recognising the challenging outlook for 2026/27. With the forthcoming election, we also anticipate the need for plans to remain agile and responsive. There is significant work ahead to deliver the Plan and, beyond that, move towards a sustainable health and care system for West Wales. We look forward to continuing to work with you to achieve this.

Yours sincerely



Prof Phil Kloer
Chief Executive



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Ein cyf/Our ref: CEO.19167

Gofynnwch am/Please ask for:

Lia Mapuranga

Dyddiad/Date: 31/03/2026

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Dear Jacqueline,

Accountable Officer Letter regarding Hywel Dda University Health Board Annual Plan 2026/27

Please find attached Hywel Dda University Health Board's Annual Plan for 2026/27, which was considered and approved for submission by our Public Board on 26th March 2026. As this represents approval for submission of a deficit plan, please accept this letter as an Accountable Officer notification regarding the novel and contentious actions we have taken as a Board.

Over the past twelve months, we have delivered real and measurable improvements across the organisation. When the Health Board was placed in Level 4 Targeted Intervention in January 2024, concerns existed across every domain of the escalation framework. Since then, through sustained and focused effort, we have secured de-escalation in four areas: planned care and CAMHS were de-escalated to Level 3 in March 2025; cancer was de-escalated to Level 3 in July 2025 and then to Level 1 routine arrangements in February 2026; CAMHS reached Level 1 in July 2025; and leadership and governance was also de-escalated to Level 1 in December 2025.

These are significant milestones that reflect the maturity, grip and determination of the organisation, and they represent real progress towards our ambition of building a reputation for professionalism and delivery that secures Hywel Dda's place as a trusted and sustainable part of the NHS in Wales. Additionally, we have made significant steps regarding the refresh of our Strategy – A Healthier Mid and West Wales; and our Clinical Services Plan.

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Cadeirydd / Chair
Dr Neil Wooding CBE
Prif Weithredwr / Chief Executive
Professor Phil Kloor

Despite these positive steps, I must acknowledge that Hywel Dda University Health Board continues to face substantial challenges which prevent us from submitting a balanced Integrated Medium-Term Plan (IMTP). We are operating within a structural financial deficit, with a projected Year 1 position of £41.0 million including the projected Welsh Risk Pool additional costs. Within that constraint, this plan is built on disciplined choices about where to direct limited resources for the greatest impact on quality, safety and value. We remain subject to Targeted Intervention arrangements in Planning and Finance, Urgent and Emergency care and Hospital Acquired Infections.

Our 2026/27 plan is ambitious yet realistic. The approach we have taken to developing this plan is grounded in value, collaboration and rigour. Every service area has been built from detailed demand and capacity modelling, with trajectories rooted in what is already being delivered rather than untested assumptions. Our Clinical Care Groups have worked together to produce integrated chapters that tell a coherent story across urgent and emergency care, planned and specialist services, cancer and diagnostics, mental health and learning disabilities, primary care, and the enabling functions of workforce, finance and estates.

Throughout 2026/27, we will continue to prioritise urgent and high-priority patients, including those on cancer and emergency pathways, while working to improve access, reduce long waits and deliver sustainable improvements in performance. Where we cannot yet meet every standard, we have costed recovery plans ready to deploy should additional resources become available. Our commitment to delivering safe, high-quality care for every patient known to the Health Board remains unwavering, and the pursuit of value in everything we do, for patients, for staff and for the public purse will guide every decision we make in the year ahead.

However, the Plan also identifies a number of material risks, dependencies and constraints:

- As this point there is a risk to the delivery of the performance expectations and the Targeted Intervention criteria. The plan is explicit about what can and what cannot be delivered within the resources available, with productivity and efficiency a central theme of this year's Plan.
- The savings programme requires conversion of a significant proportion of non-recurrent benefits into recurrent savings. Progress on this conversion will be a critical determinant of the financial trajectory in-year.
- Workforce recruitment timelines, particularly for senior clinical roles in diagnostics, theatres and acute medicine, can exceed six months and represent a delivery risk to the phased programmes.
- The continuation of Welsh Government non-recurrent diagnostic funding is unconfirmed and its loss would materially worsen both the diagnostic and cancer performance positions.
- The Glangwili theatre estate presents a significant and ongoing operational constraint to elective activity across multiple specialties.
- Delayed pathways of care require effective system-wide partnership with local authorities that extends beyond the Health Board's direct operational control.
- The conditionally recurrent funding received in a prior year remains at risk if the Health Board does not achieve financial breakeven within the anticipated timeframe.

- A Senedd election is anticipated during the planning period, which may result in changes to ministerial priorities and expectations.

The 2026/27 Annual Plan represents another significant milestone in this journey, combining realistic and robust financial management with ambitious service transformation. Overall, I believe this plan represents a credible and deliverable approach to both financial recovery and service improvement. The Board has thoroughly scrutinised the proposals through our committee structure and board seminars, culminating in formal approval for submission on 26th March 2026. In recognition of the breach of our statutory duty to break even, the Board has:

1. **RECOGNISED** that the financial plan for 2026/27 presents a planned deficit of £41.0m, or £27.9m excluding the additional impact of Welsh Risk Pool, which does not meet the financial trajectory expectations set out in the Welsh Government's February 2026 Escalation Framework, nor does it deliver against the Health Board's statutory breakeven duty; and that this will consequently result in a qualified regularity opinion.
2. **AUTHORISED** that I, as Accountable Officer, formally notify Welsh Government that the Board's decision to approve the submission of a plan that does not meet statutory requirements represents a novel or contentious action.
3. **APPROVED** the submission of the Annual Plan to Welsh Government, in line with the NHS Wales Act 2006.
4. **APPROVED** the onward delegation and allocation of 2026/27 financial budgets based on Year 1 of the financial plan, inclusive of Long Term Agreements (LTAs) – Commissioning £207,719,882 (Excludes Public Health Wales) and for Income £25,064,098 (Excludes Public Health Wales)

As discussed at Board on 26th March, I and the Board are firmly committed to improving on our financial trajectory and establishing a clear and deliverable route map to sustainability, as evidenced in our progress throughout 2025/26. Given the financial position of the Health Board, we as a Board are ourselves dissatisfied and further work will be undertaken to financially de-risk the Plan through quarter one of 2026/27. In addition, Board has asked the Executive Team to describe what would be required to reduce our forecast deficit from £41.0m to the revised Target Control Total of £22.1m.

I look forward to continuing our constructive dialogue and welcome the opportunity to discuss the plan in more detail.

Yours sincerely,



Professor Phil Kloer
Chief Executive Officer
Hywel Dda University Health Board

2.5 - Annual Review of Standing Orders and Standing Financial Instructions

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

| For approval

Attachments

[2.5 Review of Standing Orders and SFIs ARAC April 2026.pdf](#)

[2.5 LHB Model Standing Orders Reservation and Delegation of Powers.pdf](#)

[2.5 LHB Model SFIs - FINAL version for approval.pdf](#)



PWYLLGOR ARCHWILIO A SICRWYDD RISG AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	14 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Review of Standing Orders and Standing Financial Instructions
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Director of Corporate Governance/Board Secretary
SWYDDOG ADRODD: REPORTING OFFICER:	Charlotte Wilmshurst, Assistant Director of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

To present Hywel Dda University Health Board's (HDdUHB's) reviewed Standing Orders (SOs) and Standing Financial Instructions (SFIs) to the Audit and Risk Assurance Committee for consideration, prior to their onward submission to the Board for approval on 28 May 2026.

Paragraph 12.0.2 of the Model Standing Orders states that these should be reviewed annually by Health Boards' and Trusts' Audit Committees, and any proposed amendments reported to the Board for consideration.

The reviewed HDdUHB Standing Orders and Standing Financial Instructions are therefore presented to the Audit and Risk Assurance Committee for comment, prior to recommending their onward submission for approval to the Board on 28 May 2026.

Cefndir / Background

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

Asesiad / Assessment

No further amendments to the Model Standing Orders have been made since the last review of the HDdUHB Standing Orders made in line with WHC (2025) 007 and approved by the Board in May 2025.

Section A – Introduction

Corporate Office address changed from Corporate Offices, Ystwyth Building, St Davids Park, Carmarthen. SA31 3BB to Hywel Dda University Health Board, Second Floor, Block C, Government Buildings, Picton Terrace, Carmarthen. SA31 3BT

3.2.3 Joint Committees

The Hywel Dda University Health Board and Swansea Bay University Health Board Regional Joint Committee (RJC) has been added to list of Joint Committees.

Schedule 1 – Scheme of Reservation and Delegation of Powers

No changes have been made to this Schedule.

Schedule 2 – Key Guidance, Instructions and Other Related Documents

Corporate Office address changed from Corporate Offices, Ystwyth Building, St Davids Park, Carmarthen. SA31 3BB to Hywel Dda University Health Board, Second Floor, Block C, Government Buildings, Picton Terrace, Carmarthen. SA31 3BT

Schedule 2.1 - Standing Financial Instructions

These were last approved by the Board in July 2025 in line with Welsh Health Circular (WHC/2025/012) – Interim Amendments to the Model Standing Financial Instructions Chapter 11 for Local Health Boards and NHS Trusts in Wales. Only the following local amendments have been made:

15.1.2 – Amended title from Director of Strategy to Director of Strategy and Planning

15.4.7 – Amended title from Director of Strategy to Director of Strategy and Planning

15.7.3 – Amended title from Director of Strategy to Director of Strategy and Planning

Schedule 3 – Board Committee Arrangements

No changes have been made to this Schedule.

Schedule 4 - Joint Committee Arrangements

The Hywel Dda University Health Board and Swansea Bay University Health Board Regional Joint Committee (RJC) has been added to list of Joint Committees.

Schedule 5 – Advisory Groups

No changes have been made to this Schedule.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to **RECOMMEND** the revised version of HDdUHB's Standing Orders and Standing Financial Instructions to the Board on 28 May 2026 for approval.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference:
Cyfeirnod Cylch Gorchwyl y Pwyllgor:

3.10 The Committee will be responsible for reviewing the Health Board's Standing Orders and Standing Financial Instructions and Scheme of Delegation annually, (including associated framework documents as appropriate), monitoring compliance, and reporting any proposed changes to the Board for consideration and approval.

Cyfeirnod Cofrestr Risg Datix a Sgôr
Cyfredol:

Not applicable

Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Model Standing Orders and Standing Financial Instructions
Rhestr Termiau: Glossary of Terms:	Included within the body of the report
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Robust governance arrangements underpinning financial management contribute towards internal control and value for money being achieved
Ansawdd / Gofal Claf: Quality / Patient Care:	Where applicable, included within the report.
Gweithlu: Workforce:	Where applicable, included within the report.
Risg: Risk:	A sound system of internal control ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed.

Cyfreithiol: Legal:	Model SOs are issued by Welsh Ministers to Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Health Boards in Wales must agree SOs for the regulation of their proceedings and business. SOs are designed to translate the statutory requirements set out in the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779 (W.67)) into day to day operating practice, and, together with the adoption of a Scheme of Decisions reserved to the Board; a Scheme of Delegations to officers and others; and SFIs, they provide the regulatory framework for the business conduct of the Health Board.
Enw Da: Reputational:	Not applicable
Gyfrinachedd: Privacy:	No direct impacts
Cydraddoldeb: Equality:	The Model SOs and SFIs have been subject to an Equality Impact Assessment as part of the NHS Reform Programme, and the revised SOs were subject to an in-house EqlA screening in July 2025, the outcome of which indicated no negative impacts in relation to the Health Board's duties under the Equality Act 2010. The most recent amendments outlined above and attached have been subject to an EqlA Screening, and there is no evidence at this stage of potential adverse impact in relation to equality, diversity or human rights. Should any issues arise at any stage following implementation of the revised SOs, a full EqlA will be undertaken as appropriate.

Model Standing Orders

Reservation and Delegation of Powers

For Local Health Boards

Foreword

These Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Local Health Boards (LHBs) in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business. When agreeing SOs LHBs must ensure they are made in accordance with directions as may be issued by Welsh Ministers.

These SOs are designed to translate the statutory requirements set out in the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779 (W.67)) into day to day operating practice, and, together with the adoption of a Scheme of decisions reserved to the Board; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the LHB.

These documents form the basis upon which the LHB's governance and accountability framework is developed and, together with the adoption of the LHB's Values and Standards of Behaviour framework (Standards of Behaviour Policy), is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All LHB Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Director of Corporate Governance/Board Secretary will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements within the LHB.

Further information on governance in the NHS in Wales may be accessed at <https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/>.

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Section A – Introduction

Statutory Framework

- i) The Hywel Dda University Local Health Board (the LHB) is a statutory body that was established on 1 June 2009 and became operational on the 1 October 2009 under **The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 (S.I. 2009/778)**, “the Establishment Order”.
- ii) The principal place of business of the LHB is – ~~Corporate Offices, Ystwyth Building, St David’s Park, Carmarthen, SA31 3BB.~~ **Hywel Dda University Health Board, Second Floor, Block C, Government Buildings, Picton Terrace. Carmarthen SA31 3BT.**
- iii) All business shall be conducted in the name of Hywel Dda University LHB, and all funds received in trust shall be held in the name of the LHB as a corporate Trustee.
- iv) LHBs are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how LHBs are governed and their functions.
- v) Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Welsh Ministers have made **the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779)** (“The Constitution Regulations”) which set out the constitution and membership arrangements of LHBs, which includes a requirement for LHBs to make SOs for the regulation of its proceedings and business including provision for the Boards suspension. Sections 12 and 13 of the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on LHBs and to give directions about how they exercise those functions. LHBs must act in accordance with those directions. Most of the LHB’s statutory functions are set out in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009 (S.I. 2009/1511)**.
- vi) **The National Health Service Joint Commissioning Committee (Wales) Directions 2024 (WG24-06)** provide that the seven LHBs in Wales will establish a joint committee to exercise the functions of planning, securing and commissioning:

Model Standing Orders, Reservation and Delegation of Powers for LHBs

- (a) specialised services for –
 - (i) cancer and blood disorders,
 - (ii) cardiac conditions,
 - (iii) mental health and vulnerable groups,
 - (iv) neurosciences, and
 - (v) women and children,
- (b) services where there is agreement between the Local Health Boards that they should be arranged on a regional and national basis,
- (c) emergency medical services,
- (d) non-emergency patient transport services,
- (e) emergency medical retrieval and transfer services,
- (f) NHS 111 services,
- (g) sexual assault referral centres, and
- (h) other services as directed by the Welsh Ministers.

Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Welsh Ministers have made the **National Health Service Wales Joint Commissioning Committee (Wales) Regulations 2024 (2024 No. 135 (W29))**, which make provision for the constitution and membership of the Joint Commissioning Committee, including its procedures and administrative arrangements.

- viii) In addition to directions the Welsh Ministers may from time to time issue guidance which LHBs must take into account when exercising any function. However in some cases the relevant function may be contained in other legislation. In exercising their powers LHBs must be clear about the statutory basis for exercising such powers.
- ix) As a statutory body, the LHB has specified powers to contract in its own name and to act as a corporate trustee. The LHB also has statutory powers under sections 194 and 195 of the NHS (Wales) Act 2006 to fund projects jointly planned with local authorities, voluntary organisations and other bodies.
- x) The **National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993)** have effect as made under section 33 of the NHS (Wales) Act 2006 enable LHBs, NHS Trusts and Local Authorities to enter into any partnership arrangements to exercise certain NHS functions and health-related functions as specified in the Regulations. The arrangement can only be made if it is likely to lead to an improvement in the way in which NHS functions and health-related functions are exercised, and the partners have consulted jointly with all affected parties, and the arrangements fulfil the objectives set out in the Area Plan developed in accordance with the **Social Services and Well-being (Wales) Act 2014 (2014)**.
- xi) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions. NHS bodies includes

Model Standing Orders, Reservation and Delegation of Powers for LHBs

the NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trusts and, for the purpose of this duty, also includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.

- xii) Section 82 of the NHS Act 2006 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.
- xiii) Further duties and powers placed on health boards in relation to co-operation and partnership with local authorities and other partners in Wales are set out in the **Social Services and Well-being (Wales) Act 2014**. This Act establishes the legal framework for meeting people's needs for care and support and imposes general and strategic duties on local authorities and LHBs in order to effectively plan and provide a sufficient range and level of care and support services. The **Partnership Arrangements (Wales) Regulations 2015 (2015/1989)**, made under Part 9 of the **Social Services and Well-being (Wales) Act 2014** set out the arrangements made and provides for LHBs and local authorities to pool funds for the purpose of providing specified services.

Guidance on the provisions of Part 9 can be found at <https://gov.wales/sites/default/files/publications/2020-02/part-9-statutory-guidance-partnership-arrangements.pdf>

- xiv) **The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) makes provision for:
 - Ensuring NHS bodies and ministers consider how their decisions will secure an improvement in the quality of health services (the Duty of Quality);
 - Ensuring NHS bodies and primary care services are open and honest with patients, when something may have gone wrong in their care (the Duty of Candour);
 - The creation of a new Citizens Voice Body for Health and Social Care, Wales (to be known as Llais) to represent the views of and advocate for people across health and social care in respect of complaints about services; and

The act has been commenced at various stages with the final provision, relating to the preparation and publication of a code of practice regarding access to premises coming into effect in June 2023.

Local Health Boards will need ensure they comply with the provisions of the 2020 Act and the requirements of the statutory guidance.

The Duty of Quality statutory guidance 2023 can be found at <https://www.gov.wales/duty-quality-healthcare>

The NHS Duty of Candour statutory guidance 2023 can be found at <https://www.gov.wales/duty-candour-statutory-guidance-2023>

- xv) The **Well-being of Future Generations (Wales) Act 2015** also places duties on LHBs and some Trusts in Wales. Sustainable development in the context of the Act means the process of improving economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.
- xvi) The Welsh Language (Wales) Measure 2011 makes provision with regards to the development of standards of conduct relating to the Welsh language. These standards replace the requirement for a Welsh Language Scheme previously provided for by Section 5 of the Welsh Language Act 1993. The Welsh Language Standards (No.7) Regulations 2018 (2018/411) came into force on the 29 June 2018 and specifies standards in relation to the conduct of Local Health Boards. The Local Health Board will ensure that it has arrangements in place to meet those standards which the Welsh Language Commissioner has required by way of a compliance notice under section 44 of the 2011 Measure.
- xvii) LHBs are also bound by any other statutes and legal provisions which govern the way they do business. The powers of LHBs established under statute shall be exercised by LHBs meeting in public session, except as otherwise provided by these SOs.

NHS Framework

- xviii) In addition to the statutory requirements set out above, LHBs must carry out all business in a manner that enables them to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that are expected at all levels of the service, locally and nationally.
- xix) Adoption of the principles will better equip LHBs to take a balanced, holistic view of their organisations and their capacity to deliver high quality, safe healthcare services for all its citizens within the NHS framework set nationally.
- xx) The overarching NHS governance and accountability framework incorporates these SOs; the Schedules of Reservation and Delegation of Powers; SFIs together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework*; the Health and Care Quality Standards 2023, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

Model Standing Orders, Reservation and Delegation of Powers for LHBs

* The NHS Wales Values and Standards of Behaviour Framework can be accessed via the following link: <https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/living-public-service-values/values-and-standards-of-behaviour-framework/>

- xxi) The Welsh Ministers, reflecting their constitutional obligations and legal duties under the **Well-being of Future Generations (Wales) Act 2015**, have stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.
- xxii) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at <https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/>. Directions or guidance on specific aspects of LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Local Health Board Framework

- xxiii) Schedule 2 provides details of the key documents that, together with these SOs, make up the LHB's governance and accountability framework. These documents must be read in conjunction with these SOs and will have the same effect as if the details within them were incorporated within the SOs themselves. The Standing Financial Instructions form Schedule 2.1 of these SOs.
- xxiv) LHBs will from time to time agree and approve policy statements which apply to the LHB's Board members and/or all or specific groups of staff employed by Hywel Dda University LHB and others. The decisions to approve these policies will be recorded in an appropriate Board minute and, where appropriate, will also be considered to be an integral part of the LHB's SOs and SFIs. Details of the LHB's key policy statements are also included in Schedule 2.
- xxv) LHBs shall ensure that an official is designated to undertake the role of the Director of Corporate Governance/Board Secretary (the role of which is set out in paragraph xxxiii below).
- xxvi) For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance – SOs 1.1.2 refers.

Applying Standing Orders

- xxvii) The SOs of the LHB (together with SFIs and the Values and Standards of Behaviour Framework (Standards of Behaviour Policy), will, as far as they are applicable, also apply to meetings of any formal Committees established by the LHB, including any Advisory Groups, sub-Committees, joint-Committees and joint sub-Committees. These SOs may be amended or adapted for the Committees as appropriate, with the approval of the Board. *Further details on committees may be found in Schedule 3 of these SOs and further details on joint-Committees may be found in Schedule 4.*
- xxviii) Full details of any non-compliance with these SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Director of Corporate Governance/Board Secretary, who will ask the Audit and Risk Assurance Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and LHB officers have a duty to report any non-compliance to the Director of Corporate Governance/Board Secretary as soon as they are aware of any circumstance that has not previously been reported.
- xxix) **Ultimately, failure to comply with SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

Variation and amendment of Standing Orders

- xxx) Although these SOs are subject to regular, annual review by the LHB, there may, exceptionally, be an occasion where it is necessary to vary or amend the SOs during the year. In these circumstances, the Director of Corporate Governance/Board Secretary shall advise the Board of the implications of any decision to vary or amend SOs, and such a decision may only be made if:
- The variation or amendment is in accordance with regulation 15 of the Constitution Regulations and does not contravene a statutory provision or direction made by the Welsh Ministers;
 - The proposed variation or amendment has been considered and approved by the Audit and Risk Assurance Committee and is the subject of a formal report to the Board; and
 - A notice of motion under Standing Order 7.5.14 has been given.

Interpretation

- xxxi) During any Board meeting where there is doubt as to the applicability or interpretation of the SOs, the Chair of the LHB shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair shall take appropriate

advice from the Director of Corporate Governance/Board Secretary and, where appropriate the Chief Executive or the Director of Finance (in the case of SFIs).

- xxxii) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these SOs when interpreting any term or provision covered by legislation.

The role of the Director of Corporate Governance/Board Secretary

- xxxiii) The role of the Director of Corporate Governance/Board Secretary is crucial to the ongoing development and maintenance of a strong governance framework within LHBs and is a key source of advice and support to the LHB Chair and other Board members. Independent of the Board, the Director of Corporate Governance/Board Secretary acts as the guardian of good governance within the LHB. The Director of Corporate Governance/Board Secretary is responsible for:

- Providing advice to the Board as a whole and to individual Board members on all aspects of governance;
- Facilitating the effective conduct of LHB business through meetings of the Board, its Advisory Groups and Committees;
- Ensuring that Board members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Board acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the LHB's compliance with the law, SOs and the governance and accountability framework set by the Welsh Ministers;

As advisor to the Board, the *Director of Corporate Governance/Board Secretary's* role does not affect the specific responsibilities of Board members for governing the organisation. The Director of Corporate Governance/Board Secretary is directly accountable for the conduct of their role to the Chair in respect of matters relating to responsibilities of the Board, its Committees and Advisory Groups, and reports on a day to day basis to the Chief Executive with regard to the wider governance of the organisation and their personal responsibilities.

- xxxiv) Further details on the role of the Director of Corporate Governance/Board Secretary within Hywel Dda University LHB, including details on how to contact them, are available at [Board Secretary - Hywel Dda University Local Health Board](#).

Section B – Standing Orders

1. THE LOCAL HEALTH BOARD

- 1.0.1 The LHB's principal role is to ensure the effective planning and delivery of the local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for its citizens, and in a manner that promotes human rights.
- 1.0.2 The LHB was established by the **Local Health Boards (Establishment and Dissolution) (Wales) Order 2009** (S.I. 2009/778) and most of its functions are contained in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009** (S.I. 2009/1511). The LHB must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.
- 1.0.3 To fulfil this role, the LHB will work with all its partners and stakeholders in the best interests of its population.

1.1 Membership of the Local Health Board

- 1.1.1 The membership of the LHB shall be no more than 24 members comprising the Chair, Vice Chair, non-officer members (appointed by the Minister for Health and Social Services), Associate Members, the Chief Executive (appointed by the Board with the involvement of the Chief Executive, NHS Wales) and officer members (appointed by Non-Executive Members of the Board and the Chief Executive).
- 1.1.2 For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members (which will include the Chair) shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance. Officer and non-officer members shall have full voting rights. Associate Members do not have voting rights.

Officer Members [to be known as Executive Directors]

- 1.1.3 A total of 9 (including the Chief Executive), appointed in accordance with the Constitution, Membership and Procedures Regulations, whose responsibilities include the following areas: Medical; Finance; Nursing; Primary Care and Community and Mental Health Services; Strategic and Operational Planning; Workforce and Organisational Development; Public Health; Therapies and Health Science. Executive Directors may have other responsibilities as determined by the Board and set out in the

scheme of delegation to officers.

Non Officer Members [to be known as Independent Members]

- 1.1.4 A total of 9, appointed by the Minister for Health and Social Services, including: an elected member of a local authority whose area falls within the LHB area; a current member or employee of a Third Sector organisation within the LHB area; a nominated trade union official; a person who holds a post in a University that is related to health; and five other Independent Members who together have experience and expertise in legal; finance; estates; Information Technology; and community knowledge and understanding.
- 1.1.5 In addition to the eligibility, disqualification, suspension and removal provisions contained within the Constitution Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of more than one NHS body in Wales.

Associate Members

- 1.1.6 A total of 4 associate members may be appointed to the Board. They will attend Board meetings on ex-officio basis but will not have any voting rights.
- 1.1.7 No more than three Associate Members may be appointed by the Minister for Health and Social Services. This may include:
- Director of Social Services (nominated by local authorities in the LHB area)
 - Chair of the Stakeholder Reference Group
 - Chair of the Healthcare Professionals' Forum
- 1.1.8 The Board may appoint an additional Associate Member to assist in carrying out its functions, subject to the agreement of the Minister for Health and Social Services.

Use of the term 'Independent Members'

- 1.1.9 For the purposes of these SOs, use of the term 'Independent Members' refers to the following voting members of the Board:
- Chair
 - Vice Chair
 - Non Officer Members

unless otherwise stated.

1.2 Joint Directors

- 1.2.1 Where a post of Executive Director of the LHB is shared between more than one person because of their being appointed jointly to a post:
- i) Either or both persons may attend and take part in Board meetings;
 - ii) If both are present at a meeting they shall cast one vote if they agree;
 - iii) In the case of disagreement no vote shall be cast; and
 - iv) The presence of both or one person will count as one person in relation to the quorum.

1.3 Tenure of Board members

- 1.3.1 Independent Members and Associate Members appointed by the Minister for Health and Social Services shall be appointed for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. These members can be reappointed but may not hold office as a member or associate member for the same Board for a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.
- 1.3.2 Any Associate Member appointed by the Board will be for a period of up to one year. An Associate member may be re-appointed if necessary or expedient for the performance of the LHBs functions. If re-appointed they may not hold office as an Associate Member for the same Board for a total period of more than four years. Time served includes time as a Ministerial appointment (if relevant) which need not be consecutive and will still be counted towards the total period even where there is a break in the term. An Independent or Associate Member appointed by the Minister for Health and Social Services who has already served the maximum 8 years as a Ministerial appointment to the same Board will not be eligible for appointment by the Board as an Associate Member.
- 1.3.3 Executive Directors' tenure of office as Board members will be determined by their contract of appointment.
- 1.3.4 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are applicable, as specified in Schedule 2 of the Constitution Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Chair will advise the Minister in writing of any such cases immediately.
- 1.3.5 The LHB will require Board members to confirm in writing their continued eligibility on an annual basis.

1.4 The Role of the LHB Board and responsibilities of individual members

Role

- 1.4.1 The principal role of the LHB is set out in SO 1.0.1. The Board's main role

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is to add value to the organisation through the exercise of strong leadership and control, including:

- Setting the organisation's strategic direction
- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
- Ensuring delivery of the organisation's aims and objectives through effective challenge and scrutiny of the LHB's performance across all areas of activity.

Responsibilities

- 1.4.2 The Board will function as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.
- 1.4.3 Independent Members who are appointed to bring a particular perspective, skill or area of expertise to the Board must do so in a balanced manner, ensuring that any opinion expressed is objective and based upon the best interests of the health service. Similarly, Board members must not place an over reliance on those individual members with specialist expertise to cover specific aspects of Board business and must be prepared to scrutinise and ask questions about any contribution that may be made by that member.
- 1.4.4 LHBs shall issue an indemnity to any Chair and Independent Member in the following terms: "A Board [or Committee] member, who has acted honestly and in good faith, will not have to meet out of their personal resources any personal liability which is incurred in the execution of their Board function. Such cover excludes the reckless or those who have acted in bad faith".
- 1.4.5 Associate Members, whilst not sharing corporate responsibility for the decisions of the Board, are nevertheless required to act in a corporate manner at all times, as are their fellow Board members who have voting rights.
- 1.4.6 All Board members must comply with their terms of appointment. They must equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes, engaging fully in Board activities and promoting the LHB within the communities it serves.
- 1.4.7 **The Chair** – The Chair is responsible for the effective operation of the Board, chairing Board meetings when present and ensuring that all Board business is conducted in accordance with these SOs. The Chair may have certain specific powers delegated by the Board and set out in the Scheme of Delegation.

- 1.4.8 The Chair shall work in close harmony with the Chief Executive and, supported by the Director of Corporate Governance/Board Secretary, shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.
- 1.4.9 **The Vice-Chair** – The Vice-Chair shall deputise for the Chair in their absence for any reason and will do so until either the existing chair resumes their duties or a new chair is appointed.
- 1.4.10 In addition to their corporate role across the breadth of the Board's responsibilities, the Vice-Chair has a specific brief to oversee the LHB's performance in the planning, delivery and evaluation of primary care, community health and mental health services ensuring a balanced care model to meet the needs of the population within the LHB's area.
- 1.4.11 **Chief Executive** – The Chief Executive is responsible for the overall performance of the executive functions of the LHB. They are the appointed Accountable Officer for the LHB and shall be responsible for meeting all the responsibilities of that role, as set out in their Accountable Officer Memorandum.
- 1.4.12 **Lead roles for Board members** – The Chair will ensure that individual Board members are designated as lead roles or "champions" as required by the Welsh Ministers or as set out in any statutory or other guidance. Any such role must be clearly defined and must operate in accordance with the requirements set by the LHB, the Welsh Ministers or others. In particular, no operational responsibilities will be placed upon any Independent Member fulfilling such a role. The identification of a Board member in this way shall not make them more vulnerable to individual criticism, nor does it remove the corporate responsibility of the other Board members for that particular aspect of Board business.

2. RESERVATION AND DELEGATION OF LHB FUNCTIONS

- 2.0.1 Subject to any directions that may be given by the Welsh Ministers, the Board shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the LHB may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Board must set out clearly the terms and conditions upon which any delegation is being made.
- 2.0.2 The Board's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:
- i) Schedule of matters reserved to the Board;
 - ii) Scheme of delegation to committees and others; and
 - iii) Scheme of delegation to officers.

all of which must be formally adopted by the Board in full session and form part of these SOs.

- 2.0.3 Subject to Standing Order 4, the LHB retains full responsibility for any functions delegated to others to carry out on its behalf.

2.1 Chair's action on urgent matters

- 2.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Director of Corporate Governance/Board Secretary as appropriate, may deal with the matter on behalf of the Board - after first consulting with at least two other Independent Members. The Director of Corporate Governance/Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.
- 2.1.2 Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

2.2 Delegation of Board functions

- 2.2.1 The Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board' within the Model Standing Orders (see paragraph 2.0.2.(i)) to Committees and others, setting any conditions and restrictions it considers necessary and following any directions or regulations given by the Welsh Ministers. These functions may be carried out:
- i) By a Committee, sub-Committee or officer of the LHB (or of another LHB or Trust); or
 - ii) By another LHB; NHS Trust; Strategic Health Authority or Primary Care Trust in England; Special Health Authority; or
 - iii) Jointly with one or more bodies including local authorities through a joint-Committee, sub-Committee or joint sub-Committee.
- 2.2.2 The Board may agree and formally approve the delegation of specific executive powers to be exercised by Committees, sub-Committees, joint-Committees or joint sub-Committees which it has formally constituted.

2.3 Delegation to officers

- 2.3.1 The Board may delegate certain functions to the Chief Executive. For

these aspects, the Chief Executive, when compiling the Scheme of Delegation to Officers, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Executive will still be accountable to the Board for all functions delegated to them irrespective of any further delegation to other officers.

- 2.3.2 This must be considered and approved by the Board (subject to any amendment agreed during the discussion). The Chief Executive may periodically propose amendments to the Scheme of Delegation to Officers and any such amendments must also be considered and approved by the Board.
- 2.3.3 Individual Executive Directors are in turn responsible for delegation within their own directorates/departments/localities in accordance with the framework established by the Chief Executive and agreed by the Board.

3. COMMITTEES

3.1 LHB Committees

- 3.1.1 The Board may and, where directed by the Welsh Ministers must, appoint Committees of the LHB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees. The Board shall, wherever possible, require its Committees to hold meetings in public unless there are specific, valid reasons for not doing so.

Use of the term 'Committee'

- 3.1.2 For the purposes of these SOs, use of the term 'Committee' incorporates the following:

- Board Committee
- Joint-Committee
- Sub-Committee
- Joint Sub-Committee

unless otherwise stated. The Board's Advisory Groups are referred to separately.

3.2 Joint Committees

- 3.2.1 The Board may, and where directed by the Welsh Ministers must, together with one or more LHBs or NHS Trusts or the local authorities operating within the LHB's area, appoint joint-Committees or joint sub-Committees. These may consist wholly or partly of the LHB's Board members or Board members of other health service bodies or of persons who are not LHB

Board members or Board members of other health service bodies. Any such appointments must be made in accordance with the Board's defined requirements on membership (including definition of member roles, powers and terms and conditions of appointment) and any directions given by the Welsh Ministers.

3.2.2 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others on its behalf. The Board shall wherever possible determine, in agreement with its partners, that its joint-Committees hold meetings in public unless there are specific, valid reasons for not doing so.

3.2.3 The Board shall establish, as a minimum, the following joint-Committee(s):

- The National Health Service Wales Joint Commissioning Committee (JCC)
- Hywel Dda University Health Board and Swansea Bay University Health Board Regional Joint Committee (RJC)

Joint Committee Standing Orders, terms of reference and operating arrangements

3.2.4 The Board shall formally approve SOs or terms of reference and operating arrangements for each joint-Committee established. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal; role, responsibilities and accountability; and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships and accountabilities with others (including the LHB Board its Committees and Advisory Groups);
- Any budget, financial and accounting responsibility;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.2.5 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the joint-Committee, keeping any such aspects to the minimum necessary. The detailed SOs or terms of reference and operating arrangements for those joint-Committees established by the Board are set out in Schedule 4.

3.3 Sub-Committees

3.3.1 A Committee appointed by the Board may establish a sub-Committee to

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assist it in the conduct of its business provided that the Board approves such action. Where the Board has authorised a Committee to establish sub-Committees they cannot delegate any executive powers to the sub-Committee unless authorised to do so by the Board.

3.4 Committees established by the LHB

3.4.1 The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business:

- Quality and Safety;
- Audit;
- Information governance;
- Charitable Funds;
- Remuneration and Terms of Service; and
- Mental Health Act requirements.

3.4.2 In designing its Committee structure and operating arrangements, the Board shall take full account of the need to:

- Embed corporate standards, priorities and requirements, e.g., equality and human rights across all areas of activity; and
- Maximise cohesion and integration across all aspects of governance and assurance.

3.4.3 Each Committee established by or on behalf of the Board must have its own SOs or detailed terms of reference and operating arrangements, which must be formally approved by the Board. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others (including the Board its Committees and Advisory Groups)
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.4.4 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the Committee, keeping any such aspects to the minimum necessary.

3.4.5 The membership of any such Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Board, based on the recommendation of the LHB Chair, and subject to any specific requirements, directions or regulations made

by the Welsh Ministers. Depending on the Committee's defined role and remit, membership may be drawn from the LHB Board, its staff (subject to the conditions set in Standing Order 3.4.6) or others not employed by the LHB.

- 3.4.6 Executive Directors or other LHB officers shall not be appointed as Committee Chairs, nor should they be appointed to serve as members on any Committee set up to review the exercise of functions delegated to officers or to review Mental Health Tribunals (in accordance with the Mental Health Act 1983). Designated LHB officers shall, however, be in attendance at such Committees, as appropriate.

Full details of the Committee structure established by the Board, including detailed terms of reference for each of these Committees are set out in Schedule 3.

3.5 Other Committees

- 3.5.1 The Board may also establish other Committees to help the LHB in the conduct of its business.

3.6 Confidentiality

- 3.6.1 Committee members and attendees must not disclose any matter dealt with by or brought before a Committee in confidence without the permission of the Committee's Chair.

3.7 Reporting activity to the Board

- 3.7.1 The Board must ensure that the Chairs of all Committees operating on its behalf report formally, regularly and on a timely basis to the Board on their activities. Committee Chairs' shall bring to the Boards specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4. NHS WALES SHARED SERVICES PARTNERSHIP

- 4.0.1 From 1 June 2012 the function of managing and providing Shared Services to the health service in Wales was given to Velindre NHS Trust. The Trust's Establishment Order has been amended to reflect the fact that the Shared Services function has been conferred on it.

- 4.0.2 The **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012/1261) ("the Shared Services Regulations") require the Velindre NHS Trust to establish a Shared Services Committee which will be responsible for exercising the Trust's Shared Services functions. The Shared Services Regulations (as amended) prescribe the membership of the Shared Services Committee in

order to ensure that all LHBs, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

- 4.0.3 The Director of Shared Services will be designated as Accountable Officer for Shared Services.
- 4.0.4 These arrangements necessitate putting in place a Memorandum of Co-operation Agreement and a Hosting Agreement between all LHBs and Trusts setting out the obligations of NHS bodies to participate in the Shared Services Committee and to take collective responsibility for setting the policy and delivery of the Shared Services to the health service in Wales. Responsibility for the exercise of the Shared Services functions will not rest with the Board of Velindre NHS Trust but will be a shared responsibility of all NHS bodies in Wales.
- 4.0.5 The Shared Services Committee is to be known as the Shared Services Partnership Committee for operational purposes.

5. ADVISORY GROUPS

- 5.0.1 The LHB has a statutory duty to take account of representations made by persons and organisations who represent the interests of the communities it serves, its officers and healthcare professionals. To help discharge this duty, the Board may and where directed by the Welsh Ministers must, appoint Advisory Groups to the LHB to provide advice to the Board in the exercise of its functions.
- 5.0.2 The LHB's Advisory Groups include a Stakeholder Reference Group, Healthcare Professionals' Forum and Local Partnership Forum. *The membership and terms of reference for these groups are set out in Schedule 5.*
- 5.0.3 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board shall, wherever possible, require its Advisory Groups to hold meetings in public unless there are specific, valid reasons for not doing so.

5.1 Terms of reference and operating arrangements

- 5.1.1 The Board must formally approve terms of reference and operating arrangements for the Advisory Groups. These must establish the governance arrangements and ways of working, setting out, as a minimum:
 - The scope of its work (including its purpose and any delegated

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- powers and authority);
- Membership (including member appointment and removal, role, responsibilities and accountabilities, and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships with others (including the LHB Board, its Committees and Advisory Groups) as well as other relevant local and national groups);
- Any budget and financial responsibility;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.1.2 In doing so, the Board shall specify which of these SOs are not applicable to the operation of the Advisory Group, keeping any such aspects to the minimum necessary. The detailed terms of reference and operating arrangements are set out in Schedule 5.

5.1.3 The Board may determine that the Advisory Group shall be supported by sub-groups to assist it in the conduct of its work, or the Advisory Group may itself determine such arrangements, provided that the Board approves such action.

5.2 Support to the Advisory Groups

5.2.1 The LHB's Director of Corporate Governance/Board Secretary, on behalf of the Chair, will ensure that the Advisory Groups are properly equipped to carry out their role by:

- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Advisory Group Chair on the conduct of its business and its relationship with the LHB and others;
- Ensuring the provision of secretariat support for Advisory Group meetings (for specific arrangements relating to Local Partnership Forum see Schedule 5.3, paragraph 1.7.1);
- Ensuring that the Advisory Group receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups/professionals as appropriate; and
- Facilitating effective reporting to the Board

enabling the Board to gain assurance that the conduct of business within the Advisory Group accords with the governance and operating framework it has set.

5.3 Confidentiality

- 5.3.1 Advisory Group members and attendees must not disclose any matter dealt with by or brought before a Group in confidence without the permission of the Advisory Group Chair.

5.4 Advice and feedback

- 5.4.1 The LHB may specifically request advice and feedback from the Advisory Groups on any aspect of its business, and they may also offer advice and feedback even if not specifically requested by the LHB. The Groups may provide advice to the Board:
- At Board meetings, through the SRG and HPF Chair's participation as Associate Members;
 - In written advice;
 - In any other form specified by the Board.

5.5 Reporting activity

- 5.5.1 The Board shall ensure that the Chairs of all Advisory Groups report formally, regularly and on a timely basis to the Board on their activities. Advisory Group Chairs shall bring to the Board's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.
- 5.5.2 Each Advisory Group shall also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.
- 5.5.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

5.6 THE STAKEHOLDER REFERENCE GROUP (SRG)

Role

- 5.6.1 The SRG's role is to provide independent advice on any aspect of LHB business. This may include:
- Early engagement and involvement in the determination of the LHB's overall strategic direction;
 - Provision of advice on specific service proposals prior to formal consultation; as well as
 - Feedback on the impact of the LHB's operations on the communities it serves.
- 5.6.2 The SRG provides a forum to facilitate full engagement and active debate

amongst stakeholders from across the communities served by the LHB, with the aim of reaching and presenting a cohesive and balanced stakeholder perspective to inform the LHB's decision making.

- 5.6.3 The SRG's role is distinctive from that of Liaisons, who have a statutory role in representing the interests of patients and the public in their areas. The SRG shall represent those stakeholders who have an interest in, and whose own role and activities may be impacted by the decisions of the LHB. Membership may include community partners, provider organisations, special interest and other groups operating within the LHBs area.
- 5.6.4 It does not cover those stakeholders whose interests are represented within the remit of other Advisory Groups established by the LHB, e.g., the Healthcare Professionals' Forum and Local Partnership Forum.
- 5.6.5 In addition to the provisions above the Board must set out, the relationships and accountabilities with others, such as the Regional Partnership Board.

5.7 Relationship with the Board

- 5.7.1 The SRG's main link with the Board is through the SRG Chair's membership of the Board as an Associate Member.
- 5.7.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings. The SRG's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.
- 5.7.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the SRG.
- 5.7.4 The Board's Chair shall put in place arrangements to meet with the SRG Chair on a regular basis to discuss the SRG's activities and operation.

5.8 Relationship between the SRG and others

- 5.8.1 The Board must ensure that the SRG's advice represents a balanced, co-ordinated stakeholder perspective from across the local communities served by the LHB. The SRG shall:
- Ensure effective links and relationships with other advisory groups, local and community partnerships and other key stakeholders who do not form part of the SRG membership;
 - Ensure its role, responsibilities and activities are known and understood by others; and
 - Take care to avoid unnecessary duplication of activity with other bodies/groups with an interest in the planning and provision of NHS

services, e.g., Regional Partnership Boards.

5.9 Working with Llais

- 5.9.1 The SRG shall make arrangements to ensure designated Llais members receive the SRG's papers and are invited to attend SRG meetings.
- 5.9.2 The SRG shall work together with Llais within the area covered by the LHB to engage and involve those within the local communities served whose views may not otherwise be heard.

Refer to Schedule 5.1 for detailed Terms of Reference and Operating Arrangements

5.10 THE HEALTHCARE PROFESSIONALS' FORUM (HPF)

Role

- 5.10.1 The HPF's role is to provide a balanced, multi-disciplinary view of healthcare professional issues to advise the Board on local strategy and delivery. Its role does not include consideration of healthcare professional terms and conditions of service.
- 5.10.2 The HPF shall facilitate engagement and debate amongst the wide range of clinical interests within the LHB's area of activity, with the aim of reaching and presenting a cohesive and balanced healthcare professional perspective to inform the LHB's decision making.

5.11 Terms of reference and operating arrangements

- 5.11.1 In addition to the provisions in 5.2.1 above the Board must set out, the relationships and accountabilities with others, as well as the National Professional Advisory Group.

5.12 Relationship with the Board

- 5.12.1 The HPF's main link with the Board is through the HPF Chair's membership of the Board as an Associate Member.
- 5.12.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings. The HPF's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.
- 5.12.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the HPF.
- 5.12.4 The Board's Chair shall put in place arrangements to meet with the HPF Chair on a regular basis to discuss the HPF's activities and operation.

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5.13 Rights of Access to the LHB Board for Professional Groups

5.13.1 The LHB Chair, on the advice of the Chief Executive and/or Director of Corporate Governance/Board Secretary, may recommend that the Board afford direct right of access to any professional group, in the following, exceptional circumstances:

- i) Where the HPF recommends that a matter should be presented to the Board by a particular healthcare professional grouping, e.g., due to the specialist nature of the issues concerned; or
- ii) Where a healthcare professional group has demonstrated that the HPF has not afforded it due consideration in the determination of its advice to the Board on a particular issue.

5.13.2 The Board may itself determine that it wishes to seek the views of a particular healthcare professional grouping on a specific matter, in accordance with Standing Order 7.5.7.

5.14 Relationship with the National Professional Advisory Group

5.14.1 The HPF Chair (or HPF Vice-Chair) will be a member of the National Professional Advisory Group.

Refer to Schedule 5.2 for detailed Terms of Reference and Operating Arrangements

5.15 THE LOCAL PARTNERSHIP FORUM (LPF)

Role

5.15.1 The LPF's role is to provide a formal mechanism where the LHB, as employer, and trade unions/professional bodies representing LHB employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the LHB - achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the views and interests of the LHB's workforce.

5.15.2 It is the forum where the LHB and staff organisations will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

5.16 Relationship with the Board and others

5.16.1 The LPF's main link with the Board is through the Executive members of the LPF.

5.16.2 The Board may determine that designated Board members or LHB staff shall be in attendance at LPF meetings. The LPF's Chair may also

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request the attendance of Board members or LHB staff, subject to the agreement of the LHB Chair.

- 5.16.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the LPF's staff representative members.
- 5.16.4 The Board's Chair shall put in place arrangements to meet with the LPG's Joint Chairs on a regular basis to discuss the LPF's activities and operation.
- 5.16.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

Refer to Schedule 5.3 for detailed Terms of Reference and Operating Arrangements

6. WORKING IN PARTNERSHIP

- 6.0.1 The LHB shall work constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for its citizens. This will be delivered in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers, e.g., the development of population assessments and area plans.
- 6.0.2 The Chair shall ensure that the Board has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the LHB through:
- The LHB's own structures and operating arrangements, e.g., Advisory Groups; and
 - The involvement (at very local and community wide levels) in partnerships and community groups – such as Regional Partnership and Public Service Boards – of Board members and LHB officers with delegated authority to represent the LHB and, as appropriate, take decisions on its behalf.
- 6.0.3 The Social Services and Well-Being (Wales) Act 2014 sets out duties for working in partnership with local authorities complementing existing duties under section 82 of the NHS Act 2006 (duty to cooperate with local authorities) and sections 10 (arrangements with other bodies) and 38 (duty to make services available to enable the discharge of local authority functions) of the NHS (Wales) Act 2006. This includes "Partnership Arrangements" established under the direction of Regional Partnership Boards and under which the LHB may carry out any of the specified functions on behalf of the partnership body and may established pooled funds for specified purposes. An advice note on partnership working –

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implications for health boards and NHS Trusts from the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 has been published and it can be found here: https://socialcare.wales/cms_assets/hub-downloads/Partnership-working---implications-for-health-boards-and-NHS-Trusts.pdf

- 6.0.4 The Board shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership.

6.1 The Citizen Voice Body for Health and Social Care, Wales (to be known as Llais)

- 6.1.1 Part 4 of the **Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) places a range of duties on LHBs in relation to the engagement and involvement of Llais in its operations.

- 6.1.2 The 2020 Act places a statutory duty on the LHB to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered.

- 6.1.3 The Statutory Guidance on Representations made by the Citizen Voice Body can be found at <https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf>

- 6.1.4 The 2020 Act also places a statutory duty on the LHB to promote awareness of Llais and make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. Promoting and facilitating engagement between individuals and Llais through access to relevant premises can help strengthen the public's voice and participation in shaping the design and delivery of services. The LHB must have regard to the Code of Practice on Access to Premises and Engagement with Individuals (so far as the code is relevant).

- 6.1.5 The Code of Practice on Access to Premises and Engagement with Individuals can be found at

<https://www.gov.wales/code-practice-llais-accessing-premises-and-engaging-people>

- 6.1.6 In discharging these duties, the Board shall work constructively with Llais

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to ensure both organisations are able to discharge their duties. They will ensure their involvement in:

- The planning of the provision of its healthcare services;
- The development and consideration of proposals for service change and the way in which those services are provided;
- The Board's decisions affecting the operation of those healthcare services that it has responsibility for; and
- Engaging, formally consulting and working jointly within the LHB's area on any proposals for substantial development or change of the services it is responsible for, in line with the Guidance on Changes to Health Services in Wales 2023.

The Guidance on Changes to Health Services can be found at <https://www.gov.wales/guidance-changes-health-services>

- 6.1.7 The Board shall ensure that Llais is provided with the information it needs on a timely basis to enable it to effectively discharge its functions.

Relationship with the Board

- 6.1.8 The Board may determine that a designated Llais representative(s) shall be invited to attend Board meetings.

The Board shall ensure arrangements are in place for regular meetings between LHB officers and regional representatives of Llais.

- 6.1.9 The Board's Chair shall put in place arrangements to meet with the Regional Director and relevant representatives of Llais on a regular basis to discuss matters of common interest.

7. MEETINGS

7.1 Putting Citizens first

- 7.1.1 The LHB's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens, community partners and other stakeholders. The LHB, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings when these are not held via electronic means;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read (where requested or required) and in electronic formats;
- Requesting that attendees notify the LHB of any access needs

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sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and

- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g., Disability Discrimination Act, as well as its Communication Strategy and provisions made in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011 .

- 7.1.2 The Chair will ensure that, in determining the matters to be considered by the Board, full account is taken of the views and interests of the communities served by the LHB, including any views expressed formally to the LHB, e.g., through the SRG or Llais.

7.2 Annual Plan of Board Business

- 7.2.1 The Director of Corporate Governance/Board Secretary, on behalf of the Chair, shall produce an Annual Plan of Board business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year, taking account that ordinary meetings of the Board will be held at regular intervals and as a minimum six times a year. The Plan shall also set out any standing items that will appear on every Board agenda.

- 7.2.2 The plan shall set out the arrangements in place to enable the LHB to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Board members to contribute in either English or Welsh languages, where appropriate.

- 7.2.3 The plan shall also incorporate formal Board meetings, regular Board Development sessions and, where appropriate, the planned activities of the Board's Committees and Advisory Groups.

- 7.2.4 The Board shall agree the plan for the forthcoming year by the end of March, and this plan will be published on the organisation's website.

Annual General Meeting (AGM)

- 7.2.5 The LHB must hold an AGM in public no later than the 31 July each year [Note: no later than 30 September 2023 for year 2022/2023]. At least 10 calendar days prior to the meeting a public notice of the intention to hold the meeting, the time and place of the meeting, and the agenda, shall be displayed bilingually (in English and Welsh) on the LHB's website.

The notice shall state that:

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- Electronic or paper copies of the Annual Report and Accounts of the LHB are available, on request, prior to the meeting; and
- State how copies can be obtained, in what language and in what format, e.g. as Braille, large print, easy read etc.

The AGM must include presentation of the Annual Report and audited accounts, together with (where applicable), an audited abridged version of the annual accounts and funds held on trust accounts and may also include presentation of other reports of interest to citizens and others.

- 7.2.6 A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement.

7.3 Calling Meetings

- 7.3.1 In addition to the planned meetings agreed by the Board, the Chair may call a meeting of the Board at any time. Individual Board members may also request that the Chair call a meeting provided that at least one third of the whole number of Board members, support such a request.
- 7.3.2 If the Chair does not call a meeting within seven days after receiving such a request from Board members, then those Board members may themselves call a meeting.

7.4 Preparing for Meetings

Setting the agenda

- 7.4.1 The Chair, in consultation with the Chief Executive and Director of Corporate Governance/Board Secretary, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Board business; any standing items agreed by the Board; any applicable items received from the Board's Committees and Advisory Groups; and the priorities facing the LHB. The Chair must ensure that all relevant matters are brought before the Board on a timely basis.
- 7.4.2 Any Board member may request that a matter is placed on the Agenda by writing to the Chair, copied to the Director of Corporate Governance/Board Secretary, at least 12 calendar days before the meeting. The request must set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of board business.

Notifying and equipping Board members

- 7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least 5 clear days before a formal Board meeting. This

information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

- 7.4.4 No papers will be included for consideration and decision by the Board unless the Chair is satisfied (subject to advice from the Director of Corporate Governance/Board Secretary, as appropriate) that the information contained within it is sufficient to enable the Board to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Board, and the outcome of that assessment shall accompany the report to the Board to enable the Board to make an informed decision.
- 7.4.5 In the event that at least half of the Board members do not receive the Agenda and papers for the meeting as set out above, the Chair must consider whether or not the Board would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.
- 7.4.6 In the case of a meeting called by Board members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

- 7.4.7 Except for meetings called in accordance with Standing Order 6.3, at least 10 calendar days before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda shall be displayed bilingually (in English and Welsh):
- On the LHB's website,
 - Through other methods of communication as set out in the LHB's communication strategy.
- 7.4.8 When providing notification of the forthcoming meeting, the LHB shall set out when and how the agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc. The agenda and papers will be made available to the public at least 5 clear days before each meeting of the Board.

7.5 Conducting Board Meetings

Admission of the public, the press and other observers

- 7.5.1 The LHB shall encourage attendance at its formal Board meetings by the public and members of the press as well as LHB officers or representatives from organisations who have an interest in LHB business. The venue for such meetings shall be appropriate to facilitate easy access for attendees and translation services; and shall have appropriate facilities to maximise accessibility.
- 7.5.2 The Board and its committees shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance/Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Board shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

- 7.5.3 In these circumstances, when the Board is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Board in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Board meeting held in public session.
- 7.5.4 The Director of Corporate Governance/Board Secretary, on behalf of the Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.
- 7.5.5 In encouraging entry to formal Board Meetings from members of the public and others, the Board shall make clear that attendees are welcomed as observers. The Chair shall take all necessary steps to ensure that the Board's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.
- 7.5.6 Unless the Board has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Board, its Committees and Advisory Groups

- 7.5.7 The Board will decide what arrangements and terms and conditions it feels

are appropriate in extending an invitation to observers to attend and address any meetings of the Board, its Committees and Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Board will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the LHB, (whether directly or through the activities of bodies such as Llais and the LHB's Advisory Groups representing citizens and other stakeholders) and to demonstrate openness and transparency in the conduct of business.

Chairing Board Meetings

- 7.5.8 The Chair of the LHB will preside at any meeting of the Board unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and Vice-Chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.
- 7.5.9 The Chair must ensure that the meeting is handled in a manner that enables the Board to reach effective decisions on the matters before it. This includes ensuring that Board members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the Board must have access to appropriate advice on the conduct of the meeting through the attendance of the nominated Director of Corporate Governance/Board Secretary. The Chair has the final say on any matter relating to the conduct of Board business.

Quorum

- 7.5.10 At least six Board members, at least three of whom are Executive Directors and three are Independent Members, must be present to allow any formal business to take place at a Board meeting.
- 7.5.11 If the Chief Executive or an Executive Director is unable to attend a Board meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, Board members' voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Board member in their own right, e.g., a person deputising for the Chief Executive will usually be an Executive Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.
- 7.5.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Board member disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that

particular matter or resolution cannot be considered further at that meeting and must be noted in the minutes.

Dealing with motions

- 7.5.13 In the normal course of Board business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Board member may put forward a motion proposing that a formal review of that service area is undertaken by a Committee of the Board. The Director of Corporate Governance/Board Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Board unless moved by a Board member and seconded by another Board member (including the Chair).
- 7.5.14 **Proposing a formal notice of motion** – Any Board member wishing to propose a motion must notify the Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Chair has determined that the proposed motion is relevant to the Board's business, the matter shall be included on the Agenda, or, where an emergency motion has been proposed, the Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.
- 7.5.15 The Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Board business.
- 7.5.16 **Amendments** - Any Board member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Board alongside the motion.
- 7.5.17 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e., the substantive motion.
- 7.5.18 **Motions under discussion** – When a motion is under discussion, any Board member may propose that:
- The motion be amended;
 - The meeting should be adjourned;
 - The discussion should be adjourned and the meeting proceed to the next item of business;
 - A Board member may not be heard further;
 - The Board decides upon the motion before them;

- An ad hoc Committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

7.5.19 Rights of reply to motions – The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

7.5.20 Withdrawal of motion or amendments – A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Chair.

7.5.21 Motion to rescind a resolution – The Board may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Board members.

7.5.22 A motion that has been decided upon by the Board cannot be proposed again within six months except by the Chair, unless the motion relates to the receipt of a report or the recommendations of a Committee/Chief Executive to which a matter has been referred.

Voting

7.5.23 The Chair will determine whether Board members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Chair must require a secret ballot or recorded vote if the majority of voting Board members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted. Associate Members may not vote in any meetings or proceedings of the Board.

7.5.24 In determining every question at a meeting the Board members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of the community and healthcare professionals within the LHB's area. Such views will usually be presented to the Board through the Chairs of the LHB's Advisory Groups and the Liaison representative(s).

7.5.25 The Board will make decisions based on a simple majority view held by the Board members present. In the event of a split decision, i.e., no majority view being expressed, the Chair shall have a second and casting vote.

7.5.26 In no circumstances may an absent Board member or nominated deputy vote by proxy. Absence is defined as being absent at the time of the vote.

7.6 Record of Proceedings

- 7.6.1 A record of the proceedings of formal Board meetings (and any other meetings of the board where the Board members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Board member attendance (including the Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the Board, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.
- 7.6.2 Agreed minutes shall be circulated in accordance with Board members' wishes, and, where providing a record of a formal Board meeting shall be made available to the public both on the LHB's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act 2018, the General Data Protection Regulation 2018, and the LHB's Communication Strategy and Welsh language requirements.

7.7 Confidentiality

- 7.7.1 All Board members (including Associate Members), together with members of any Committee or Advisory Group established by or on behalf of the Board and LHB officials must respect the confidentiality of all matters considered by the LHB in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Chair of the Board or relevant Committee, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the Values and Standards of Behaviour framework (Standards of Behaviour Policy), or legislation such as the Freedom of Information Act 2000, etc.

8. VALUES AND STANDARDS OF BEHAVIOUR

- 8.0.1 The Board must adopt a set of values and standards of behaviour for the LHB that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the LHB, including Board members, LHB officers and others, as appropriate. The framework adopted by the Board – Standards of Behaviour Policy - will form part of these SOs.

8.1 Declaring and recording Board members' interests

- 8.1.1 ***Declaration of interests*** – It is a requirement that all Board members must declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Board member. This includes any interests that may influence or be perceived to

influence their judgement in the course of conducting the Board's business. Board members must be familiar with the Values and Standards of Behaviour Framework (Standards of Behaviour Policy), and their statutory duties under the Constitution Regulations. Board members must notify the Chair and Director of Corporate Governance/Board Secretary of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Board members.

8.1.2 Board members must also declare any interests held by family members or persons or bodies with which they are connected. The Director of Corporate Governance/Board Secretary will provide advice to the Chair and the Board on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour framework. If individual Board members are in any doubt about what may be considered as an interest, they should seek advice from the Director of Corporate Governance/Board Secretary. However, the onus regarding declaration will reside with the individual Board member.

8.1.3 **Register of interests** – The Chief Executive, through the Director of Corporate Governance/Board Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Board members. The register will include details of all Directorships and other relevant and material interests which have been declared by Board members.

8.1.4 The register will be held by the Director of Corporate Governance/Board Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Board members. The Director of Corporate Governance/Board Secretary will also arrange an annual review of the Register, through which Board members will be required to confirm the accuracy and completeness of the register relating to their own interests.

8.1.5 In line with the Board's commitment to openness and transparency, the Director of Corporate Governance/Board Secretary must take reasonable steps to ensure that the citizens served by the LHB are made aware of, and have access to view the LHB's Register of Interests. This may include publication on the LHB's website.

8.1.6 **Publication of declared interests in Annual Report** – Board members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in the LHB's Annual Report.

8.2 Dealing with Members' interests during Board meetings

8.2.1 The Chair, advised by the Director of Corporate Governance/Board Secretary, must ensure that the Board's decisions on all matters brought

before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Board members must demonstrate, through their actions, that their contribution to the Board's decision making is based upon the best interests of the LHB and the NHS in Wales.

- 8.2.2 Where individual Board members identify an interest in relation to any aspect of Board business set out in the Board's meeting agenda, that member must declare an interest at the start of the Board meeting. Board members should seek advice from the Chair, through the Director of Corporate Governance/Board Secretary before the start of the Board meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Board minutes.
- 8.2.3 It is the responsibility of the Chair, on behalf of the Board, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions made by the Welsh Ministers. The range of possible actions may include determination that:
- i) The declaration is formally noted and recorded, but that the Board member should participate fully in the Board's discussion and decision, including voting. This may be appropriate, for example where the Board is considering matters of strategy relating to a particular aspect of healthcare and an Independent Member is a healthcare professional whose profession may be affected by that strategy determined by the Board;
 - ii) The declaration is formally noted and recorded, and the Board member participates fully in the Board's discussion, but takes no part in the Board's decision;
 - iii) The declaration is formally noted and recorded, and the Board member takes no part in the Board discussion or decision;
 - iv) The declaration is formally noted and recorded, and the Board member is excluded for that part of the meeting when the matter is being discussed. A Board member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Board.
- 8.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Board member is compatible with an identified conflict of interest.
- 8.2.5 Where the Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice Chair, on behalf of the Board.
- 8.2.6 In all cases the decision of the Chair (or the Vice Chair in the case of an interest declared by the Chair) is binding on all Board members. The Chair should take advice from the Director of Corporate Governance/Board Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of

judgement is consistently applied.

8.2.7 *Members with pecuniary (financial) interests* – Where a Board member, or any person they are connected with¹ has any direct or indirect pecuniary interest in any matter being considered by the Board, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Board may determine that the Board member concerned shall be excluded from that part of the meeting.

8.2.8 The Constitution Regulations define ‘direct’ and ‘indirect’ pecuniary interests and these definitions always apply when determining whether a member has an interest. These SOs must be interpreted in accordance with these definitions.

8.2.9 *Members with Professional Interests* - During the conduct of a Board meeting, an individual Board member may establish a clear conflict of interest between their role as a LHB Board member and that of their professional role outside of the Board. In any such circumstance, the Board shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Director of Corporate Governance/Board Secretary.

8.3 Dealing with officers’ interests

8.3.1 The Board must ensure that the Director of Corporate Governance/Board Secretary, on behalf of the Chief Executive, establishes and maintains a system for the declaration, recording and handling of LHB officers’ interests in accordance with the Values and Standards of Behaviour Framework.

8.4 Reviewing how Interests are handled

8.4.1 The Audit Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

8.5 Dealing with offers of gifts², hospitality and sponsorship

8.5.1 The Values and Standards of Behaviour Framework (Standards of Behaviour Policy) approved by the Board prohibits Board members and LHB officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their

¹ In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.

² The term gift refers also to any reward or benefit.

official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

8.5.2 Gifts, benefits or hospitality must never be solicited. Any Board member or LHB officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Board member or LHB officer. Failure to observe this requirement may result in disciplinary and/or legal action.

8.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Director of Corporate Governance/Board Secretary as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;
- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the LHB;
- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);
- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the LHB; and
- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it should always be declined.

8.5.4 A distinction may be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be

accepted if they can be used for official purposes.

8.6 Sponsorship

- 8.6.1 In addition gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.
- 8.6.2 All sponsorship must be approved prior to acceptance in accordance with the **Values and Standards of Behaviour Framework** (Standards of Behaviour Policy) and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

8.7 Register of Gifts, Hospitality and Sponsorship

- 8.7.1 The Director of Corporate Governance/Board Secretary, on behalf of the Chair, will maintain a register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Board members. Executive Directors will adopt a similar mechanism in relation to LHB officers working within their Directorates.
- 8.7.2 Every Board member and LHB officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship, including those offers that have been refused. The Director of Corporate Governance/Board Secretary, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship are kept under active review, taking appropriate action where necessary.
- 8.7.3 When determining what should be included in the Register with regard to gifts and hospitality, individuals shall apply the following principles, subject to the considerations in Standing Order 8.5.3:
- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value, e.g., seasonal items such as diaries/calendars would not usually need to be recorded.
 - **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate'³ hospitality need not be included in the Register.

³ Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

- 8.7.4 Board members and LHB officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:
- Acceptance would further the aims of the LHB ;
 - The level of hospitality is reasonable in the circumstances;
 - It has been openly offered; and,
 - It could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.
- 8.7.5 The Director of Corporate Governance/Board Secretary will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the LHB to be submitted to the Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the Board upon the adequacy of the LHB's arrangements for dealing with offers of gifts, hospitality and sponsorship.

9. SIGNING AND SEALING DOCUMENTS

- 9.0.1 The common seal of the LHB is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board.
- 9.0.2 Where it is decided that a document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised independent Member) and the Chief Executive (or another authorised individual) both of whom must witness the seal.

9.1. Register of Sealing

- 9.1.1 The Director of Corporate Governance/Board Secretary shall keep a register that records the sealing of every document. Each entry must be signed by the persons who approved and authorised the document and who witnessed the seal. A report of all sealings shall be presented to the Board at least bi-annually.

9.2 Signature of Documents

- 9.2.1 Where a signature is required for any document connected with legal proceedings involving the LHB, it shall be signed by the Chief Executive, except where the Board has authorised another person or has been otherwise directed to allow or require another person to provide a signature.
- 9.2.2 The Chief Executive or nominated officers may be authorised by the Board to sign on behalf of the LHB any agreement or other document (not required to be executed as a deed) where the subject matter has been

approved either by the Board or a Committee to which the Board has delegated appropriate authority.

9.3 Custody of Seal

- 9.3.1 The Common Seal of the LHB shall be kept securely by the Director of Corporate Governance/Board Secretary.

10. GAINING ASSURANCE ON THE CONDUCT OF LHB BUSINESS

- 10.0.1 The Board shall set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of LHB business, its governance and the effective management of the organisation's risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.
- 10.0.2 The Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit Committee (or equivalent).
- 10.0.3 Assurances in respect of the services provided by the NHS Wales Shared Services Partnership shall primarily be achieved by the reports of the Director of Shared Services to the Shared Services Partnership Committee, and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the Director of Shared Services. The Director of Shared Services and the Shared Services Partnership Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the LHB.
- 10.0.4 Assurances in respect of the functions discharged by the National Health Services Wales Joint Commissioning Committee (the JCC) shall be achieved by the reports of the JCC Chair, and reported back by the Chief Executive. Reference should be made to paragraph 3.2 above regarding the governance arrangements which should be agreed for the Joint Committees.
- 10.0.5 Arrangements for seeking and providing assurance in respect of any other services provided on behalf of or in association with the LHB shall be clearly identified and reflected within the practice of the organisation and within the relevant agreements.

10.1 The role of Internal Audit in providing independent internal assurance

- 10.1.1 The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Ministers.

Model Standing Orders, Reservation and Delegation of Powers for LHBs

10.1.2 The Board shall set out the relationship between the Head of Internal Audit (HIA), the Audit Committee (or equivalent) and the Board. It shall:

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);
- Ensure the HIA communicates and interacts directly with the Board, facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and
- Ensure that the Head of Internal Audit reports periodically to the Board on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

10.2 Reviewing the performance of the Board, its Committees and Advisory Groups

10.2.1 The Board shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Where appropriate, the Board may determine that such evaluation may be independently facilitated.

10.2.2 Each Committee and, where appropriate, Advisory Group must also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-Committees it has established.

10.2.3 The Board shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;
- Its Board Development Programme, as part of an overall Organisation Development framework; and
- The Board's report of its alignment with the Welsh Government's Citizen Centred Governance Principles.

10.3 External Assurance

10.3.1 The Board shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the LHB's operations, e.g., the Auditor General for Wales and Healthcare Inspectorate Wales.

10.3.2 The Board may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

10.3.3 The Board shall keep under review and ensure that, where appropriate,

the LHB implements any recommendations relevant to its business made by the Welsh Government's Audit Committee, the Senedd Cymru/Welsh Parliament's Public Accounts Committee and other appropriate bodies.

10.3.4 The LHB shall provide the Auditor General for Wales with any assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

11. DEMONSTRATING ACCOUNTABILITY

11.0.1 Taking account of the arrangements set out within these SOs, the Board shall demonstrate to the communities it serves and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of the communities it serves and other stakeholders, including its officers and healthcare professionals.

11.0.2 The Board shall, in publishing its strategic and operational level plans, set out how those plans have been developed taking account of the views of others, and how they will be delivered by working with their community and other partners.

11.0.3 The Board shall also facilitate effective scrutiny of the LHB's operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

11.0.4 The Board shall ensure that within the LHB, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

12. REVIEW OF STANDING ORDERS

12.0.1 A summary equality impact assessment has been carried out on these SOs prior to their formal adoption by the Board.

12.0.2 These SOs shall be reviewed annually by the Audit and Risk Assurance Committee, which shall report any proposed amendments to the Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SOs, including the appropriate impact assessments.

Schedule 1

**MODEL SCHEME OF RESERVATION AND DELEGATION
OF POWERS**

**This Schedule forms part of, and shall have effect as if incorporated in the
Local Health Board Standing Orders**

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

Introduction

As set out in Standing Order 2, the Board - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the LHB may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The Board may delegate functions to:

- i) A Committee, e.g., Quality and Safety Committee;
- ii) A sub-Committee, e.g., a locality based Quality and Safety Committee taking forward matters within a defined area. Any such delegation would, subject to the Board's authority, usually be via a main Committee of the Board;
- iii) A joint-Committee or joint sub-Committee, e.g., with other LHBs established to take forward matters relating to specialist services; and
- iv) Officers of the LHB (who may, subject to the Board's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Board is notified of any matters that may affect the operation and/or reputation of the LHB.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Board;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officers.

all of which form part of the LHB's SOs.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Board will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- ***Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in SOs or SFIs***
- ***The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management***
- ***Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility***
- ***The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development***
- ***The Board must take appropriate action to assure itself that all matters delegated are effectively carried out***
- ***The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes***
- ***Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others***
- ***The Board may delegate authority to act, but retains overall responsibility and accountability***
- ***When delegating powers, the Board will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.***

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Board

The Board will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Chief Executive

The Chief Executive will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Board must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Executive will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer; and
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

The Chief Executive may re-assume any of the powers they have delegated to others at any time.

The Director of Corporate Governance/Board Secretary

The Director of Corporate Governance/Board Secretary will support the Board in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Board is presented to the Board for its formal agreement;
- Effective arrangements are in place for the delegation of LHB functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Board for revision, as appropriate.

The Audit and Risk Assurance⁴ Committee

The Audit and Risk Assurance Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the LHB's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Director of Corporate Governance/Board Secretary of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will be exercised by the individual to whom that officer reports, unless the Board has set out alternative arrangements.

If the Chief Executive is absent their nominated Deputy may exercise those powers delegated to the Chief Executive on their behalf. However, the guiding principles governing delegations will still apply, and so the Board may determine that it will reassume certain powers delegated to the Chief Executive or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the LHB. The Scheme is to be used in conjunction with the system of control and other established procedures within the LHB.

The LHB's Scheme of Delegation was approved by the Board at its meeting on ~~25 May 2023~~ **26 March 2026**. This detailed electronic scheme of delegation encompasses all delegations including Standing Orders, Standing Financial Instructions, financial delegations, legislative compliance, other delegations and responsibilities, both at delegated lead and operational responsibility level. It has been further expanded through Directorate delegations and is kept under regular

⁴ LHB to insert title for the committee that carries out these functions.

review. It can be accessed via the following hyperlink to LHB's website:

[Standing Orders and Standing Financial Instructions – Hywel Dda University Health Board \(nhs.wales\)](#)

SCHEDULE OF MATTERS RESERVED TO THE BOARD⁵

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
1	FULL	GENERAL	Board may determine any matter for which it has statutory or delegated authority in accordance with SOs (except for those decisions delegated to the NHS Wales Joint Commissioning Committee (the JCC)).
2	FULL	GENERAL	The Board must determine any matter that will be reserved to the whole Board.
3	FULL	GENERAL	Approve the LHB's Governance Framework
4	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: ▪ SOs; ▪ SFIs; ▪ Schedule of matters reserved to the LHB; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements.
6	NO – Audit Committee	OPERATING ARRANGEMENTS	Formal consideration of report of Director of Corporate Governance/Board Secretary on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken.

⁵ Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements.

7	FULL	OPERATING ARRANGEMENTS	Receive report and proposals regarding any non-compliance with Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	FULL	OPERATING ARRANGEMENTS	Authorise use of the LHB's official seal.
9	FULL	OPERATING ARRANGEMENTS	Approve the LHB's Values and Standards of Behaviour framework (Standards of Behaviour Policy).
10	NO – Chair on behalf of Joint Committee, Vice-Chair on behalf of Joint Committee if Chair is declaring interest	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. From Audit Committee or Director of Corporate Governance/Board Secretary.
11	FULL	STRATEGY & PLANNING	Determine the LHB's strategic aims, objectives and priorities.
12	FULL	STRATEGY & PLANNING	Approve the LHB's key strategies and programmes related to: - Population Health Needs Assessment and Commissioning Plan - The development and delivery of patient and population centred health and care/clinical services - Improving quality and patient safety outcomes - Workforce and Organisational Development - Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)
13	FULL	STRATEGY & PLANNING	Approval of Joint Area Plan prepared under the direction of the Regional Partnership Board and in response to the population assessment.
14	FULL	STRATEGY & PLANNING	Agreement of Well-being objectives in accordance with the requirements of the Well-being and Future Generations (Wales) Act 2015.

15	FULL	STRATEGY & PLANNING	Approval of Well-being Plan prepared and agreed by the Public Service Board.
16	FULL	STRATEGY & PLANNING	Approve the LHB's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan.
17	FULL	STRATEGY & PLANNING	Approve the LHB's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure).
18	FULL	OPERATING ARRANGEMENTS	Approve the LHB's framework and strategy for performance management.
19	FULL	STRATEGY & PLANNING	Approve the LHB's framework and strategy for risk and assurance.
20	FULL	OPERATING ARRANGEMENTS	Ratify policies for dealing with raising concerns, complaints and incidents in accordance with the Putting Things Right and health and safety requirements.
21	FULL	OPERATING ARRANGEMENTS	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the LHB, including standards/ requirements determined by Welsh Government, regulators, professional bodies/others, e.g. National Institute of Health and Care Excellence (NICE).
22	FULL	STRATEGY & PLANNING	Approve the LHB's patient, public, staff, partnership and stakeholder engagement and co-production strategies.
23	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the LHB's aims, objectives and priorities.
24	FULL	ORGANISATION STRUCTURE & STAFFING	Appointment of officer members of the Board (Chief Executive and Directors) in accordance with the provisions of the Regulations and in accordance with Ministerial Instructions.
25	NO – Remuneration and Terms of Service	ORGANISATION STRUCTURE & STAFFING	Termination of appointment and suspension officer members in accordance with the provisions of the Regulations and in accordance with Ministerial instructions.

	Committee		
26	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider appraisal of officer members of the Board (Chief Executive and Directors).
27	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Board level appointments and other senior employees, in accordance with Ministerial Instructions e.g. the Director of Corporate Governance/Board Secretary.
28	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
29	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the LHB's top level organisation structure and corporate policies.
30	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss LHB Committees, including any joint-Committees directly accountable to the Board.
31	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Committee, joint-Committee or Group set up by the Board.
32	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups.
33	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the standing orders and terms of reference and reporting arrangements of all Committees, joint-Committees and groups established by the Board.

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34	NO – Audit Committee	OPERATING ARRANGEMENTS	Approve arrangements relating to the discharge of the LHB's responsibility as a bailee for patients' property.
35	FULL – except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with the provisions of Annex 4 to Chapter 6 of the Welsh Government Manual for Accounts.
36	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers.
37	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the LHB.
38	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the arrangements relating to the discharge of the LHB's responsibilities as a corporate trustee of funds held on trust in accordance with the provision of Paragraph 20 of the Standing Financial Instructions.

39	FULL	STRATEGY & PLANNING	Approve new contracts for the LHB to provide, or to secure provision from providers for Personal Medical; Dental; Pharmacy; Optometry services to some or all of the LHB's population where the value exceeds the delegated limit of the Chief Executive.
40	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions.
41	FULL	PERFORMANCE & ASSURANCE	Approve the LHB's audit and assurance arrangements.
42	FULL	PERFORMANCE & ASSURANCE	Receive reports from the LHB's Executive on progress and performance in the delivery of the LHB's strategic aims, objectives and priorities and approve action required, including improvement plans, as appropriate.
43	FULL	PERFORMANCE & ASSURANCE	Receive reports from the LHB's Committees, groups and other internal sources on the LHB's performance and approve action required, including improvement plans, as appropriate.
44	FULL	PERFORMANCE & ASSURANCE	Receive reports on the LHB's performance produced by external regulators and inspectors (including, e.g., Audit Wales, HIW, etc) that raise significant issue or concerns impacting on the LHB's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Board Committees (as appropriate).
45	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the LHB's Chief Internal Auditor and approve action required, including improvement plans.
46	FULL	PERFORMANCE & ASSURANCE	Receive the annual management report from the Auditor General for Wales and approve action required, including improvement plans.
47	FULL	PERFORMANCE & ASSURANCE	Receive assurance regarding the LHB's performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.
48	FULL	REPORTING	Approve the LHB's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government where required.

49	FULL	REPORTING	Receive, approve and ensure the publication of LHB reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued.

DELEGATION OF POWERS TO COMMITTEES AND OTHERS⁶

Standing Order 2 provides that the Board may delegate powers to Committees and others. In doing so, the Board has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such Committees; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Board has delegated a range of its powers to its Committees and others:

The scope of the powers delegated, together with the requirements set by the Board in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these documents form the LHB's Scheme of Delegation to Committees which can be accessed via the following hyperlink to the LHB's website:

[Standing Orders and Standing Financial Instructions - Hywel Dda University Health Board \(nhs.wales\)](https://www.nhs.uk/healthboards/healthboardpages/standingordersandstandingfinancialinstructions-hywel-dda-university-health-board-nhs-wales)

⁶ As defined in Standing Orders

SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OFFICERS

The LHB SOs and SFIs specify certain key responsibilities of the Chief Executive, the Director of Finance and other officers. The Chief Executive's Job Description, together with their Accountable Officer Memorandum sets out their specific responsibilities, and the individual job descriptions determined for Executive Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents and the associated financial delegations set out in the SFIs form the basis of the LHB's Scheme of Delegation to Officers.

This scheme only relates to matters delegated by the Board to the Chief Executive and their Executive Directors, together with certain other specific matters referred to in SFIs.

Each Executive Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

Schedule 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

LHB framework

The LHB's governance and accountability framework comprises these SOs, incorporating schedules of Powers reserved for the Board and Delegation to others, together with the following documents:

- **SFIs** (see Schedule 2.1 below) – available via the following hyperlink to the LHB's website:
[Standing Orders and Standing Financial Instructions - Hywel Dda University Health Board \(nhs.wales\)](#)
- **Values and Standards of Behaviour Framework**
[Our values – Hywel Dda University Health Board \(nhs.wales\)](#)
- **Standards of Behaviour Policy** – available via the following hyperlink to the LHB's website:
[hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/policies/standards-of-behaviour-policy/](#)
- **Risk and Assurance Framework**
[hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/policies/risk-management-framework/](#)
- **Key policy documents** – available via the following hyperlink to the LHB's website:
[Policies and written control documents - Hywel Dda University Health Board \(nhs.wales\)](#)

agreed by the Board. These documents must be read in conjunction with the SOs and will have the same effect as if the details within them were incorporated within the SOs themselves.

These documents may be accessed by contacting the Corporate Governance Team, **Second Floor, Block C, Government Buildings, Picton Terrace, Carmarthen. SA31 3BT**, ~~corporate Offices, Ystwyth Building, St David's Park, Carmarthen, SA31 3BB.~~

Model Standing Orders, Reservation and Delegation of Powers for LHBs

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NHS Wales framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual which can be accessed at <https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/>. Directions or guidance on specific aspects of LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Schedule 2.1

MODEL STANDING FINANCIAL INSTRUCTIONS FOR LOCAL HEALTH BOARDS

**This Schedule forms part of, and shall have effect as if incorporated in the
Local Health Board Standing Orders**

Available via the following hyperlink to the LHB's website:

[Standing Orders and Standing Financial Instructions - Hywel Dda University Health Board \(nhs.wales\)](#)

Schedule 3

BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

- Audit and Risk Assurance Committee
- Charitable Funds Committee
- Digital, Data and Innovation Committee
- Finance and Performance Committee
- Health and Safety Committee
- Mental Health Legislation Committee
- People, Organisational Development and Culture Committee
- Quality, Safety and Experience Committee
- Remuneration and Terms of Service Committee
- Strategy and Planning Committee

Terms of Reference for Board Committees are available via the following hyperlink to the LHB's website:

[Board committees - Hywel Dda University Health Board \(nhs.wales\)](https://nhs.uk/healthboards/healthboardcommittees)

Schedule 4

JOINT COMMITTEE ARRANGEMENTS

**This Schedule forms part of, and shall have effect as if incorporated in the
Local Health Board Standing Orders**

Available via the following hyperlinks:

- Schedule 4.1 – National Health Service Wales Joint Commissioning Committee

[Standing Orders - NHS Wales Joint Commissioning Committee](#)

[Standing Financial Instructions - NHS Wales Joint Commissioning Committee](#)

- Schedule 4.2 - Hywel Dda University Health Board and Swansea Bay University Health Board Regional Joint Committee (RJC)

[Terms of Reference - Regional Joint Committee](#)

Schedule 5

ADVISORY GROUPS

Terms of Reference and Operating Arrangements

**This Schedule forms part of, and shall have effect as if incorporated in the
Local Health Board Standing Orders**

Schedule 5.1 – Stakeholder Reference Group

Schedule 5.2 – Health Professionals Forum

Schedule 5.3 – Local Partnership Forum

Terms of Reference for Board Advisory Groups available via the following
hyperlink to the LHB's website:

[Advisory groups - Hywel Dda University Health Board \(nhs.wales\)](#)

Schedule 2.1

MODEL STANDING FINANCIAL INSTRUCTIONS FOR HYWEL DDA UNIVERSITY LOCAL HEALTH BOARD

This Schedule forms part of and shall have effect as if incorporated in the Local Health Board Standing Orders (incorporated as Schedule 2.1 of SOs).

Foreword

These Model Standing Financial Instructions are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Local Health Boards in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. Designed to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability in the conduct of business, they translate statutory and Welsh Government financial requirements for the NHS in Wales into day-to-day operating practice. Together with the adoption of Standing Orders (SOs), a Scheme of decisions reserved to the Board and a scheme of delegations to officers and others, they provide the regulatory framework for the business conduct of the LHB.

These documents form the basis upon which the LHB's governance and accountability framework is developed and, together with the adoption of the LHB's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All LHB Board members and officers must be made aware of these Standing Financial Instructions and, where appropriate, should be familiar with their detailed content. The Director of Finance will be able to provide further advice and guidance on any aspect of the Standing Financial Instructions. The Director of Corporate Governance/Board Secretary will be able to provide further advice and guidance on the wider governance arrangements within the LHB. Further information on governance in the NHS in Wales may be accessed at <https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/>

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Schedule 1

Hywel Dda University Local Health Board

1. INTRODUCTION

1.1 General

- 1.1.1 These Model Standing Financial Instructions are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Local Health Boards (LHBs) in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. They shall have effect as if incorporated in the Standing Orders (SOs) (incorporated as Schedule 2.1 of SOs).
- 1.1.2 These SFIs detail the financial responsibilities, policies and procedures adopted by Hywel Dda University LHB (the LHB). They are designed to ensure that the LHB's financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability. They should be used in conjunction with the Schedule of decisions reserved to the Board and the Scheme of delegation adopted by the LHB.
- 1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the LHB and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial control procedure notes. All financial procedures must be approved by the Director of Finance and Finance and Performance Committee.
- 1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Corporate Governance/Board Secretary or Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the LHB's SOs.

1.2 Overriding Standing Financial Instructions

- 1.2.1 Full details of any non-compliance with these SFIs, including an explanation of the reasons and circumstances must be reported in the first instance to the Director of Finance and the Director of Corporate Governance/Board Secretary, who will ask the Audit Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and LHB officers have a duty to

report any non-compliance to the Director of Finance and Director of Corporate Governance/Board Secretary as soon as they are aware of any circumstances that has not previously been reported.

- 1.2.2 Ultimately, the failure to comply with SFIs and SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

1.3 Financial provisions and obligations of LHBs

- 1.3.1** The financial provisions and obligations for LHBs are set out under Sections 174 to 177 of, and Schedule 8 to, the National Health Service (Wales) Act 2006 (c. 42). The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer for the organisation, must ensure the LHB meets its statutory obligation to perform its functions within the available financial resources.

2. RESPONSIBILITIES AND DELEGATION

2.1 The Board

2.1.1 The Board exercises financial supervision and control by:

- a) Formulating and approving the Medium-Term Financial Plan (MTFP) as part of developing and approving the Integrated Medium-Term Plan (IMTP);
- b) Requiring the submission and approval of balanced budgets within approved allocations/overall funding
- c) Defining and approving essential features in respect of important financial policies, systems and financial controls (including the need to obtain value for money and sustainability); and
- d) Defining specific responsibilities placed on Board members and LHB officers, and LHB committees and Advisory Groups as indicated in the 'Scheme of delegation' document.

2.1.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Schedule of matters reserved to the Board' document. The Board, subject to any directions that may be made by Welsh Ministers, shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Health Board may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. This will be via powers and authority delegated to committees, sub-committees, joint committees or joint sub-committees that the LHB has established or to an officer of the LHB in accordance with the 'Scheme of delegation' document adopted by the LHB.

2.2 The Chief Executive and Director of Finance

2.2.1 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

2.2.2 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Welsh Government, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the LHB's activities; is responsible to the Chair and the Board for ensuring that financial

provisions, obligations and targets are met; and has overall responsibility for the LHB's system of internal control.

2.2.3 It is a duty of the Chief Executive to ensure that Board members and LHB officers, and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

2.3 The Director of Finance

2.3.1 The Director of Finance is responsible for:

- a) Implementing the LHB's financial policies and for co-coordinating any corrective action necessary to further these policies;
- b) Maintaining an effective system of internal financial control including ensuring that detailed financial control procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
- c) Ensuring that sufficient records are maintained to show and explain the LHB's transactions, in order to disclose, with reasonable accuracy, the financial position of the LHB at any time; and
- d) Without prejudice to any other functions of the LHB, and Board members and LHB officers, the duties of the Director of Finance include:
 - (i) the provision of financial advice to other Board members and LHB officers, and LHB Committees and Advisory Groups,
 - (ii) the design, implementation and supervision of systems of internal financial control, and
 - (iii) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the LHB may require for the purpose of carrying out its statutory duties.

2.3.2 The Director of Finance is responsible for ensuring an ongoing training and communication programme is in place to affect these SFIs.

2.4 Board members and LHB officers, and LHB Committees and Advisory Groups

2.4.1 All Board members and LHB officers, and LHB Committees and Advisory Groups, severally and collectively, are responsible for:

- a) The security of the property of the LHB;
- b) Avoiding loss;
- c) Exercising economy, efficiency and sustainability in the use of resources; and
- d) Conforming to the requirements of SOs, SFIs, Financial Control Procedures and the Scheme of delegation.

2.4.2 For all Board members and LHB officers, and LHB Committees and Advisory Groups who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board, Committees, Advisory Groups and employees discharge their duties must be to the satisfaction of the Director of Finance.

2.5 Contractors and their employees

2.5.1 Any contractor or employee of a contractor who is empowered by the LHB to commit the LHB to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

3. AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT

3.1 Audit Committee

- 3.1.1 An independent Audit Committee is a central means by which a Board ensures effective internal control arrangements are in place. In addition, the Audit Committee provides a form of independent check upon the executive arm of the Board. In accordance with SOs the Board shall formally establish an Audit Committee with clearly defined terms of reference. Detailed terms of reference and operating arrangements for the Audit Committee are set out in Schedule 3 to the SOs. This committee will follow the guidance set out in the NHS Wales Audit Committee Handbook.

nwssp.nhs.wales/a-wp/governance-e-manual/governance-e-manual-documents/useful-documents/nhs-wales-audit-committee-handbook-june-2012/

3.2 Chief Executive

- 3.2.1 The Chief Executive is responsible for:

- a) Ensuring there are arrangements in place to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;
- b) Ensuring that the Internal Audit function meets the Public Sector Internal Audit Standards and provides sufficient independent and objective assurance to the Audit Committee and the Accountable Officer;

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/641252/PSAIS_1_April_2017.pdf

- c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;
- d) Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

- a clear opinion on the effectiveness of internal control in

accordance with the requirements of the Public Sector Internal Audit Standards.

- major internal financial control weaknesses discovered,
- progress on the implementation of Internal Audit recommendations,
- progress against plan over the previous year,
- a strategic audit plan covering the coming three years, and
- a detailed plan for the coming year.

3.2.2 The designated internal and external audit representatives are entitled (subject to provisions in the Data Protection Act 2018 and the UK General Data Protection Legislation) without necessarily giving prior notice to require and receive:

- a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- b) Access at all reasonable times to any land or property owned or leased by the LHB;
- c) Access at all reasonable times to Board members and LHB officers;
- d) The production of any cash, stores or other property of the LHB under a Board member or a LHB official's control; and
- e) Explanations concerning any matter under investigation.

3.3 Internal Audit

3.3.1 The Accountable Officer Memorandum requires the Chief Executive to have an internal audit function that operates in accordance with the standards and framework set for the provision of Internal Audit in the NHS in Wales. This framework is defined within an Internal Audit Charter that incorporates a definition of internal audit, a code of ethics and Public Sector Internal Audit Standards. Standing Order 10.1 details the relationship between the Head of Internal Audit and the Board. The role of the Audit Committee in relation to Internal Audit is set out within its Terms of Reference, incorporated in Schedule 3 of the

3.4 External Audit

3.4.1 Pursuant to the Public Audit (Wales) Act 2004 (c. 23), the Auditor General for Wales (Auditor General) is the external auditor of the LHB. The Auditor General may nominate his representative to represent him within the LHB and to undertake the required audit work. The cost of the audit is paid for by the LHB. The LHB's Audit Committee must ensure that a cost-efficient external audit service is delivered. If there are any problems relating to the service provided, this should be raised with the Auditor General's representative and referred on to the Auditor General if the issue cannot be resolved.

3.4.2 The objectives of the external audit fall under three broad headings, to review and report on:

- a) Whether the expenditure to which the financial statements relate has been incurred lawfully and in accordance with the authority that governs it;
- b) The audited body's financial statements, and on its Annual Governance Statement and remuneration report ¹;
- c) Whether the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

3.4.3 The Auditor General's representatives will prepare a risk-based annual audit plan, designed to deliver the Auditor General's objectives, for consideration by the Audit Committee. The annual plan will set out details of the work to be carried out, providing sufficient detail for the Audit Committee and other recipients to understand the purpose and scope of the defined work and their level of priority. The Audit Committee should review the annual plan and the associated fees, although in so doing it needs to recognise the statutory duties of the Auditor General. The annual audit plan should be kept under review to identify any amendment needed to reflect changing priorities and emerging audit needs. The Audit Committee should consider material changes to the annual audit plan.

3.4.4 The Auditor General's representative should be invited to attend every

¹ Note: The Healthcare Inspectorate Wales will review and report on the Annual Quality Statement.

Audit Committee meeting. The cycle of approving and monitoring the progress of external audit plans and reports, culminating in the opinion on the annual report and accounts, is central to the core work of the Audit Committee.

- 3.4.5 The Auditor General's representatives will liaise with Internal Audit when developing the external audit plan. The Auditor General's representative will ensure that planned external audit work takes into account the work of Internal Audit to avoid duplication wherever possible and considers where Internal Audit work can be relied upon for opinion purposes.
- 3.4.6 The Auditor General and his representatives shall have a right of access to the Chair of the Audit Committee at any time.
- 3.4.7 The Government of Wales Act 2006 (GOWA) provides that the Auditor General has statutory rights of access to all documents and information, as set out in paragraph 3.2.2a of these SFIs, that relate to the exercise of many of his core functions, including his statutory audit of accounts, value for money examinations and improvement studies. The rights of access include access to confidential information; personal information as defined by the Data Protection Act 2018 and the UK General Data Protection Legislation; information subject to legal privilege; personal information and sensitive personal information that may otherwise be subject to protection under the European Convention of Human Rights; information held by third parties; and electronic files and IT systems. Paragraph 17 of Schedule 8 to GOWA operates to provide the Auditor General with a right of access to every document relating to the LHB that appears to him to be necessary for the discharge of any of these functions. Paragraph 17(3) of Schedule 8 also requires any person that the Auditor General thinks has information related to the discharge of his functions to give any assistance, information and explanation that he thinks necessary. It also requires such persons to attend before the Auditor General and to provide any facility that he and his representatives may reasonably require, such as audit accommodation and access to IT facilities. The rights apply not just to the LHB and its officers and staff, but also to, among others, suppliers to the LHB.
- 3.4.8 The Auditor General's independence in the exercise of his audit functions is protected by statute (section 8 of the Public Audit (Wales) Act 2013), and audit independence is required by professional and ethical standards. Accordingly, the LHB (including its Audit Committee) must be careful not to seek to fetter the Auditor General's discretion in the exercise of his functions. While the LHB may offer comments on the plans and outputs of the Auditor General, it must not seek to direct the Auditor General.

3.4.9 The Auditor General will issue a number of reports over the year, some of which are specified in the Auditor General's Code of Audit and Inspection Practice and International Standards on Auditing. Other reports will depend on the contents of the audit plan.

The main mandatory reports are:

- Report to those charged with governance (incorporating the report required under ISA 260) that sets out the main issues arising from the audit of the financial statements and use of resources work
- Statutory report and opinion on the financial statements
- Annual audit report.

In addition to these reports, the Auditor General may prepare a report on a matter the Auditor General considers would be in the public interest to bring to the public's attention; or make a referral to the Welsh Ministers if significant breaches occur.

3.4.10 The Auditor General also has statutory powers to undertake Value for Money Examinations and Improvement Studies within the LHB and other public sector bodies. At LHBs he also undertakes a Structured Assessment to help him assess whether there are proper arrangements for securing economy, efficiency and effectiveness in the use of resources. The Auditor General will take account of audit work when planning and undertaking such examinations and studies. The Auditor General and his representatives have the same access rights in relation to these examinations and studies as they do in relation to annual audit work.

3.5 Fraud and Corruption

3.5.1 In line with their responsibilities, the LHB Chief Executive and Director of Finance shall monitor and ensure compliance with Directions issued by the Welsh Ministers on fraud and corruption.

3.5.2 The LHB shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by Directions to NHS bodies on Counter Fraud Measures 2005 (as amended).
nwssp.nhs.wales/ourservices/counter-fraud-service/counter-fraud-service-documents/counter-fraud-services-in-nhs-wales/

- 3.5.3 The LCFS shall report to the LHB Director of Finance and the LCFS must work with NHS Counter Fraud Authority (NHSCFA) and the NHS Counter Fraud Service Wales (CFSW) Team in accordance with the Directions to NHS bodies on Counter Fraud Measures 2005.
- 3.5.4 The LCFS will provide a written report to the Director of Finance and Audit Committee, at least annually, on proactive and reactive counter fraud work within the LHB.
- 3.5.5 The LHB must participate in the annual National Fraud Initiative (NFI) led by Audit Wales and must provide the necessary data for the mandatory element of the NFI by the due dates. The LHB should participate in appropriate risk measurement or additional dataset matching exercise in order to support the detection of fraud across the whole public sector.

3.6 Security Management

- 3.6.1 In line with their responsibilities, the LHB Chief Executive will monitor and ensure compliance with Directions issued by the Welsh Ministers on NHS security management.
- 3.6.2 The Chief Executive has overall responsibility for controlling and coordinating security.

4. FINANCIAL DUTIES

4.1 Legislation and Directions

4.1.1 The Health Board has two statutory financial duties, the basis for which is section 175 of the National Health Service (Wales) Act 2006, as amended by the National Health Service Finance (Wales) Act 2014. Those duties are then set out and retained in the Welsh Health Circular “WHC/2016/054 - Statutory Financial Duties of Local Health Boards and NHS Trusts.” They are as follows:

- First Duty - A duty to secure that its expenditure, which is attributable to the performance by it of its functions, does not exceed the aggregate of the funding allotted to it over a period of 3 financial years.
- Second Duty - A duty to prepare a plan to secure compliance with the first duty while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

4.1.2 The details and requirements for the two duties are set out in the Welsh Health Circular “WHC/2016/054 - Statutory Financial Duties of Local Health Boards and NHS Trusts.” Full details of the WHC can be obtained by contacting the HSSG Director of Finance at hywel.jones38@gov.wales

4.2 First Financial Duty – The Breakeven Duty

4.2.1 The Health Board has a statutory duty to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years, that is to breakeven over a 3-year rolling period.

4.2.2 Welsh Government will determine revenue and capital allocations prior to the start of each financial year and notify Health Boards.

4.2.3 Health Boards must ensure their boards approve balanced revenue and capital plans in line with their notified allocations before the start of each financial year.

4.2.4 The Director of Finance of the LHB will:

- a) Prior to the start of each financial year submit to the Board for approval a report showing the total allocations received, assumed in-year allocations and other adjustments and their proposed

distribution to delegated budgets, including any sums to be held in reserve;

- b) Ensure that any ring-fenced or non-discretionary allocations are disbursed in accordance with Welsh Ministers' requirements;
- c) Periodically review any assumed in-year allocations to ensure that these are reasonable and realistic; and
- d) Regularly update the Board on significant changes to the initial allocations and the application of such funds.

4.2.5 The Chief Executive has overall executive responsibility for the LHB's activities and is responsible to the Board for ensuring that it meets its First Financial Duty.

4.3. Second Financial Duty – The Planning Duty

4.3.1 The Health Board has a statutory duty to prepare a plan, the Integrated Medium-Term Plan (IMTP), to secure compliance with the first duty while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

4.3.2 The Integrated Medium-Term Plan must reflect longer-term planning and delivery objectives and should be continually reviewed based on latest Welsh Government policy and local priority requirements. The Integrated Medium-Term Plan, produced and approved annually, will be 3 year rolling plans. In particular the Integrated Medium-Term Plan must reflect the Welsh Ministers' priorities and commitments as detailed in the NHS Planning Framework published annually by Welsh Government.

4.3.3 The NHS Planning Framework directs Local Health Boards to develop, approve and submit an Integrated Medium-Term Plan (IMTP) for approval by Welsh Ministers. The plan must

- describe the context, including population health needs, within which the Health Board will deliver key policy directives from Welsh Government.
- demonstrate how the Health Board are
 - delivering their well-being objectives, including how the five ways of working have been applied
 - contributing to the seven Well-being Goals,
 - establishing preventative approaches across all care and services
- demonstrate how the Health Board will utilise its existing services

and resources, and planned service changes, to deliver improvements in population health and clinical services, and at the same time demonstrate improvements to efficiency of services.

- demonstrate how the three-year rolling financial breakeven duty is to be achieved.

4.3.4 An Integrated Medium Term Plan should be based on a reasonable expectation of future service changes, performance improvements, workforce changes, demographic changes, capital, quality, funding, income, expenditure, cost pressures and savings plans to ensure that the Integrated Medium Term Plan (including a balanced Medium Term Financial Plan) is balanced and sustainable and supports the safe and sustainable delivery of patient centred quality services.

4.3.5 The Integrated Medium-Term Plan will be the overarching planning document enveloping component plans and service delivery plans. The Integrated Medium-Term Plan will incorporate the balanced Medium Term Financial Plan and will incorporate the LHB's response to delivering the

- NHS Planning Framework,
- Quality, governance and risk frameworks and plans and
- Outcomes Framework

4.3.6 The Integrated Medium-Term Plan will be developed in line with the NHS Planning Framework and include:

- A statement of significant strategies and assumptions on which the plans are based;
- Details of major changes in activity, service delivery, service and performance improvements, workforce, revenue and capital resources required to achieve the plans; and
- Profiled activity, service, quality, workforce and financial schedules.
- Detailed plans to deliver the NHS Planning Framework and quality, governance and risk requirements and outcome measures;

4.3.7 The Chief Executive has overall executive responsibility to develop and submit to the Board, on an annual basis, the rolling 3 year Integrated Medium Term Plan (IMTP).

4.3.8 The Board will:

- a) Approve the Integrated Medium-Term Plan prior to the beginning of the financial year of implementation and in accordance with the guidance issued annually by Welsh Government. Following Board

approval, the Plan will be submitted to Welsh Government prior to the beginning of the financial year of implementation.

- b) Approve a balanced Medium Term Financial Plan as part of the Integrated Medium-Term Plan, which meets all financial duties, probity and value for money requirements; and
- c) Prepare and agree with the Welsh Government a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance where the LHB plan is not in place or in balance.

4.3.9 The Board approved Integrated Medium-Term Plan will be submitted to Welsh Government, for approval by the Minister, in line with the requirements set out in the NHS Planning Framework.

4.3.10 The finalised approved Integrated Medium-Term Plan will form the basis of the Performance Agreement between the LHB and Welsh Government.

5. FINANCIAL MANAGEMENT AND BUDGETARY CONTROL

5.1. Budget Setting

5.1.1 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board. Such budgets will:

- a) Be in accordance with the aims and objectives set out in the Board approved Integrated Medium-Term Plan, and Medium-Term Financial Plan, and focussed on delivery of improved population health, safe patient centred quality services;
- b) Be in line with Revenue, Capital, Commissioning, Activity, Service, Quality, Performance, and Workforce plans contained within the Board approved balanced IMTP;
- c) Take account of approved business cases and associated revenue costs and funding;
- d) Be produced following discussion with appropriate Directors and budget holders;
- e) Be prepared within the limits of available funds;
- f) Take account of ring-fenced, specified and non-recurring

allocations and funding;

- g) Include both financial budgets (£) and workforce establishment budgets (budgeted whole-time equivalents)
- h) Be within the scope of activities and authority defined by the National Health Service (Wales) Act 2006, including pooled budget arrangements;
- i) Identify available reserves;
- j) Take account of the principles of Well-being of Future Generations (Wales) Act 2015 including the seven Well-being Goals and the five ways of working; and
- k) Identify potential risks and opportunities.

5.2. Budgetary Delegation

5.2.1 The Chief Executive may delegate, via the Director of Finance, the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Regulations made in accordance with section 33 of the National Health Service (Wales) Act 2006 (c. 42). This delegation must be in writing, in the form of a letter of accountability, and be accompanied by a clear definition of:

- a) The amount of the budget;
- b) The purpose(s) of each budget heading;
- c) Individual or committee responsibilities;
- d) Arrangements during periods of absence;
- e) Authority to exercise virement;
- f) Achievement of planned levels of service; and
- g) The provision of regular reports.

The budget holder must sign the accountability letter formally delegating the budget.

5.2.2 The Chief Executive, Director of Finance and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

5.2.3 Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

- 5.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.
- 5.2.5 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled and managed appropriately.
- 5.2.6 All budget holders will sign up to their allocated budgets at the commencement of the financial year.
- 5.2.7 The Director of Finance has a responsibility to ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist budget holders managing their budgets successfully.

5.3. Financial Management, Reporting and Budgetary Control

- 5.3.1 The Director of Finance shall monitor financial performance against budget and plans and report the current and forecast position, and financial risks, on a monthly basis and at every Board meeting. Any significant variances should be reported to LHB Board as soon as they come to light and the Board shall be advised on any recommendations and action to be taken in respect of such variances.
- 5.3.2 The Director of Finance will devise and maintain systems of financial management, performance reporting and budgetary control. These will include:
- a) Regular financial reports, for revenue and capital, to the Board in a form approved by the Board containing sufficient information for the Board to:
- Understand the current and forecast financial position
 - Evaluate risks and opportunities
 - Use insight to make informed decisions
 - Be consistent with other Board reports, and as a minimum the reports will cover:
 - Current and forecast year end position on statutory financial duties
 - Actual income and expenditure to date compared to budget and showing trends and run rates
 - Forecast year end positions
 - A statement of assets and liabilities, including analysis of cash flow and movements in working capital.

- Explanations of material variances from plan
 - Capital expenditure and projected outturn against plan
 - Investigations and reporting of variances from financial, activity and workforce budgets.
 - Details of corrective actions being taken, as advised by the relevant budget holder and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;
 - Statement of performance against savings targets
 - Key workforce and other cost drivers
 - Income and expenditure run rates, historic trends, extrapolation and explanations
 - Clear assessment of risks and opportunities
 - Provide a rounded and holistic view of financial and wider organisational performance.
- b) The issue of regular, timely, accurate and comprehensible advice and financial reports to each delegated budget holder, covering the areas for which they are responsible;
- c) An accountability and escalation framework to be established for the organisation to formally address material budget variances
- d) Investigation and reporting of variances from financial, activity and workforce budgets;
- e) Monitoring of management action to correct variances;
- f) Arrangements for the authorisation of budget transfers and virements.

5.3.3 Each Budget Holder will

- be held to account for managing services within the delegated budget
- investigate causes of expenditure and budget variances using information from activity, workforce and other relevant sources
- develop plans to address adverse budget variances.

5.3.4 Each Budget Holder is responsible for ensuring that:

- a) Any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Chief Executive subject to the Board's scheme of delegation;
- b) The amount provided in the approved budget is not used in whole

or in part for any purpose other than that specifically authorised, subject to the rules of virement;

- c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.

5.3.5 The Chief Executive is responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the requirements of the Medium-Term Financial Plans and SFI 9.1.

5.4. Capital Financial Management, Reporting and Budgetary Control

5.4.1 The general rules applying to revenue Financial Management, Reporting and Budgetary Control delegation and reporting shall also apply to capital plans, budgets and expenditure subject to any specific reporting requirements required by the Welsh Ministers.

5.5 Reporting to Welsh Government - Monitoring Returns

5.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring returns are submitted to the Welsh Ministers in accordance with published guidance and timescales.

5.5.2 All monitoring returns must be supported by a detailed commentary signed by the Director of Finance and Chief Executive. This commentary should also highlight and quantify any significant risks with an assessment of the impact and likelihood of these risks maturing.

5.5.3 All information made available to the Welsh Ministers should also be made available to the Board. There must be consistency between the Medium-Term Financial Plan, budgets, expenditure, forecast position and risks as reported in the monitoring returns and monthly Board reports.

6. ANNUAL ACCOUNTS AND REPORTS

- 6.1 The Board must approve the LHB's annual accounts prior to submission to the Welsh Ministers and the Auditor General for Wales in accordance with the annual timetable.
- 6.2 The Chair and Chief Executive have responsibility for signing the accounts on behalf of the LHB. The Chief Executive has responsibility for signing the Performance Report, Accountability Report, Statement of Financial Position and the Governance Statement.
- 6.3 The Director of Finance, on behalf of the LHB, is responsible for ensuring that financial reports and returns are prepared in accordance with the accounting policies, guidance and timetable determined by the Welsh Ministers, as per Welsh Government's Manual for Accounts, and consistent with Financial Reporting Manual (FReM) and International Financial Reporting Standards.
- 6.4 The LHB's annual accounts must be audited by the Auditor General for Wales. The LHB's audited annual accounts must be adopted by the Board at a public meeting and made available to the public.
- 6.5 The LHB will publish an annual report, in accordance with guidelines on local accountability, and present it at its Annual General Meeting. The Director of Corporate Governance/Board Secretary will ensure that the Annual Report is prepared in line with the Welsh Government's Manual for Accounts. The Annual Report will include
- The Accountability Report containing:
 - o Corporate Governance Report
 - o Remuneration Report and Staff Report
 - o Accountability and Audit Report
 - The Performance Report, which must include:
 - o An overview
 - o A performance Analysis

7. BANKING ARRANGEMENTS

7.1 General

7.1.1 The Director of Finance is responsible for managing the LHB's banking arrangements and for advising the Board on the provision of banking services and operation of accounts. This advice will take into account guidance/Directions issued from time to time by the Welsh Ministers. LHBs are required to use the Government Banking Service (GBS) for its banking services.

7.1.2 The Board shall approve the banking arrangements.

7.2 Bank Accounts

7.2.1 The Director of Finance is responsible for:

- a) Establishing bank accounts and ensuring that the Government Banking Service is utilised for main Health Board business transactions;
- b) Establishing additional commercial accounts only exceptionally and where there is a clear rationale for not utilising the Government Banking Service;
- c) Establishing separate bank accounts for the LHB's non-exchequer funds;
- d) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;
- e) Ensuring accounts are not overdrawn except in exceptional and planned situations.
- f) Reporting to the Board all arrangements made with the LHB's bankers for accounts to be overdrawn;
- g) Monitoring compliance with Welsh Ministers' guidance on the level of cleared funds.

7.2.2 With the exception of Project Bank Accounts, all bank accounts should be held in the name of the LHB. No officer other than the Director of Finance shall open any account in the name of the LHB or for the purposes of furthering LHB activities.

7.2.3 Any Project Bank Account that is required may be held jointly in the name of the LHB and the relevant third-party contractor.

7.3 Banking Procedures

7.3.1 The Director of Finance will prepare detailed instructions on the operation of bank accounts, that ensure there are sound controls over the day-to-day operation of bank accounts, which must include:

- a) The conditions under which each bank account is to be operated;
- b) Those authorised to sign cheques or other orders drawn on the LHB's accounts.
- c) Effective divisions of duty for employees working within the banking and treasury management function to minimise the risk of fraud and error.
- d) Authorised signatories are identified with sufficient seniority, and in the case of e banking approvers, together with an appropriate payment approval hierarchy.
- e) Procedures are in place for prompt banking of money received.
- f) Ensure there are physical security arrangements in place for cheque stationery, e banking access devices and payment cards.
- g) Cheques and payable orders are treated as controlled stationery with management responsibility given to a duly designated employee.
- h) Frequent reconciliations are undertaken between cash books, bank statements and the general ledger so that all differences are fully understood and accounted appropriately.
- i) Commercial bank accounts should only be used exceptionally where there is a sound rationale and demonstrates value for money. Commercial accounts should be procured through a tendering exercise and the outcome reported to the Audit Committee on behalf of the Board.

7.3.2 The Director of Finance must advise the LHB's bankers in writing of the conditions under which each account will be operated.

7.3.3 The Director of Finance shall approve security procedures for any payable orders issued without a hand-written signature e.g. automatically printed. All Payable Orders shall be treated as controlled

stationery, in the charge of a duly designated officer controlling their issue.

7.4 Review

- 7.4.1 The Director of Finance will review banking arrangements of the LHB at regular intervals to ensure they reflect best practice, that they are efficient and effective and represent best value for money. The results of the review should be reported to the Audit Committee.

8. CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS

8.1 General

8.1.1 The Director of Finance is responsible for:

- a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
- b) Ordering and securely controlling any such stationery, ensuring all cash related stationery treated as controlled stationery with management responsibility given to a duly designated employee;
- c) The provision of adequate physical facilities and systems for officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and
- d) Establishing systems and procedures for handling cash and negotiable securities on behalf of the LHB.
- e) Ensuring effective control systems are in place for the use of payment cards,
- f) Ensuring that there are adequate control systems in place to minimise the risk of cash/card misappropriation.

8.1.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs (informal documents acknowledging debt).

8.1.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

8.1.4 The holders of safe/cash box combinations/keys shall not accept unofficial funds for depositing in their safe/cash box unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the LHB is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the LHB from responsibility for any loss.

8.1.5 The opening of coin operated machines (including telephone, if applicable) and the counting and recording of takings shall be

undertaken by two officers together, except as may be authorised in writing by the Director of Finance and the coin box keys shall be held by a nominated officer.

- 8.1.6 During the absence (for example, on holiday) of the holder of a safe/cash box combination/key, the officer who acts in their place shall be subject to the same controls as the normal holder of the combination/key. There shall be written discharge for the safe and/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

8.2 Petty Cash

- 8.2.1 The Director of Finance will issue instructions restricting the use and value of petty cash purchases.
- 8.2.3 Petty cash use should be minimised and be subject to regular cash balance reviews in order to minimise cash levels held.
- 8.2.3 Petty cash should be operated under an imprest system and be subject to regular checks to ensure physical and book cash levels are consistent.

9. INCOME, FEES AND CHARGES

9.1 Income Generation and Participation in/Formation of Companies

- 9.1.1 The LHB shall only generate income for those goods and services that are approved by the Welsh Ministers. Any income generating activities must be complementary to the provision of NHS services and must be in accordance with the Welsh Ministers' policy and powers to raise money as set out in section 169 of the National Health Service (Wales) Act 2006 (c. 42).
- 9.1.2 The LHB can only form or participate in a company for income generation, improving health, healthcare care and health services, purposes with the consent and/or direction of Welsh Ministers. The LHB should obtain advice from Welsh Government officials prior to undertaking substantive work on formation or participation in any company.

9.2 Income Systems

- 9.2.1 The Director of Finance is responsible for designing and maintaining procedures to ensure compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.
- 9.2.2 The Director of Finance is also responsible for ensuring that systems are in place for the prompt banking of all monies received.

9.3 Fees and Charges

- 9.3.1 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Welsh Ministers or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.
- 9.3.2 All officers must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

9.4 Income Due and Debt Recovery

- 9.4.1 Delegated budget holders and managers are responsible for informing the Director of Finance of any income due that arises from any contracts, service levels agreements, leases, activities such as private patients or other transactions.

- 9.4.2 Delegated budget holders and managers must inform the Director of Finance when overpayment of salary or expenses have been made, in order that recovery can be made.
- 9.4.3 The Director of Finance is responsible for recovering income due and for ensuring debt recovery procedures are in place to secure early payment and minimise bad debt risk on all outstanding debts.
- 9.4.4 Income not received should be dealt with in accordance with losses procedures.
- 9.4.5 Overpayments should be detected (or preferably prevented) and recovery initiated.
- 9.4.6 The Chief Executive and the Director of Finance are responsible for ensuring the Welsh Ministers' guidance on disputed debt arbitration is strictly adhered to.

10. NON-PAY EXPENDITURE

10.1 Scheme of Delegation, Non-Pay Expenditure Limits and Accountability

10.1.1 The Board must agree a Scheme of Delegation in line with that set out in its Standing Orders Scheme of Reservation and Delegation of Powers.

10.1.2 The Chief Executive will approve the level of non-pay expenditure and the operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the LHB's scheme of delegation.

10.9.1 The Chief Executive will set out in the operational scheme of delegation and authorisation:

- The list of managers who are authorised to place requisitions for the supply of goods, services and works and for the awarding of contracts; and
- The maximum level of each requisition and the system for authorisation above that level.

10.2 The Director of Finance's responsibilities

10.2.1 The Director of Finance will:

- a) Advise the Board regarding the NHS Wales national procurement and payment systems thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds would be incorporated in SOs and SFIs;
- b) Prepare procedural instructions or guidance within the Scheme of Delegation on non-pay expenditure;
- c) Ensure systems are in place for the authorisation of all accounts and claims;
- d) Ensure Directors and officers strictly follow NHS Wales system and procedures of verification, recording and payment of all amounts payable.
- e) Maintain a list of Executive Directors and officers (including specimens of their signatures) authorised to certify invoices.
- f) Be responsible for ensuring compliance with the Public Sector

Payment policy ensuring that a minimum of 95 percent of creditors are paid within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

- g) Ensure that where consultancy advice is being obtained, the procurement of such advice must be in accordance with applicable procurement legislation, guidance issued by the Welsh Ministers and SFIs;
- h) Be responsible for Petty Cash system, procedures, authorisation and record keeping, and ensure purchases from petty cash are restricted in value and by type of purchase in accordance with procedures.

10.3 Duties of Budget Holders and Managers

10.3.1 Budget holders and managers must ensure that they comply fully with the Scheme of Delegation, guidance and limits specified by the Chief Executive and Director of Finance, and that:

- a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of both any commitment being made and NWSSP Procurement Services being engaged;
- b) Contracts above specified thresholds are advertised and awarded, through NWSSP Procurement Services, in accordance with UK and HM Treasury rules on public procurement;
- c) Contracts above specified thresholds are approved by the Welsh Ministers prior to any commitment being made;
- d) goods have been duly received, examined and are in accordance with specification and order,
- e) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct,
- f) No requisition/order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Board members or LHB officers, other than:
 - (i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars,

- (ii) Conventional hospitality, such as lunches in the course of working visits;

This provision needs to be read in conjunction with Standing Order 8.5, 8.6 and 8.7.

- g) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;
- h) All goods, services, or works are ordered on official orders
- i) Requisitions/orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
- j) Goods are not taken on trial or loan in circumstances that could commit the LHB to a future uncompetitive purchase;

10.3.2 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by the Welsh Ministers. The technical audit of these contracts shall be the responsibility of the relevant Director as set out in the LHB's scheme of delegation.

10.4 Departures from SFI's

10.4.1 Departing from the application of Chapters 10 and 11 of these SFI's is only possible in very exceptional circumstances. Health Boards must consult with NWSSP Procurement Services, Director of Finance and Director of Corporate Governance/Board Secretary prior to any such action undertaken. Any expenditure committed under these departures must receive prior approval in accordance with the Health Board Scheme of Delegation.

10.5 Accounts Payable

10.5.1 NWSSP Finance, shall on behalf of the LHB, maintain and deliver detailed policies, procedures systems and processes for all aspects of accounts payable

10.6 Prepayments

10.6.1 Prepayment should be exceptional and should only be considered if a good value for money case can be made for them (i.e. that "need" can be demonstrated). Prepayments are only permitted where either:

- The financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%);
- It is the industry norm e.g. courses and conferences;
- In line with requirements of Managing Welsh Public Money
- There is specific Welsh Ministers' approval to do so e.g. voluntary services compact.

10.6.2 In **exceptional** circumstances prepayments can be made subject to:

- a) The appropriate Executive Director providing, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the LHB if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;
- b) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the associated subordinate instruments (together "**the 2023 Act**") and the The Health Services (Provider Selection Regime) (Wales) Regulations 2025 (Wales) Regulations 2025 where the contract is above a stipulated financial threshold); and
- c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

11. PROCUREMENT AND CONTRACTING

General Information

11.1 Procurement Services

11.1.1 While the Chief Executive is ultimately responsible for procurement the service is delivered by NHS Wales Shared Services Partnership NWSSP Procurement Services ("Procurement Services").

11.1.2 The Procurement staff employed by NWSSP provide a procurement support function to all health organisations in NHS Wales. Although NWSSP is responsible for the provision of a Procure to Pay service and provision of appropriate professional procurement and commercial advice, ultimate responsibility for compliance with legislation and policy guidelines remains with the Health Board. Where the term 'Procurement staff' or 'department' is used in this chapter it should be read as equally applying to those departments where the procurement

function is undertaken locally of Procurement Services, for example 'pharmacy' and 'works' who undertake procurement on a devolved basis.

11.2 Policies and Procedures

11.2.1 Procurement Services shall, on behalf of the LHB, maintain detailed policies and procedures for all aspects of procurement, including tendering and contracting processes. The policies and procedures shall comply with these SFIs, the NWSSP Procurement Manual (existing and future revised) and the Revised General Consent to enter Individual Contracts [included as **Schedule 1** of these SFIs].

11.2.2 The Chief Executive is ultimately responsible for ensuring that the LHB's Executive Directors, Independent Members and officers within the organisation strictly follow procurement, tendering and contracting procedures.

11.2.3 NWSSP's Director of Procurement Services is responsible for ensuring that procurement, tendering and contracting policies and procedures

- Are kept up to date;
- Conform to statutory requirements and regulations;
- Adhere to guidance issued by the Welsh Ministers; and
- Are consistent with the principles of sustainable development.

11.2.4 All procurement guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

11.3 Legislation Governing Public Procurement

11.3.1 Legislation governs public sector procurement in the UK. From the 24 February 2025, the Procurement Act 2023 and associated subordinate instruments (together "the 2023 Act") and the The Health Services (Provider Selection Regime) (Wales) Regulations 2025 (Wales) Regulations 2025 and associated subordinate instruments (together "the PSR Wales Regulations") are the key pieces of legislation which governs public sector procurement in the UK. The PSR Wales Regulations only apply to certain health services ("In-Scope Health Services") and further detail these can be found in the Welsh Government's statutory guidance titled "Health service procurement: statutory guidance". Goods and services which are not In-Scope Health Services ("Goods and Non-Health Services") fall within the scope of the 2023 Act. `

11.3.2 Where specific instruction relates only to procurements undertaken under the PSR Wales Regulations, the words '**In-Scope Health**

Services Only’ will appear at the start of the instruction paragraph. Where specific instruction relates only to procurements undertaken under the Act, the words **‘Goods and Non-Health Services Only’** will appear at the start of the instruction paragraph. If such references do not appear at the start of the instruction paragraph, all information detailed is applicable to the procurement regimes under both the PSR Wales Regulations and the 2023 Act, save for any bracketed instruction reference following a phrase to either regimes applicability.

11.3.3 **‘Goods and Non-Health Services Only’** The Act governs the procurement of Goods and Non-Health Services. The Welsh Government’s Policy Framework and the Wales Procurement Policy Statement (WPPS) under section 14 of the 2023 Act also govern this area. A key objective of the legislation is to establish a flexible, accessible and equitable framework for public procurement in Wales that maximises social, economic, environmental and cultural outcomes for communities across Wales. Legislation, policy, and guidance setting out procedures and requirements for awarding all forms of regulated contracts shall have effect as if incorporated in the LHBs SFIs. **In the event of any conflict between what is contained in the 2023 Act and the LHB’s SFIs, the former shall prevail.**

11.3.4 **‘In Scope Health Services Only’** The PSR Wales Regulations governs the procurement of In-Scope Health Services. Under this legislation, relevant organisations to which the PSR Wales Regulations apply must also have regard to the Wales Procurement Policy Statement (WPPS) under section 14 of the 2023 Act. They must also have regard to the statutory guidance issued by the Welsh Government which sets out how the PSR Wales Regulations should be adopted. One of the key objectives of this legislation is to ensure there is more flexibility when selecting providers for health services, with competitive tendering being one tool for the LHB to use when it is of benefit; alongside other routes that may be more proportionate, and which better enable the development of stable partnerships and the delivery of collaborative care. Legislation, policy, and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the LHB’s SFIs. **In the event of any conflict between what is contained in the PSR Wales Regulations and the LHB’s SFIs, the former shall prevail.**

11.3.5 All Directors and their staff are responsible for ensuring that all legal requirements in the area of public procurement are understood and fully complied with. The provisions set out in the 2023 Act, the PSR Wales Regulations, Welsh Procurement Policy Notices, and all associated subordinate instruments are the model upon which all procurement exercises should be based.

- 11.3.6 Procurement advice should be sought in the first instance from Procurement Services. The commissioning of further specialist advice shall be jointly agreed between the LHB and Procurement Services e.g., engagement of NWSSP Legal and Risk Services prior to 3rd party Legal Service providers.
- 11.3.7 All other relevant legislation, guidance and policy documents must also be observed, including but not limited to the following:
- Social Partnership and Public Procurement (Wales) Act 2023
 - The Well-being of Future Generations (Wales) Act 2015
 - Welsh Language (Wales) Measure 2011
 - Modern Slavery Act 2015
 - Bribery Act 2010
 - Equality Act 2010
 - Welsh Government's Code of Practice for Ethical Employment in Supply Chains.
 - The Producer Responsibility Obligations (Packaging Waste) Regulations 2007
 - Welsh Government 'Towards zero waste: our waste strategy'
 - The Welsh Government Procurement Policy Framework, including:
 - Wales Procurement Policy Notes (extant at the time of undertaking the procurement exercise)
 - The Wales Procurement Policy Statement (WPPS) (section 14 of the Procurement Act 2023)

11.4 Procurement Principles and Objectives

- 11.4.1 The term "procurement" embraces the complete process from planning, sourcing to taking delivery of all works, goods and services required by the LHB to perform its functions, and furthermore embrace all building, equipment, consumables, and services including health services. Procurement further embraces contract and/or supplier management, including market engagement and industry monitoring.
- 11.4.2 **'Goods and Non-Health Services Only'** The legal and governing principles guiding 'covered procurement' under the 2023 Act, and incorporated into these SFIs include but are not limited to the following:
- Having regard to the objectives of delivering value for money; maximising public benefit; sharing information for the purpose of allowing suppliers and others to understand the authority's procurement policies and decisions; acting, and being seen to act, with integrity; and removing or reducing the barriers faced by SMEs.
 - Ensuring equal treatment by treating suppliers the same, unless differences between the suppliers justify different treatment (and where

different treatment of suppliers is justified, to take all reasonable steps to make sure the different treatment does not put a supplier at an unfair advantage or disadvantage).

11.4.3 ‘In Scope Health Services Only’ The legal and governing principles guiding procurement of In Scope Health Services under the PSR Wales Regulations, and incorporated into these SFIs include but is not limited to the Health Board doing the following:

- Making decisions in the best interests of people who use the service by acting with a view to (1) securing the needs of the people who use the services; (2) improving the quality of the services; (3) improving efficiency in the provision of the services;
- Acting transparently, fairly, and proportionately;
- Having regard to the Welsh Government’s Health Service Procurement: Statutory Guidance; and
- Having regard to the Wales Procurement Policy Statement published under section 14 of the 2023 Act.

11.5 Procurement Procedures

11.5.1 To help towards ensuring that the Health Board is fully compliant with the legislation governing public sector procurement in the UK, and Welsh Ministers’ guidance and policy, the Health Board shall, through NWSSP Procurement Services, ensure that it shall have procedures that set out:

- a) Requirements and exceptions to formal competitive tendering (**‘Goods and Non- Health Services Only’**);
- b) Tendering processes including post tender discussions;
- c) Requirements and exceptions to obtaining quotations (**‘Goods and Non-Health Services Only’**)
- d) Evaluation and scoring methodologies; and
- e) Approval of firms for providing goods and services.

11.5.2 All procurement procedures must comply with all relevant legislation, the Welsh Ministers’ guidance and the LHB’s delegation arrangements and approval processes.

11.6 Notification to Welsh Government and consent from the Welsh Ministers

11.6.1 **Schedule 1** details the requirements and notification process for entering into contracts.

11.6.2 The provisions of Schedule 1 do not remove the requirement for the Health Board to comply with Standing Orders, SFIs or to obtain any

other consents or approvals required by law for the transactions concerned.

Planning

11.7 Sustainable Procurement

11.7.1 To further nurture the Welsh economy, in support of social, environmental, economic and cultural goals in Wales, the Health Board must also be mindful to structure requirements ensuring Welsh companies have the opportunity to transparently and fairly compete to deliver services regionally or across Wales where possible within the legislative framework. The principles of Well-being of Future Generations (Wales) Act 2015 (the **WBFG Act 2015**) should be adopted at the earliest stage of planning.

11.7.2 For example, the WBFG Act 2015 requires affected public bodies to act in a manner which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs. The WBFG Act 2015 also provides for a share purpose through seven well-being goals for Wales which are indivisible from each other and explain what is meant by the well-being of Wales.

11.7.3 The 7 Wellbeing goals are

- a prosperous Wales
- a resilient Wales
- a healthier Wales
- a more equal Wales
- a Wales of cohesive communities
- a Wales of vibrant culture and thriving Welsh language
- a globally responsible Wales.

11.7.4 The WBFG Act 2015 puts in place a “sustainable development principle” which tells relevant public bodies how to go about meeting their well-being duty. Such bodies need to make sure that when making their decisions they take into account the impact they could have on people living in Wales now and in the future. The WBFG Act 2015 includes five principles that those public bodies need to think about to show they have applied the sustainable development principle, which by way of brief summary are as follows:

- **Collaboration:** acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives;
- **Integration:** considering how the public body’s well-being objectives may impact upon each of the well-being goals, on

- their other objectives, or on the objectives of other public bodies;
- **Involvement:** the importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves;
- **Long term:** the importance of balancing short-term needs with the need to safeguard the long-term needs; and
- **Prevention:** how acting to prevent problems occurring or getting worse may help public bodies meet their objectives.

11.7.5 The LHB is required to consider the Welsh Government Guidance on Ethical Employment Practices in Public Sector Supply Chains and the Code of Practice on ethical employment in supply chains which includes aims to commit public, private and third sector organisations to a set of action designed to eliminate modern slavery and support ethical employment practices.

11.7.6 The LHB shall make use of the tools developed by Welsh Government Commercial Delivery Team in implementing the principles of the WBFGA 2015. The LHB shall benchmark its performance against the WBFGA 2015. As detailed in WPPN 005, for the procurement of all contracts over £25,000, LHBs are required to take into account the social, economic, environmental and cultural goals in the WBFG Act 2015 using the Sustainable Risk Assessment Template (SRA).

11.8 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)

11.8.1 In accordance with the 'covered procurement' objectives in the 2023 Act, Welsh Government's commitments are set out in Welsh Government's 'technical guidance for covered procurement' and the current and subsequent versions of the Wales Procurement Policy Statement (WPPS). The Health Board shall ensure that it provides opportunities for SMEs, TSOs and SFBs to quote or tender for contracts.

11.9 Planning Procurements

11.9.1 The LHB must ensure that all staff with delegated budgetary responsibility or who are part of the procurement process for goods, services and works are aware of the legislative and policy frameworks and requirements governing public procurement. the requirement of open competition.

11.9.2 A process of planning all procurement exercises must be undertaken with the Procurement Services and appropriate representative from the

service and other appropriate stakeholders, (depending on the value, risk and complexity of the procurement) The purpose of a planning phase is to determine:

- the likely financial value of the procurement, including whole life cost
- the likely 'route to market' which will consider the legislative and policy framework set out above.
- The availability of funding to be able to award a contract following a successful procurement process, and
- That the procurement follows current legislative and policy frameworks including Value Based Procurement

11.9.3 The procurement specification should factor in the four principles of prudent healthcare:

- Equal partners through co-production;
- Care for those with the greatest health need first;
- Do only what is needed; and
- Reduce inappropriate variation.

For '**Goods and Non-Health Services Only**' Value based outcome/experience/delivery principles must also be included where appropriate ensuring best value for money, sustainability of services and the future financial position. For '**In Scope Health Services Only**' Value Based Healthcare should be considered under the Key Criteria 'Value' where this is appropriate and applicable. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement (and is also a core objective of the 2023 Act).

11.9.4 Where free of charge services are made available to the Health Board, NWSSP Procurement Services must be consulted to ensure that any competition requirements are not breached, particularly in the case of pilot activity to ensure that the Health Board does not unintentionally commit itself to a single provider or longer-term commitment. Regular reports on free of charge services provided to the Health Board should be submitted by Director of Corporate Governance/Board Secretary to Audit Committee.

11.9.5 Health Boards are required to participate in all-Wales collaborative planning activity where the potential to do so is identified by the procurement professional involved in the planning process. Cross sector collaboration may also be required.

Joint or Collaborative Initiatives

11.9.6 Specialist advice should be obtained from Welsh Government's Health and Social Care Finance Department and the opinions of NWSSP Procurement Services and NWSSP Legal and Risk prior to external opinion being sought where there is an undertaking to commence joint or collaborative initiatives which may be deemed as novel or contentious.

11.10 Procurement Process

11.10.1 Where there is a requirement for goods or services, the manager must source those goods or services from the Health Board's approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as those provided by the Welsh Government's Commercial Delivery Team, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks (where access is permissible) shall take precedence over frameworks led by Public Sector Bodies outside of Wales.

11.10.2 **'Goods and Non-Health Services Only'** - In the absence of an existing suitable procurement framework to source the required item, a competition must be run in accordance with the 2023 Act and the table below. The LHB must ensure the value of their requirement considers cumulative spend across the LHB for like requirements and opportunity for collaboration with other NHS Wales Organisations.

TABLE 'Goods and Non-Health Services Only'

Goods/Services/Works Whole Life Cost Contract value (excl. VAT)	Minimum competition (1)	Form of Contract
Below £5,000	Evidence of value for money has been achieved	Purchase Order
£5,000 - £24,999	Evidence of 3 written quotations	Simple Form of Contract/Purchase Order
£25,000 plus to the prevailing Procurement Act 2023 threshold (2)	Advertised open call for competition. Minimum of 4 tenders received if available	Formal contract and Purchase Order
Over the prevailing Procurement Act 2023 threshold	Advertised open call for competition. Minimum of 5 tenders received if available or appropriate	Formal contract and Purchase Order

	to the procurement route	
Contracts above £1 million	Welsh Government approval required (3)	Formal contract and Purchase Order

- (1) subject to the existence of suitable suppliers
- (2) The Procurement Act 2023 – Schedule 1 - threshold amounts
- (3) In accordance with the requirements set out in the Schedule 1.

11.10.3 **‘In Scope Health Services Only’** – in the absence of an existing suitable procurement framework to source the required item, the Health Board is required to follow the most appropriate and proportionate procurement process as set out under the PSR Wales Regulations and the Health service procurement: statutory guidance. The Health Board should note that one of the key objectives of the PSR Wales Regulations are to provide more flexibility when selecting providers for health services with competitive tendering being one tool for the Health Board to use when it is of benefit; alongside other routes that may be more proportionate, with a view to enabling the development of stable supplier partnerships and the delivery of collaborative care. Legislation, policy, and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the LHB’s SFIs.

11.10.4 Agreements awarded are required to deliver best value for money over the whole life of the agreement. Value for money is defined as the optimum combination of whole life cost and quality to meet the requirement.

Competition Requirements

11.11 Procurement Thresholds

11.11.1 **‘Goods and Non-Health Services Only’** The LHB must consider the minimum financial thresholds for quotes and competitive tendering arrangements when undertaking a procurement. The total value of the contract, whole life cost, over its entire period is the qualifying sum that should be applied (except in specific circumstances relating to aggregation and contracts of an indeterminate duration) as set out below, and in the Schedule 1 of the 2023 Act.

11.11.2 **‘Goods and Non-Health Services Only’** Advice from the Procurement Services must be sought for all requirements in excess of £5,000 (excluding VAT).

11.11.3 **‘Goods and Non-Health Services Only’** The deliberate sub-dividing of contracts to fall below a specific threshold is strictly prohibited. Any

attempt to avoid these limits may expose the Board to risk of legal challenge and could result in disciplinary action against an individual[s].

11.11.4 **‘Goods and Non-Health Services Only’** Deliberate re-engagement of a supplier, where the value of the individual engagement is less than £5,000, (excluding VAT) must not be undertaken where the total value of engagements taken as a whole would exceed £5,000 (excluding VAT) and require competition.

11.11.5 **‘In Scope Health Services Only’** There is no minimum financial threshold for application of the PSR Wales Regulations.11

11.12 Designing Competitions

11.12.1 The budget holder or manager responsible for the procurement is required to engage with the Procurement team to ensure:

- required timescales are achievable
- specifications are drafted which:
 - are fit for inclusion in competition documents;
 - are drafted in a manner encouraging innovation by the market;
 - are capable of being responded to and do not narrow competition;
 - deliver in line with legislative and policy frameworks.
 - include robust performance measures to effectively measure and manage supplier performance; and
 - consider the ability of the market to deliver.

11.12.2 Appropriate performance measures are included in agreements awarded, thus ensuring best value for money decisions taken that return maximum benefit for the organisation and ultimately the improvement of patient outcomes and wider health and social care communities. **‘Goods and Non-Health Services Only’**, under the 2023 Act there is a requirement to set and publish at least 3 Key Performance Indicators (KPI’s) for contracts above £5m, and to publish a notice on these at least annually during the term of the contract (note: this does not apply to ‘light touch regime’ contracts) and in circumstances where the LHB considers that the supplier’s performance under the contract could not appropriately be assessed by reference to key performance indicators (s.52(2) of the 2023 Act)).

11.12.3 **‘Goods and Non-Health Services Only’** Criteria for selecting suppliers and achieving an award recommendation must be evaluated on the basis of the “Most Advantageous Tender”, which provides contracting authorities with greater flexibility to take into account wider

social and environmental issues where that is decided to be relevant for the best solution. Such criteria must:

- be appropriately weighted;
- be transparent and proportionate;
- deliver value for money outcomes;
- fully explore complexity/risk; and
- consider whole life cost, including (where appropriate) the cost of change and/or end of life costs.

- 11.12.4 **‘In-Scope Health Services Only’** Criteria for selecting suppliers and achieving an award recommendation must follow (where applicable) the provisions in the PSR Wales Regulations, regarding:
- Key Criteria (regulation 6);
 - Basic Selection Criteria (regulation 22); and
 - Exclusions (regulations 25 and 26)

The LHB is required to ensure the appropriate criteria is set with regards to the selected procurement process, as set out under the PSR Wales Regulations and Health service procurement: statutory guidance

11.13 Single Quotation Application or Single Tender Application – ‘Goods and Non-Health Services Only’

- 11.13.1 In exceptional circumstances, there may be a need to secure goods/services/works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character. Such circumstances may include:

- follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- a technical compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;
- a need to retain a particular contractor for genuine business continuity issues (not just preferences); or
- when joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all-Wales competition/national strategy.

- 11.13.2 Procurement Services must be consulted prior to any such application being submitted for approval. The Director of Finance must approve such applications up to £25,000, the Chief Executive or designated deputy, and Director of Finance, are required to approve applications

exceeding £25,000. A register must be kept for monitoring purposes and all single tender actions must be reported to the Audit Committee.

11.13.3 In all applications, through Single Quotation Application or Single Tender Application (SQA or STA) forms, the applicant must demonstrate adequate consideration to the Chief Executive and Director of Finance, as advised by the Head of Procurement, that securing best value for money is a priority. The Head of Procurement will scrutinise and endorse each request to ensure:

- robust justification is provided;
- a value for money test has been undertaken;
- no bias towards a particular supplier;
- future competitive processes are not adversely affected;
- no distortion of the market is intended;
- an acceptable level of assurance is available before presentation for approval in line with the Health Board Scheme of Delegation; and
- an “or equivalent” test has been considered proving the request is justified.

11.13.4 Under no circumstances will Procurement Services endorse a retrospective SQA/STA, where the Health Board has already entered into an arrangement directly.

11.13.5 As SQA or STA are only used in exceptional circumstances the Health Board, through the Chief Executive, must report each, including the specifics of the exceptional circumstances and the total financial commitment, in sufficient detail to its Audit Committee. The report will include any corrective action/advice provided by the Chief Executive, Director of Finance or NWSSP Director of Procurement Services to prevent repeated inappropriate use of a SQA or a STA by the Health Board.

11.13.6 The Audit Committee may consider further steps to be appropriate, such as:

- instruct a representative of the Health Board to attend Audit Committee;
- escalate to the Board;
- request an internal Audit Review;
- request further training or
- take internal disciplinary action.

11.13.7 No SQA/STA is required where the seeking of competition is not possible, nor would the application of the SQA/STA procedure add

value to the process/aid the delivery of a value for money outcome. Procurement Manual details schedule of departures from SQA/STA where competition not possible.

- 11.13.8 For performance monitoring purposes, the NWSSP Procurement Service will retain a central register of all such activity including SQA/STA's not endorsed by Procurement or any exceptional matters.

11.14 Disposals – 'Goods and Non-Health Services Only'

- 11.14.1 Disposal of surplus, obsolete equipment/consumables is also subject to the competition rules.

- 11.14.2 Obsolete or condemned articles and stores, which may be disposed of in accordance with applicable regulations and law at the prevailing time (e.g. Waste Electrical and Electronic Equipment (WEEE)) and the procedures of the Health Board making use of any agreements covering the disposal of such items.

- 11.14.3 The Health Board must obtain the best possible market price.

Approval & Award

11.15 Evaluation, Approval and Award

- 11.15.1 The evaluation of procurement competitions must be undertaken by a minimum of 2 evaluators from within the operational service of the Health Board. Evaluation Teams for competitions of greater complexity and value must be multi-disciplinary and reach a consensus recommendation for internal approval.
- 11.15.2 The internal approval of any recommendation to award a competition must follow the Board's Scheme of Delegation.
- 11.15.3 The communication of the external notification to the market to award the contract must be managed by the Procurement Service.
- 11.15.4 Information throughout the process must be handled and retained as 'commercial in confidence' and not shared outside of staff directly involved in the competition process.
- 11.15.5 All associated communication throughout the competition process must also be managed by the Procurement Service.

Implementation & Contract Management

11.16 Contract Management

11.16.1 Contract Management is the process which ensures that both parties to a contract fully meet their respective obligations as effectively and efficiently as possible, in order to deliver the business and operational objectives required by the contract and in particular, to achieve value for money. The relevant budget holder shall oversee and manage each contract on behalf of the LHB so as to ensure that these implicit obligations are met. This contract management will include:

- retaining accurate records
- monitoring contract performance measures
- engaging suppliers to ensure performance delivery
- implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement Services; and
- permitting stage payments as part of a formally agreed implementation/delivery plan which must be supported by written evidence issued by the budget holder.

11.16.2 Contract management on All Wales contracts will be provided by NWSSP Procurement Services.

11.16.3 Advice on best practice on Contract Management is available from NWSSP Procurement Services.

11.17 Extending and Varying Contracts

11.17.1 'Goods and Non-Health Services Only'

11.17.1.1 Extending, modifying or varying the scope of an existing contract is possible, if the provision to do so was included as an option in the original awarded contract, e.g. scope of requirement, further expenditure due to unforeseen circumstances, change in regulatory requirements, etc.

11.17.1.2 If there is no such provision, the 2023 Act define such limitations. Further information on contract modifications can be found in sections 74-77 of the Act and in Guidance: Contract Modifications

11.17.2 'In Scope Health Services Only'

11.17.2.1 Modification of the scope of an existing contract is possible if:

11.17.2.1.1 the modification is clearly an unambiguously provided for in the original contract or framework agreement

documents, or

11.17.2.1.2 the original contract was awarded under Direct Award Process 1 and the modification does not render the contract 'materially different' in character.

11.17.2.2 If provisions set out in 11.17.2.1.1 are not met, the PSR Wales Regulations define limitations concerning modifications of contracts as being, the modification must be:

- solely a change in the identity of the provider however continues to meet the basic selection criteria, and there are no other considerable changes to the contract; or
- made in response to external factors beyond the control of the 'relevant authority' (as defined under section 10A of the National Health Service (Wales) 2006), and the provider, for example changes in patient or service user volume; changes in prices in accordance with a formula provided for in the contract documents and neither of these modifications render the contract or framework agreement materially different in character; or
- made at the discretion of the relevant authority and does not render the contract or framework agreement materially different in character and the cumulative change in the estimated lifetime value of the contract or framework agreement is under £500,000 or is under 25% of the estimated lifetime value.

11.17.3 Further approval is not required to extend an agreement beyond the original term/scope where prior approval was granted as part of the procurement process.

11.17.4 If there was no provision to extend, further approvals are required from the Health Board budget holder and the local Head of Procurement. Budget holders must also be mindful of the threshold under which the original contract was awarded. Any increase in the contract value may require a more senior level of approval in line with the Scheme of Delegation.

11.17.6 This ensures an appropriate identification and assessment of potential risks to the Health Board's compliance of approvals being granted within the Scheme of Delegation and assurance that value for money continues to be delivered from public funds.

11.17.7 The budget holder must seek advice from NWSSP Procurement Services in advance of committing further expenditure to ensure the contract is reflective of requirements. The budget holder must assess whether there is sufficient evidence to support the justification and whether the budget is available to support the additional

requirements.

Transactional Processes

11.18 Requisitioning

- 11.18.1 The budget manager in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the LHB. The budget holder will source those goods (**'Goods or Non-Health Services Only'**) or services from the approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as those managed by Welsh Government's Commercial Delivery team, NHS Supply Chain or Crown Commercial Services.
- 11.18.2 Where a required item is not on catalogue or on framework contract the budget manager shall request the NWSSP Procurement Services to undertake quotation / tendering exercises (**'Goods and Non-Health Services Only'**) on their behalf in line with SFI 11.11 thresholds. (**'Goods and Non-Health Services Only'**)
- 11.18.3 All orders for goods (**'Goods and Non-Health Services Only'**) and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order number.

11.19 No Purchase Order, No Pay

- 11.19.1 The LHB will ensure compliance with the 'No Purchase Order, No Pay' policy, the All-Wales policy which was introduced to ensure that Procure to Pay continues to provide world-class services on a 'Once for Wales' basis.
- 11.19.2 The policy ensures that a purchase order is raised at the beginning of a purchase in circumstances where a purchase order is required under the policy. This follows industry standard best practice as it provides a commitment as to what is likely to be spent. The supplier must obtain a purchase order number for their invoice in order for it to be processed for payment.

11.20 Official orders

- 11.20.1 Official Orders, issued following approved requisition and sourcing, must:
- a) Be consecutively numbered;

b) State the LHB's terms and conditions of trade.

11.20.2 Official Orders will be issued on behalf of the Health Board by NWSSP Procurement Services.

12. HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES

12.1 Health Care Agreements

12.1.1 The Health Board will commission healthcare services for its resident population both internally, from its own LHB provided services, and externally, from other LHBs, Trusts and other providers. The Chief Executive is responsible for ensuring the LHB enters into suitable Health Care Agreements (or Individual Patient Commissioning Agreements, where appropriate) for the provision of health care services from external providers.

12.1.2 All Health Care Agreements should aim to implement the agreed priorities contained within the Integrated Medium-Term Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- The standards of service quality expected;
- The relevant quality, governance and risk frameworks and plans;
- The relevant national service framework (if any);
- The provision of reliable information on quality, volume and cost of service; and
- That the agreements are based on integrated care pathways.

12.1.3 All agreements must be in accordance with the functions conferred on the LHB by the Welsh Ministers.

12.2 Statutory provisions

The National Health Service (Wales) Act 2006 (c. 42) enables Health Boards to commission certain healthcare services. The relevant sections under the Act are as follows:

- Section 7 sets out the definition of an NHS contract, being an arrangement under which one health service body arranges for the provision to it by another of goods or services which it reasonably requires for the purposes of its functions. It also provides a definition of a health service body;
- Section 9 sets out arrangements to be treated as NHS contracts for ophthalmic and pharmaceutical services;
- Section 32 makes provision in relation to services which can be provided to Health Boards by local authorities;
- Section 33 enables the Welsh Ministers to make provision which enables Health Boards and Local Authorities to enter into prescribed arrangements as to the provision of services which are

in connection with specified circumstances, if they are likely to lead to an improvement in the way in which each of their functions are exercised;

- Part 4 enables Health Boards to make arrangements for the provision of primary medical services;
- Part 5 enables Health Boards to make arrangements for the provision of primary dental services;
- Part 6 enables Health Boards to make arrangements for the provision of general ophthalmic services;
- Part 7 enables Health Boards to make arrangements for the provision of pharmaceutical services;
- Section 188 enables the Welsh Ministers to make provision which enables Health Boards and the prison service to enter into prescribed arrangements as to the provision of services which are in connection with specified circumstances, if they are likely to lead to an improvement in the way in which each of their functions are exercised;
- Section 194 sets out the Health Boards powers to make payments towards expenditure on community services; and
- Section 195 sets out the conditions for payment where expenditure proposed under section 194 is in connection with services to be provided by a voluntary organisation.

12.3 Reports to Board on Health Care Agreements (HCAs)

12.3.1 The Chief Executive will need to ensure that regular reports are provided to the Board detailing performance, quality and associated financial implications of all health care agreements with external providers. These reports will be linked to, and consistent with, other Board reports on commissioning and financial performance.

13 GRANT FUNDING

It is a matter for LHBs to determine whether individual activities should be procured, or be eligible to receive grant funding, seeking legal advice as necessary. (Grants are defined as all non-procured payments to external bodies or individuals for activities which are linked to delivering policy objectives and statutory obligations. Payments are made to fund or reimburse expenditure on agreed items or functions in accordance with legally binding conditions.)

13.1 Legal Advice

13.1.1 Before the award of funding is made, legal advice where necessary must be sought to ensure that:

- The award does not breach the LHBs functions or its regularity of expenditure duty (that is, the activities for which the grant is made are within the scope of activities that the LHB has a legal remit to undertake);
- The activities would not be deemed to be normally subject to procurement legislation and policy; and
- A legally binding agreement is made with all delivery organisations.

toolkit for grants v procurement

13.2 Policies and procedures

13.2.1 The LHB shall maintain detailed policies and procedures for all aspects of grant funding. The policies and procedures shall comply with these SFIs, and where appropriate the Welsh Government's Code of Practice to funding the third sector:

Final Third Sector Scheme and annexed Code of Practice

13.2.2 The Chief Executive is ultimately responsible for ensuring that the LHB's grant procedures:

- Are kept up to date;
- Conform to statutory requirements;
- Adhere to guidance issued by the Welsh Ministers;
- Are consistent with the principles of sustainable development; and
- Are strictly followed by all Executive Directors, Independent Members and staff within the organisation.

13.2.3 The award of grant funding must comply with the policy and principles set out in the Procurement section of these SFIs and ensure that the award meets the requirements of regularity, propriety and value for

money.

13.2.4 All grant guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

13.3 Corporate Principles underpinning Grants Management

13.3.1 While there is a need to make the financial arrangements for awarding funding as simple and streamlined as possible, LHBs should also ensure that taxpayers' money is spent appropriately and that it provides good value for money.

13.3.2 The overarching principles for managing public resources in Wales are set out in Managing Welsh Public Money. The document states that the award of funding should be made in accordance with the law and the requirements of propriety, regularity and value for money.

13.3.3 Regularity requires compliance with appropriate authorities, regulations and legislation. Propriety requires both public authorities and funded bodies to deliver appropriate standards of conduct, behaviour and corporate governance. In addition, the public expects official decisions to be made fairly and impartially with public money spent wisely and appropriately, delivering value for money and ensuring that best use is made of resources.

13.3.4 The **corporate principles** of grants management are:

- The development of grant management processes and procedures that are transparent, accountable, proportionate and consistent;
- The delivery of a high-quality regulatory framework that responds to demands but does not place unnecessary administrative burdens on LHBs or funded bodies;
- A regulatory framework that will take into consideration the need for proportionality, balancing the need for governance with the burden of administration, thus striking an appropriate balance between accountability and simplicity;
- An effective grant management process to ensure funded bodies spend the funding efficiently, transparently and for the purpose intended, with a view to maximising the impact and outcome from budgets;
- An appropriate evidence-based approach to underpin the design and development of all new funding programmes to ensure efficient and effective use of public funds, ensuring that the funding programme is the optimal solution and that funding is targeted where it is most needed and where it can have most impact;
- A consistent framework that will reinforce respect and effectiveness

- of the rules for both administrators and funded bodies; and
- Compliance of the grant funding with State aid requirements in accordance with the State aid rules.

13.4 Grant Procedures

- 13.4.1 It is vital that money is put to use in a way that delivers the maximum benefit to the people of Wales. Grants funding programmes need to be managed as efficiently and cost effectively as possible to make sure that every penny is spent appropriately and in an accountable manner. When establishing grant funding programmes, LHBs should ensure principles of good practice available from a number of external sources are considered and reflected in grant programmes.
- 13.4.2 Health Boards must agree a clear purpose for each grant and how it will measure the delivery organisation's success in delivering those purposes. It should also agree appropriate targets with the delivery organisation.
- 13.4.3 For grant programmes that span a number of financial years, the LHB is responsible for evaluating the programmes to ensure they are fit for purpose, achieving required outcomes and continue to provide value for money.
- 13.4.4 LHBs are responsible for ensuring that appropriate procedures exist in relation to all the grants and funding for which they are accountable. **They are also responsible for ensuring that any grant provided to an entity that engages in economic activity complies with the State aid rules.**
- 13.4.5 LHBs are required to undertake due diligence checks on all potential delivery organisations to determine the economic and financial viability of any organisation(s) to administer public funds, and the reliability of the organisation(s). These checks are important in order to identify any risks or issues that could expose the LHB to potential financial loss, fraud or reputational damage. A proportionate level of due diligence should be carried out, both prior to the award of any grant funding and throughout the life of the award.
- 13.4.6 The LHB must enter into legally binding funding agreements with all delivery organisations. When developing funding agreements, the LHB should ensure principles of good practice available from a number of external sources are considered and reflected.
- 13.4.7 The LHB is responsible for ensuring that all third-party delivery organisations comply with and adhere to the terms and conditions of

the Funding Agreement.

14. PAY EXPENDITURE

14.1 Remuneration and Terms of Service Committee

- 14.1.1 In accordance with SOs the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference and operating arrangements that specify which posts fall within its area of responsibility. This Standing Financial Instruction should be read in conjunction with Standing Order 3.4.
- 14.1.2 The Committee shall report in writing to the Board the basis for its decisions made under the delegated authority from the Board (as per schedule 1 in Standing Orders). The Board shall use the report as the basis for their decisions but remain accountable for taking decisions on the remuneration and terms of service of Directors and other senior employees, in accordance with the framework set by the Welsh Ministers. Minutes of the Board's meetings should record such decisions.
- 14.1.3 The Board will, after due consideration and amendment if appropriate approve proposals presented by the Chief Executive for the setting of remuneration and terms of service for those employees and officers not covered by the Committee.
- 14.1.4 The LHB will remunerate the Chair, Chief Executive, Executive Directors and Independent Members of the Board in accordance with instructions issued by the Welsh Ministers. Welsh Ministers approval will be required in the exceptional event that remuneration needs to be above the maximum of the salary band range, administratively this approval will be exercised by the Director General HSSG.
- 14.1.5 The Remuneration and Terms of Service Committee will consider cases of redundancy and Voluntary Early Release applications. The Remuneration and Terms of Service Committee will consider any novel employment and pay cases, such as compromise agreements and non-disclosure agreements, ensuring Welsh Government advice has been sought and considered.

14.2 Funded Establishment

- 14.2.1 The workforce plans incorporated within the approved Integrated Medium-Term Plan will form the funded establishment, i.e., the budget for all approved posts. (The financial budgets (£) and workforce establishment budgets (budgeted whole-time equivalents) as per SFI

5.1.1 g)

14.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or an officer with delegated authority.

14.3 Staff Appointments

14.3.1 Staff must only be engaged by authorised managers, in accordance with the Board's Scheme of Delegation. The engagement must be within the approved budget and funded establishment.

14.3.2 No Board member or LHB official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.

14.4 Pay Rates and Terms and Conditions

14.4.1 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees in accordance with pay, terms and conditions set out in Ministerial directions on Agenda for Change and Medical and Dental pay, and any staff with pre-existing terms and conditions of service, following a TUPE transfer into employment or ad hoc salaried staff.

14.4.2 The Remuneration Committee will determine pay rates and conditions of services for board members, and other senior employees, in accordance with ministerial instructions.

14.5 Payroll

14.5.1 The Director of Workforce and Organisational Development, has responsibility for securing an efficient, well-controlled payroll service from NHS Wales Shared Services Partnership that:

- pays the correct staff with the correct amount,
- all payments are supported by properly authorised documentation.

14.5.2 The Director of Workforce and Organisational Development is responsible for:

- a) The control framework and detailed procedures which are in place to:

- To ensure all payments comply with HMRC, Pensions Agency and other regulation in relation to the deduction and payment of tax, national insurance, pension or other payments,
 - reduce the risk of fraud and error within the payroll function.
- b) Specifying timetables for submission of properly authorised time records and other notifications;
 - c) The final determination of pay and allowances including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;
 - d) Agreeing the timing and method of payment with the payroll service;
 - e) Authorising the release of payroll data where in accordance with the provisions of the applicable Data Protection Legislation (the Data Protection Act 2018 and the UK General Data Protection Legislation);
 - f) Verification and documentation of data;
 - g) The timetable for receipt and preparation of payroll data and the payment of employees and allowances;
 - h) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
 - i) Security and confidentiality of payroll information;
 - j) Checks to be applied to completed payroll before and after payment; and
 - k) A system to ensure the recovery from those leaving the employment of the LHB of sums of money and property due by them to the LHB.

14.5.3 The Chief Executive is responsible for:

- a) Ensuring that arrangements for a payroll service from NHS Wales Shared Services Partnership (NWSSP) is supported by appropriate Service Level Agreements, terms and conditions, adequate internal controls and internal audit review procedures;
- b) Ensuring a sound system of internal control and audit review of any internally provided payroll service; and

- c) Maintenance and/or the authorisation of regular and independent reconciliation of pay control accounts.

14.5.4 Appropriately nominated managers have delegated responsibility for:

- a) Submitting time records, and other notifications in accordance with agreed timetables;
- b) Completing time records and other notifications in accordance with the Service Level Agreements; and
- c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Workforce and Organisational Development and/or Chief Executive must be informed immediately. In circumstances where fraud is suspected, this must be reported to the Director of Finance.

14.6 Contracts of Employment

14.6.1 The Director of Workforce and Organisational Development must:

- a) Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and
- b) Deal with variations to, or termination of, contracts of employment.

15. CAPITAL PLAN, CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

15.1 Capital Plan

15.1.1 Capital plans, and annual capital programmes, must be approved by the Board before the commencement of a financial year and should be in line with the objectives set out in the approved Integrated Medium-Term Plan (IMTP) for the organisation. The actual capital plan and programmes must be delivered within Welsh Government capital finance resource limits.

15.1.2 The Director of **Strategy and Planning** (or nominated responsible director) will develop a capital plan, and detailed capital programme, for the organisation that sets out a detailed capital investment plan to support the objectives set out in the IMTP. The capital programme must be affordable and within the capital allocations, as set out in the Welsh Government (WG) Capital Resource Limit for the year, and the LHB must not exceed the allocation resource limit. There must be an approved revenue funding plan in place to support any revenue costs associated with the capital plan. Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.1.3 The Board must approve a three-year Capital Plan, and an annual Capital Programme, as set out in the Integrated Medium-Term Plan and Budgetary Control chapters of these SFI.

15.2 Capital Investment Decisions

15.2.1 Robust business case and capital investment appraisal must be undertaken prior to formal submission to Welsh Government, the level of detail within the appraisal commensurate with the value and risk of the investment. Capital investment decisions should be undertaken in line with Welsh Government requirements and guidance for the development of business cases as set out in:

- NHS Wales Infrastructure Investment Guidance (Welsh Health Circular WHC (2018) 043)
<https://gov.wales/nhs-wales-infrastructure-investment-guidance>
- Better business cases: investment decision-making framework
<https://gov.wales/better-business-cases-investment-decision-making-framework>

15.2.2 The Director of Finance must provide a professional opinion on the financial elements of the business case. Capital investment decisions will be taken by the organisation in line with the financial thresholds specified by Welsh Government and in the Health Board's Scheme of

Delegation.

15.3 Capital Projects

15.3.1 The Chief Executive shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that formal confirmation of capital resources has been received.

15.3.2 When capital investment decisions are taken and a Capital Programme is approved the project cannot be initiated until the authority to commit expenditure is formally delegated to a manager, in line with the organisation's Scheme of Delegation. The capital project must then be procured in line with normal procurement procedures or the Designed for Life or other approved procurement framework and in line with Welsh Government requirements and guidance and the applicable procurement legislation. Management control and financial reporting systems must be established to ensure that the project is:

- delivered on time;
- on budget; and
- within contractual obligations.

15.3.3 Project management controls and financial reporting systems must be established to ensure these objectives are met. Reporting requirements to Welsh Government will be set out in the approval letter provided post Ministerial approval.

15.3.4 Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.4 Capital Procedures and Responsibilities

15.4.1 The Chief Executive:

- a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;
- b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;
- c) Shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received;

- d) Shall ensure that the three-year Capital Plan, and detailed annual Capital Programme, is approved by the Board, as part of the IMTP, prior to the commencement of the financial year;
- e) Shall ensure the availability of resources to finance all revenue consequences of the investment, including capital charges; and
- f) Shall ensure that any 3rd party use of NHS estate is properly controlled, reimbursed and reported. This will include ensuring that appropriate security, insurance and indemnity arrangements are in place and that there is a written agreement as to each party's responsibilities and liabilities.

15.4.2 For every capital expenditure proposal, the Chief Executive shall ensure:

- a) That a business case is produced in line with Welsh Ministers' guidance and where appropriate the 5-case Model;
- b) That the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate LHB personnel and external agencies in the process.

15.4.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management in accordance with the Welsh Ministers' guidance.

15.4.4 The approval of a capital programme by the Health Board shall not constitute approval for the initiation of expenditure on any scheme.

15.4.5 The Chief Executive shall issue to the manager responsible for any scheme:

- a) Specific authority to commit expenditure;
- b) Authority to proceed to tender; and
- c) Approval to accept a successful tender.

15.4.6 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Welsh Ministers' guidance and the LHB's SOs.

15.4.7 The Director of **Strategy and Planning** and Director of Finance shall issue detailed procedures governing the project, financial and contractual management, including variations to contract, of capital

investment projects and valuation for accounting purposes. These procedures shall fully take into account the requirements and delegated limits for capital schemes set out in Welsh Ministers' guidance and approval letters. The procedures will also cover post project benefits realisation to ensure benefits set out in the business case supporting the investment are delivered. The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

15.4.8 The Director of Finance shall ensure, for each capital project over £2m, that the Welsh Government Project Bank Accounts policy is applied unless there are compelling reasons not to do so. The Director of Finance should apply to Welsh Government officials for exemption from use of Project Bank Accounts, setting out the compelling reasons.

15.5 Capital Financing with the Private Sector

15.5.1 The LHB must not enter into any new capital financing arrangements with the private sector, including Private Financing Initiatives, Mutual Investment Model and 3rd Party Developments, without the consent of the Welsh Ministers.

15.6 Asset Registers

15.6.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Planning and Director of Finance, concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted periodically.

15.6.2 The LHB shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be in accordance with the Welsh Ministers' guidance and to satisfy the financial disclosure requirements for the Annual Accounts.

15.6.3 Additions to the fixed asset register must be clearly identified to the operational or departmental manager or delegated budget holder and be validated by reference to appropriate documentation to provide evidence of the financial value recorded, including:

- a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
- b) Stores, requisitions and wages records for own materials and labour including appropriate overheads; and

- c) Lease agreements in respect of assets held under a finance lease and included on the LHB's balance sheet.

15.6.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). Disposal receipts are to be treated in accordance with the Welsh Ministers' guidance and clearly set out in the over-arching business case.

15.6.5 The Director of Finance shall apply accounting policies for fixed assets in line with Welsh Government guidance and accounting standards and values recorded in the asset register, including depreciation and revaluations. The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in general ledgers against balances on fixed asset registers.

15.6.6 The value of each asset, and depreciation, shall be considered annually in accordance with valuation guidance and methods specified by the Welsh Ministers. Assets should be considered for early revaluation where there is the likelihood of impairment as a result in a change of valuation or asset life.

15.7 Security of Assets

15.7.1 The overall control of fixed assets is the responsibility of the Chief Executive.

15.7.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

- a) Recording managerial responsibility for each asset;
- b) Identification of additions and disposals;
- c) Identification of all repairs and maintenance expenses;
- d) Physical security of assets;
- e) Regular verification of the existence of, condition of, and title to, assets recorded;
- f) Identification and reporting of all costs associated with the retention of an asset; and

- g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

15.7.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of **Strategy and Planning** and Director of Finance.

15.7.4 Whilst individual officers have a responsibility for the security of property of the LHB, it is the responsibility of Board members and senior LHB officers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

15.7.5 Any damage to the LHB's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and LHB officers in accordance with the procedure for reporting losses.

15.7.6 Where practical, assets should be marked as LHB property.

16. STORES AND RECEIPT OF GOODS

16.1 General position

16.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

- a) Kept to a minimum;
- b) Subjected to annual stock take; and
- c) Valued at the lower of cost and net realisable value.

16.2 Control of Stores, Stocktaking, condemnations and disposal

16.2.1 Subject to the responsibility of the Director of Finance for the systems of financial control, overall responsibility for the control of stores shall be delegated to a senior officer by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental officers/managers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Manager; the control of any fuel oil and coal of a designated estates manager.

16.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Manager. Wherever practicable, stocks should be marked as health service property.

16.2.3 The Director of Finance is responsible for developing financial control systems and procedures for the regulation and operation of the stores, to include the accounting arrangements for receipt, issues, and returns of goods to stores, and losses.

16.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

16.2.5 Where a complete system of controlled stores is not justified, alternative stores arrangements shall require the approval of the Director of Finance.

16.2.6 The designated officer/manager shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer/manager shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI 17, Disposals

and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

16.3 Goods supplied by an NHS supplies agency

- 16.3.1 For goods supplied via NHS Wales Shared Services Partnership – Procurement Services (NWSSP-PS) or any other NHS purchasing and supplies agency central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance or authorised officer who shall satisfy himself that the goods have been received before accepting the recharge.

17. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

17.1 Disposals and Condemnations

17.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets and goods, including condemnations, and ensure that these are notified to managers.

17.1.2 When it is decided to dispose of a LHB asset and goods, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

17.1.3 All unserviceable assets and goods shall be:

- a) Condemned or otherwise disposed of by an officer, the Condemning Officer, authorised for that purpose by the Director of Finance;
- b) Recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the assets and goods are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second officer authorised for the purpose by the Director of Finance.

17.1.4 The Condemning Officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

17.2 Losses and Special Payments

17.2.1 Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for NHS Wales or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments, and special notation in the accounts to draw them to the attention of the Welsh Government.

17.2.2 The Director of Finance is responsible for ensuring procedural instructions on the recording of and accounting for losses and special payments are in place; and that all losses or special payments cases are properly managed in accordance with the guidance set out in the Welsh Government's Manual for Accounts.

- 17.2.3 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and/or the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or the Chief Executive.
- 17.2.4 Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the Local Counter Fraud Specialist (LCFS) and the CFS Wales Team in accordance with Directions issued by the Welsh Ministers on fraud and corruption.
- 17.2.5 The Director of Finance or the LCFS must notify the Audit Committee, the Auditor General's representative and the fraud liaison officer within the Welsh Government's Health and Social Services Group Finance Directorate of all frauds.
- 17.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must notify:
- a) The Audit Committee on behalf of the Board, and
 - b) An Auditor General's representative.
- 17.2.7 The Director of Finance shall be authorised to take any necessary steps to safeguard the LHB's interests in bankruptcies and company liquidations.
- 17.2.8 The Director of Finance shall ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write-off' action is recorded on the system (i.e. case closure date, case status, etc.).
- 17.2.9 The Audit Committee shall approve the writing-off of losses or the making of special payments within delegated limits determined by the Welsh Ministers and as set out by Welsh Government in its Losses and Special Payments guidance as detailed in Schedule 3 of the SOs.
- 17.2.10 For any loss or special payments, the Director of Finance should consider whether any insurance claim could be made from the Welsh Risk Pool or from other commercial insurance arrangements.
- 17.2.11 No losses or special payments exceeding delegated limits shall be authorised or made without the prior approval of the Health and Social

Services Group Director of Finance.

17.2.12 All novel, contentious and repercussive cases must be referred to the Welsh Government's Health and Social Services Group Finance Directorate, irrespective of the delegated limit.

17.2.13 The Director of Finance shall ensure all losses and special payments are reported to the Audit Committee at every meeting.

17.2.14 The LHB must obtain the Health and Social Services Group Director General's approval for special severance payments.

18. DIGITAL, DATA and TECHNOLOGY

18.1 Digital Data and Technology Strategy

18.1.1 The Board shall approve a Digital Data and Technology Strategy which sets out the development needs of the LHB for the medium term based on an appropriate assessment of risk. The Integrated Medium-Term Plan shall include costed implementation plans of the strategy. The Board shall also ensure that a Director has responsibility for Digital Data and Technology.

18.1.2 The LHB shall publish and maintain a Freedom of Information (FOI) Publication Scheme or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the LHB that are made publicly available.

18.2 Responsibilities and duties of the responsible Director

18.2.1 The responsible Director for Digital Data and Technology has responsibility for the accuracy, availability and security of the LHB digital systems and data and shall:

- a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection and availability of the LHB's digital systems and data, for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Network and Information Systems Regulations 2018, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018;
- b) Ensure that, following risk assessment of threats, adequate (reasonable) controls exist over access to systems, data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
- c) Ensure that an adequate management (audit) trail is maintained of access to digital systems and data and that such audit reviews as the Director may consider necessary to meet the organisational requirements under the Network and Information System Regulations 2018 are being carried out;

- d) Shall ensure that policies, procedures and training arrangements are in place to ensure compliance with information governance law and the Network and Information System Regulations 2018; and
- e) Shall ensure comprehensive incident reporting.

18.3 Responsibilities and duties of the Director of Finance

18.3.1 The Director of Finance shall need to ensure that new financial data and systems, and amendments to current financial data and systems, are developed in a controlled manner and thoroughly tested prior to implementation and business as usual phases. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation and business as usual phases.

18.4 Contracts for data and digital services with other health bodies or outside agencies

18.4.1 The responsible Director for Digital Data and Technology shall ensure that contracts for data and digital services for clinical, management and financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for

- the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage, and
- the availability of the service including the resilience required to maintain continuity of the service.

The contract should also ensure rights of access for audit purposes.

18.4.2 Where another health organisation or any other agency provides a data or digital service for clinical, management and financial applications, the responsible Director for Digital Data and Technology shall, to maintain the confidentiality, integrity and availability of the service provided, periodically seek assurances that adequate controls, based on risk assessment, are in operation.

18.5 Risk assurance

18.5.1 The responsible Director for Digital Data and Technology shall ensure that the risks to the LHB arising from the use of data, information and digital are effectively identified and considered and that appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate resilience plans, including both a business continuity and disaster recovery plan.

19. PATIENTS' PROPERTY

19.1 LHB Responsibility

- 19.1.1 The LHB has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of patients that lack capacity, or found in the possession of patients dead on arrival.
- 19.1.2 Where the Welsh Ministers' instructions require the opening of separate accounts for patient monies, these shall be opened and operated under arrangements agreed by the Director of Finance.
- 19.1.3 In all cases where property, including cash and valuables, of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965 (c. 32)), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.
- 19.1.4 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.
- 19.1.5 Where patient property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

19.2 Responsibilities of the Chief Executive

- 19.2.1 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, that the Health Board will not accept responsibility or liability for patient property brought onto health service premises, unless it is handed in for safe custody and a copy of an official patient property record is retained as a receipt, by:
- a) Notices and information booklets;
 - b) Hospital admission documentation and property records; and
 - c) The oral advice of administrative and nursing staff responsible for admissions.

19.3 Responsibilities of the Director of Finance

19.3.1 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patient property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

20. FUNDS HELD ON TRUST (CHARITABLE FUNDS)

20.1 Corporate Trustee

20.1.1 Paragraph (x) of Section A to the SOs refers to the LHB having specified powers to act as corporate trustee for the management of funds it holds on trust (charitable funds). SFI 20.2 defines the need for compliance with Charities Commission latest guidance and best practice.

20.1.2 The discharge of the LHB's corporate trustee responsibilities for funds held on trust are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

20.1.3 The LHB shall establish a Charitable Funds Committee as set out in Standing Order 3.4 to ensure that each fund held on trust which the LHB is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

20.2 Accountability to Charity Commission and the Welsh Ministers

20.2.1 The trustee responsibilities must be discharged separately and full recognition given to the LHB's dual accountabilities to the Charity Commission for charitable funds and to the Welsh Ministers for exchequer funds.

20.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Board members and LHB officers must take account of that guidance before taking action.

20.2.3 The LHB shall make appropriate arrangements for the Annual Accounts and audit of Funds held on Trust in accordance with Charity Commission requirements.

20.3 Applicability of Standing Financial Instructions to funds held on Trust

20.3.1 In so far as it is possible to do so, most of the sections of these SFIs will apply to the management of funds held on trust.

20.3.2 The over-riding principle is that the integrity of each Trust must be maintained, and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

21. RETENTION OF RECORDS

21.1 Responsibilities of the Chief Executive

21.1.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with the Welsh Ministers' guidance, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018, and the Freedom of Information Act 2000 (c. 36).

21.1.2 The records held in archives shall be capable of retrieval by authorised persons.

21.1.3 Records held shall only be destroyed in accordance with the applicable data protection laws and at the express instigation of the Chief Executive. Details shall be maintained of records so destroyed.

Schedule 1

GENERAL CONSENT TO ENTER INDIVIDUAL CONTRACTS

This schedule included as “General Consent to enter individual contracts” replaces all previous versions of Schedule 1 and should be read in conjunction with the revised Model Standing Financial Instructions (SFI’s) issued in relation to Chapter 11 for Local Health Boards and NHS Trusts and Chapter 12 for Health Education and Improvement Wales (HEIW) and Digital Health and Care Wales (DHCW).

PROCESSES FOR NHS WALES CONTRACTS, AND INTERESTS IN PROPERTY

Paragraph 13 of Schedule 2 to the National Health Service (Wales) Act 2006 states as follows:

“(1) Subject to sub-paragraph (3), a Local Health Board may do anything which appears to it to be necessary or expedient for the purposes of or in connection with its functions.

(2) In particular it may—

- (a) acquire and dispose of property,*
- (b) enter into contracts,*
- (c) accept gifts of property (including property to be held on trust, either for the general or any specific purposes of the Local Health Board or for any purposes relating to the health service).*

(3) A Local Health Board may not do anything mentioned in sub-paragraph (2) without the consent of the Welsh Ministers (which may be given in general terms covering one or more descriptions of case).”

Section 10.1 of the NHS Wales Infrastructure Investment Guidance issued on 22 October 2018 (“the Investment Guidance”) includes the following in relation to Local Health Boards:

“Contract approvals over £1m for individual schemes will be sought as part of the normal business case submission process where funding from the NHS Capital Programme is required. For schemes funded via discretionary allocations, a request for approval will need to be submitted to Chief Executive NHS Wales, copying in the Deputy Director of Capital, Estates & Facilities Division.

Detailed arrangements in respect of approval process linked to the acquisition and disposal of leases, where consent does not form part of the business case process are included in Welsh Health Circular WHC(2015)031.

Organisations should ensure that the monitoring arrangements and the requisite forms and returns are included as part of their own assurance arrangements.”

This is also to be regarded as being applicable to HEIW and DHCW, which were both established after the two WHC’s mentioned above were issued.

Section 10.2 of the Investment Guidance includes the following in relation to Trusts:

“Whilst formal Cabinet Secretary consent is not required for Trusts as detailed above, general consent arrangements are still applicable in terms of relevant transactions. Detailed requirements in terms of appropriate notifications were sent in the Welsh Health Circular referenced above.”

Section 11 of the Investment Guidance also includes provision as to disposals and property protocols.

Welsh Health Circular WHC (2015) 031 issued 22 June 2015 includes arrangements for consent to acquire or dispose of a lease in property (where not covered by any business case approval process.

That WHC is also to be regarded as being applicable to HEIW and DHCW in the same way as it applies to LHBs.

Entering into contracts

This schedule confirms to all NHS Wales bodies that the authorisation and consideration of notified contracts and applications for the acquisition or disposal of a lease or any interest in property are delegated to the Director General, Health Social Care and Early Years.

The Director General may, as with any other matter relating to the operation of the NHS in Wales, brief the Cabinet Secretary for Health and Social Care on any arrangement of particular policy note, or with a novel, contentious or innovative nature.

Accordingly, any issues relevant to the exercise of the Cabinet Secretary for Health, and Social Care’s consent will, as a matter of course, be drawn to his attention.

The process which NHS Wales bodies entering into contracts must follow is:

- All NHS contracts (unless exempt) >£1m in total to be notified to the Director General HSCEY prior to tendering for the contract;

- All eligible LHB and HEIW and DHCW contracts >£1m in total to be submitted to the Director General HSCEY for consent prior to award;
- All eligible NHS Trust contracts >£1m in total to be submitted to the Director General HSCEY for notification prior to award; and
- All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSCEY for notification prior to award.

The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

- (i) Contracts of employment between LHBs, HEIW, or DHCW and their staff;
- (ii) Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs, HEIW, or DHCW;
- (iii) Out of Hours contracts;
- (iv) All NHS contracts; that is where one health services body contracts with another health service body;
- (v) Contracts entered into by HEIW for services which are the consequences of annual commissioning approved by the Cabinet Secretary e.g. annual education and training commissioning also do not require further Ministerial notification or consent; and
- (vi) Contracts between £500k - £1 million (for noting) and £1 million + (for approval).
 - a. Wales Public Sector Framework Agreements e.g., Frameworks established by the Welsh Government's Commercial Delivery team or NWSSP (not exhaustive) – no written approval required to award contracts under these Frameworks through a direct award or mini competition.
 - b. Third-Party Public-Sector Framework Agreements e.g., Frameworks established by Crown Commercial Services, NHS Supply Chain (not exhaustive) – no further approval required to award contracts under these Frameworks through a direct award. Approval will however be required for award of contracts under these Framework Agreements through mini competition or where the specification of the product/service required is modified from that stated within the Framework Agreement.

For non-capital contracts requiring DG approval, the request for approval or notification should be sent to Rob Eveleigh in the Financial Control and Governance team: Robert.Eveleigh@gov.wales.

3 - Audit Wales

3.1

09:55, 5 Mins

3.1 - Audit Wales Update Report

*Anne Beegan,
Urvisha Perez, David
Williams*

| For assurance

Attachments

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

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

Date issued: March 2026



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

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

Introduction

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

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

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 the management of outpatients

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

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

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

Review of radiology services

- **Executive Lead:** Director of Operations
- **Focus of the work:** This work has examined the effectiveness of arrangements to manage current and future demand for the Health Board's radiology services and will assess the extent of progress made in implementing the recommendations from our 2017 radiology service review.
- **Status:** Report drafting
- **Expected committee date:** June 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 will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.
- **Status:** Fieldwork underway
- **Expected committee date:** August 2026

Review of cancer services

- **Executive Lead:** Director of Operations
- **Focus of the work:** This work follows on from the review of national leadership arrangements for cancer services. The work will focus on whether the Health Board is taking the necessary action to provide timely and equitable access to cancer diagnosis and treatment, in line with national targets, standards and plans.
- **Status:** Project set-up
- **Expected committee date:** August 2026

Other relevant publications

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

<u>Managing the Regional Integration Fund Report / Article</u>	March 2026
<u>Auditor General's letter to Senedd committees</u>	March 2026
<u>Senedd nominates Catherine Mealing Jones for appointment as next Auditor General for Wales</u>	March 2026
<u>Private Finance – Public Impact (Examining decision-making for the new Velindre Cancer Centre</u>	February 2026

Audit Wales has not published any corporate documents since the last committee update.

There are no relevant Audit Wales consultations currently underway.

Further information

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

Visit our [website](#) to find:



Our [publications](#) which cover our audit work at public bodies.



Information on our upcoming work and forward work programme for [performance audit](#).



[Data tools](#) to help you better understand public spending trends.



Details of our [Good Practice](#) work and events including the sharing of emerging practice and insights from our audit work.



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



Audit Wales

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Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

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



3.2

10:00, 5 Mins

3.2 - Audit Wales Audit Plan 2026/27

*Anne Beegan,
Urvisha Perez, David
Williams*

| For approval

Attachments

[3.2 HDUHB Audit Plan 2026 \(Final\).pdf](#)

Hywel Dda University Health Board – Audit Plan 2026

Date issued: March 2026



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Introduction



Adrian Crompton

Auditor General for
Wales

I am pleased to share my 2026 Audit Plan. The Plan sets out how I will undertake your audit.

My audit team has developed the Plan following a structured and risk-based planning process, which will remain ongoing throughout the audit. My Code of Audit Practice provides further detail on how my audit and certain other functions are to be carried out by my auditors.

At the core of all our work is our commitment to maintaining the highest standards of professional integrity, objectivity, independence and audit quality. Our three

lines of assurance model (page 20) sets out how we will ensure those standards of quality are met. Our latest annual Audit Quality Report provides more information about our audit quality arrangements.

My audit team will work constructively with your staff to understand the issues you are facing, ensure the audit process operates as smoothly as possible, and provide valuable insights about any areas for improvement.

My local performance audit work programme, as outlined in this Plan, sits alongside other national audit work that may include coverage of your organisation. Local performance audit work may also inform wider national reporting.

Should you have any questions about your audit my audit team will be happy to discuss them with you. They will also keep you regularly updated as work progresses.

Our aims and ambitions

Our purpose



Assure people that public money is being managed well



Explain how that money is being spent



Inspire the public sector to improve

Our vision



Fully exploiting our unique perspective, expertise and depth of insight



Strengthening our position as an authoritative, trusted and independent voice



Increasing our visibility, influence, and relevance



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

Our areas of focus



A strategic, dynamic, and high-quality audit programme



A targeted and impactful approach to communications and influencing



A culture and operating model that enables us to thrive

You can find out more about Audit Wales in our [Annual Plan 2025-26](#) and Our [Strategy 2022-27](#).

Financial audit work

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness', their proper preparation in accordance with accounting standards and legal requirements, and the regularity of income and expenditure and the proper preparation of key elements of your Accountability and Performance Report. I lay them before the Senedd together with any report that I make on them.

I will also report by exception on a number of matters which are set out in more detail in our [Statement of Responsibilities](#).

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

There have been no limitations imposed on me in planning the scope of this audit.

Financial statements materiality

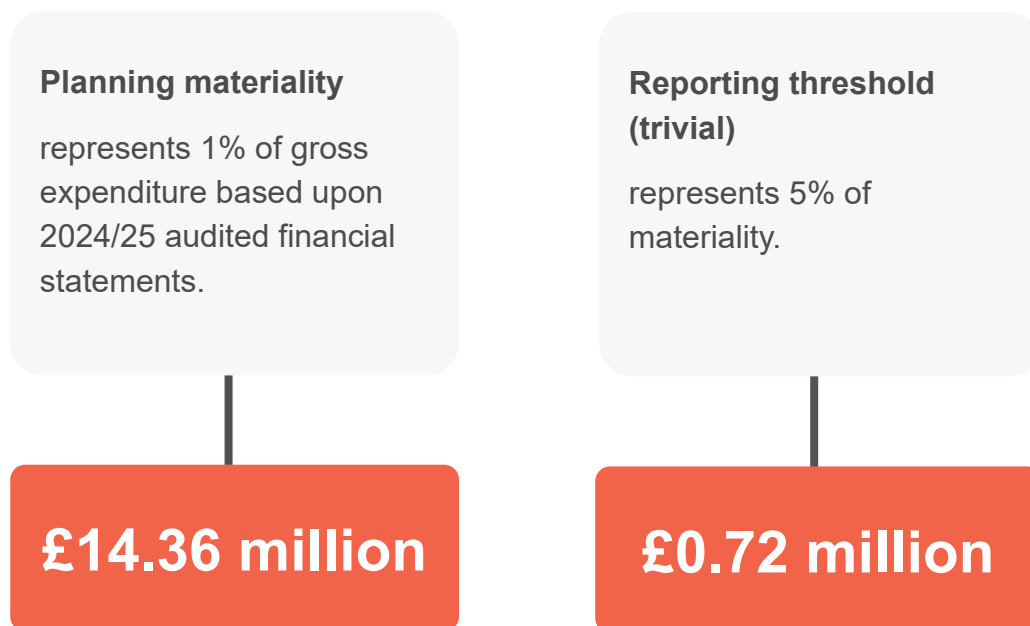
I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material and correct misstatements, that is, those that might result in a reader of the accounts being misled. Materiality applies not only to financial misstatements, but also to disclosure requirements and adherence to the applicable accounting framework and law.

I set planning and performance materiality to:

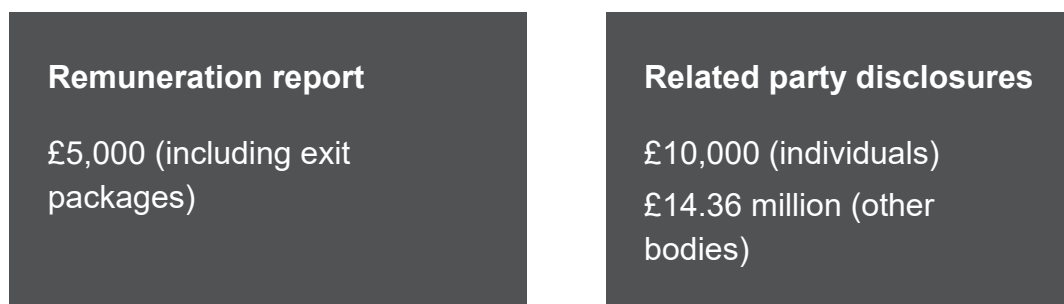
- determine the level of misstatement that could cause the user of the accounts to be misled;
- assist in the scoping of our audit approach and resultant audit tests;
- determine sample sizes;
- assess the effect of known and likely misstatements in the financial statements; and

- report to those charged with governance any unadjusted misstatements above a trivial level, our reporting threshold.

The levels at which I judge such misstatements to be material is set out below.



There are some areas of the accounts that may be of more importance to the user of the accounts, and we have set a lower materiality level for these:



My audit team will assess materiality levels throughout the audit.

Significant financial statements risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other International Standard on Auditing (ISAs). The ISAs require us to focus more attention on these significant risks.

Risk of management override

The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].

Our planned response

My audit team will:

- test the appropriateness of journal entries and other adjustments made in preparing the financial statements;
- review accounting estimates for bias; and
- evaluate the rationale for any significant transactions outside the normal course of business.

Other areas of focus

I set out below other identified risks of material misstatement which, although not determined to be significant risks as above, I would like to bring to your attention.

Failure of financial duties

Health Boards are required to meet two statutory duties – known as the first and second financial duties.

The Health Board will fail to meet your first financial duty to break even over a three-year period. The position at month 10 shows a year-to-date deficit of £16.112 million and a forecast year-end deficit of £22.100 million. This combined with the outturns for 2023-24 and 2024-25, predicts a three-year deficit of £112.052 million.

Where you fail this financial duty, we will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion.

Whilst there is virtually no risk of management judgements and estimates being biased to enable the Health Board to achieve the financial duty to break even over three years, there is however an expectation that the Health Board will meet its in-year control total set by Welsh Government of £22.100 million (deficit).

The second financial duty requires Health Boards to prepare and have approved by Welsh Ministers a rolling three year integrated medium-term plan. Should you fail this financial duty, we will place a substantive report on the financial statements highlighting this fact.

Our planned response

My audit team will:

- continue to monitor the Health Board's financial position for 2025-26 and the cumulative three-year position to 31 March 2026; and
- undertake testing on areas of the financial statements which contain judgements such as year-end accruals, to ensure that transactions have been reported in the correct accounting period.

Remuneration report disclosures

There have been some new permanent and interim appointments to senior officer and board member posts during 2025-26 which need to be captured in the remuneration report.

There is a risk that these are not appropriately disclosed in the remuneration report as remuneration paid to senior officers and board members continues to be of high interest and is material by nature.

Therefore, there is a risk that even low value errors in the disclosure could result a material misstatement.

Our planned response

My audit team will:

- understand the movements in the senior management team during 2025-26;
- ensure that remuneration disclosed is consistent with supporting evidence;
- ensure that amounts paid are consistent with those approved by the Board and are in accordance with Welsh Government pay rates; and
- ensure that disclosures are complete based on the team's knowledge and are prepared in accordance with requirements.

Valuation of property assets

The value of property assets reflected in the balance sheet and notes to the accounts are material estimates.

Property assets are required to be held on a valuation basis which is dependent on the nature and use of the assets. This estimate is subject to a high degree of subjectivity, depending on the specialist and management assumptions, and changes in these can result in material changes to valuations.

Assets are required to be formally revalued every five years as a minimum, with indexation applied in interim years, but values may also change year on year, particularly where there are ongoing refurbishment projects resulting in subsequent expenditure being capitalised.

There is a risk that the carrying value of assets recognised in the accounts could be materially different to the current value of assets as at 31 March 2026.

Our planned response

My audit team will:

- review the indices used by management for reasonableness;
- evaluate the competence, capabilities and objectivity of the professional valuer who provide indices to management and undertake valuations as necessary;

- test a sample of assets revalued in the year to ensure the valuation basis, key data and assumptions used in the valuation process are reasonable, and the revaluations have been correctly reflected in the financial statements;
- confirm that indexation has been appropriately applied and has been correctly reflected in the financial statements; and
- test the reconciliation between the financial ledger and the asset register.

Related party disclosures

The financial statements must disclose any related party relationships along with the transactions and balances between the Health Board and the other body/party.

The Health Board has many relationships that could be considered a related party. Many are well known for example, Welsh Government as funder.

However, where related party relationships arise via individual officer or member relationships, there is likely to be less transparency regarding these relationships. These transactions are of high interest and are considered to be material by their nature.

There is a risk of material misstatement due to incomplete or inaccurate disclosures, even where these are of relatively low value.

Our planned response

My audit team will:

- review management's process for identifying related party relationships and associated transactions and balances;
- undertake procedures to confirm the completeness of related party relationships; and
- ensure disclosures are complete, accurate, consistent with evidence and are in accordance with requirements.

Financial statements audit timetable

Below is a timetable showing the key stages of the audit and our key audit deliverables that we will provide to you.

Exhibit 1: Financial statements audit timetable

Planning January to March 2026	Planning meeting High level risk assessment procedures Fraud risk assessment Accounting estimates planning IT environment risk assessment Indicative audit fee Draft Audit Plan
Interim January to March 2026	Information flows Detailed risk assessment procedures IT controls review Develop testing strategy Early sample testing
Fieldwork May to June 2026	Update risk assessment Audit of financial statements to include narrative report and annual governance statement Complete audit testing Evaluate audit findings Audit closure meeting
Reporting June to July 2026	Audit of Accounts Report Recommendations for improvement Present findings to those charged with governance Auditor General certification Submission of accounts to Welsh Government Laying of accounts with Senedd Cymru Post project learning

Performance audit work

Proper arrangements

As set out in the Code of Audit Practice, I must satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources ('value for money'), and conclude accordingly.

I do this by undertaking an appropriate programme of performance audit work each year. I base my work programme on an assessment of risks of the Health Board and the wider NHS in Wales not having the proper arrangements in place, with the work typically focusing on the areas of greatest risk.

In designing the programme, my auditors must have considered corporate and service level arrangements, including:

 Strategic planning	 Asset management
 Financial planning	 Collaborative working
 Performance and risk management	 Overall governance.
 Workforce planning	

My auditors will also have taken account of relevant work that is being undertaken or planned by other audit, regulatory and inspection bodies at the Health Board.

I conduct my performance audit work using the ISSAI 3000 standard developed by the International Organisation of Supreme Audit Institutions (INTOSAI). INTOSAI is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special

consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

Well-being of future generations

Section 15 of the Well-being of Future Generations (Wales) Act 2015 (the Act) requires me to carry out examinations of public bodies for the purposes of assessing the extent to which a body has acted in accordance with the sustainable development principle when setting well-being objectives and taking steps to meet those objectives.

The **Sustainable development principle** is defined as acting in a manner...

...which seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs.'

To do this, they must take account of the '**five ways of working**'.



Long-term



Prevention



Integration



Collaboration



Involvement

I must carry out these examinations at each public body covered by the Act at least once during a specified period.

These could be stand-alone examinations as part of my performance audit programme. However, where relevant and appropriate to do so, my auditors will integrate the work required into other planned performance audit work for the [Health Board/Trust/SHA]. My auditors will continue to engage closely with the Office of the Future Generations Commissioner for Wales to help coordinate our respective activities.

Planned performance audit work

I set out below details of my planned performance audit work.

Structured Assessment

Scope of the work

Structured assessment will continue to form a key part of the work my audit teams do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources.

My 2026 structured assessment work will review the following areas:

- Board and committee cohesion and effectiveness.
- Corporate systems of assurance.
- Corporate planning arrangements; and
- Corporate financial planning and management arrangements.

My structured assessment work will also include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.

As part of the planning for my 2026 Structured Assessment work, I will be considering how that work may be extended to form a view on the governance arrangements of hosted bodies, particularly the Joint Commissioning Committee (JCC) and the NHS Wales Shared Services Partnership (NWSSP).

Indicative timescales

Fieldwork to commence between June and August 2026 and reporting by the end of December 2026.

All-Wales thematic review of the management and prevention of diabetes

Scope of the work

I plan to undertake work to examine the extent to which NHS bodies are improving the management and prevention of diabetes across Wales. Whilst the exact focus of this work is still to be determined, 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.

Indicative timescales

Fieldwork to commence between September and October 2026 and reporting by the end of March 2027.

Local project work – Review of eye care services

Scope of the work

The local performance audit 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.

Indicative timescales

We will discuss the delivery timescales with senior management early in the 2026-27 financial year.

Timing of Performance Audit Work

My team will work with officers in the Health Board to arrange exact timescales for the individual projects and progress will be communicated regularly through our Audit Committee update. My auditors aim to substantially complete the performance audit work set out in this plan by the end of March 2027.

Audit fee

In January 2026 we published our 2026-27 Fee Scheme following approval by the Senedd Finance Committee which details the average increase to fee rates of 5.3%.

The actual fee that any individual audited body will pay depends not just on our fee rates but on the quantum of work and the skill mix required.

Based on those requirements, my estimated audit fee for 2026 will be £436,451, an increase of 5.3% on my estimated 2025 fee.

Your estimated total audit fee: £436,451

Planning will be ongoing, and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge. I shall make no changes without my auditors first discussing them with the Director of Finance. **Exhibit 2** sets out a further breakdown of your estimated audit fee.

I base my audit fee on the following assumptions:

- The agreed audit deliverables set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.
- The audit requirements of my individual performance audit projects are met by the audited body, or suitable alternative arrangements are put in place that satisfy the needs of my audit team.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

Exhibit 2: Breakdown of my estimated audit fee for 2026 (and 2025 for comparison)

Estimated fee for 2026 (£) ¹		Estimated fee for 2025 (£)	
Audit of financial statements ²	Performance audit work ²	Audit of financial statements	Performance audit work
£238,512	£197,939	£226,598	£188,027
Total fee: £436,451		Total fee: £414,625	

¹ The fees shown in this document are exclusive of VAT.

² Payable November 2025 to October 2026

Audit team

My audit team will continue to work and engage remotely using technology, but some on-site audit work will continue where it is appropriate to do so.

Audited bodies have a responsibility to ensure the safety and wellbeing of Audit Wales staff when they are on your premises.

The main members of my team, together with their contact details, are summarised in **Exhibit 3**.

Exhibit 3: My local audit team

Engagement Director	Anthony Veale anthony.veale@audit.wales	
	Financial Audit	Performance Audit
Engagement Lead	Anthony Veale anthony.veale@audit.wales	Tom Haslam tom.haslam@audit.wales
Audit Manager	David Williams david.williams@audit.wales	Anne Beegan anne.beegan@audit.wales
Audit lead	Eleanor Ansell eleanor.ansell@audit.wales	Urvisha Perez urvisha.perez@audit.wales

I can confirm that my team members are all independent of the Health Board and your officers.

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by the Institute of Chartered Accountants in England and Wales and our Chair of the Board, acts as a link to our Board on audit quality. For more information see our [Audit Quality Annual Report](#).



Our People

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



Arrangements for achieving audit quality

Selection of right team

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



Independent assurance

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

Further Information

Audit Wales has a range of resources to support the scrutiny of Welsh public bodies, and to support them in continuing to improve the services they provide to the people of Wales.

Visit our [website](#) to find:



Our [publications](#) which cover our audit work at public bodies.



Information on our upcoming work and forward work programme for [performance audit](#).



[Data tools](#) to help you better understand public spending trends



Details of our [Good Practice](#) work and events including the sharing of emerging practice and insights from our audit work.



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



Audit Wales

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Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

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



3.3

10:05, 10 Mins

3.3 - Structured Assessment - Progress Update on Recommendations

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

| For assurance

Attachments

[3.3 Structured Assessment 2024 and 2025 Progress Update ARAC April 2026.pdf](#)

[3.3 Appendix 1 - Structured Assessment Reports and Recommendations April 2026.pdf](#)



PWYLLGOR ARCHWILIO A SICRWYDD RISG AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	14 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Structured Assessment 2024 and 2025 – Management Response Updates
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Professor Phil Kloer, Chief Executive Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Wilson, Director of Corporate Governance/Board Secretary

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

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

- Structured Assessment 2024
- Structured Assessment 2025

Cefndir / Background

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

Asesiad / Assessment

As part of the Structured Assessment process in 2025, Audit Wales made two new recommendations and assessed the Health Board's response to the recommendations made in previous reports. One recommendation from the Structured Assessment 2024 was assessed as in progress following AW review which reported to the Board in January 2026.

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

Structured Assessment 2024

Recommendation	Executive Lead	Date for implementation	RAG status as at 31/03/2026
R1 (Improving Together Framework)	Executive Director of Finance	31/03/2025	AW

R2 (Quality Improvement Strategic Framework)	Executive Director of Nursing, Quality and Patient Experience	30/04/2025	
R3 (Well-being objectives and strategy refresh)	Executive Director of Public Health	31/03/2026	The revised Well-Being objectives were presented to the Board in March 2026

Structured Assessment 2025

Recommendation	Executive Lead	Date for implementation	RAG status as at 31/03/2026
R1 Clarifying the use of the Triple A (Alert, Advise, Assure) process	Director of Corporate Governance/Board Secretary	31/01/2026	Complete
R2 Updating the Board Assurance Framework Dashboard to include committee oversight arrangements	Director of Corporate Governance/Board Secretary	30/11/2025	Complete

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to receive assurance on the progress made in respect of the recommendations from the Structured Assessments 2024 and 2025.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.3 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, Clinical Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable

Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Structured Assessment 2025 report
Rhestr Termiau: Glossary of Terms:	Included in report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	All relevant Executive Directors have been asked to provide progress updates to the management response.

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

Audits and Inspection Reports

Audit Wales: Structured Assessment Reports - Update

Report issued by	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Total number of recs	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Unable to Complete	Any Barriers to Completion Noted?
Audit Wales	Structured Assessment 2024 (issued Nov 24)	Corporate Services	Director of Corporate Governance	Mar-26	Mar-26	3	0	0	3	0	0	0	None noted.
Audit Wales	Structured Assessment 2025 (issued Oct 25)	Corporate Services	Director of Corporate Governance	Jan-26	Jan-26	2	0	0	2	0	0	0	None noted.

Audits and Inspection Reports

Audit Wales: Structured Assessment Recommendations - Update



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Report Issued By	Report Title	Status of report	Recommendation Reference	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Audit Wales	Structured Assessment 2024 (issued Nov 24)	Closed	AW_SA2024_HDU HB_001	R1. The Health Board should update its Improving Together Framework documentation, ensuring it adequately reflects current performance management and internal escalation arrangements. In updating the framework, the Health Board should also ensure documentation includes arrangements: • Escalating and supporting directorates at the highest level of escalation for extended periods; and • Coordinating support for directorates escalated over several domains (see paragraph 53).	The Improving Together Framework will be updated to address the points raised in this recommendation. Timeline for completion: • February 2025 - full draft submitted to Strategic Development and Operational Delivery Committee for consideration • March 2025 – final draft submitted to Board for approval	Executive Director of Finance	Mar-25	N/A	Complete
Audit Wales	Structured Assessment 2024 (issued Nov 24)	Closed	AW_SA2024_HDU HB_002	R2. The Quality, Safety and Experience Committee should receive, at least annual, a standalone update on Quality Improvement activities, including the Health Board's progress in implementing the Quality Improvement Strategic Framework (2023-2026), a roundup of improvement initiatives and the impact they are having to date (see paragraph 60).	A standalone annual report on Quality Improvement Activities will be added to the work plan for the Quality Safety and Experience Committee for 2025/26	Executive Director of Nursing, Quality and Patient Experience	Apr-25	Apr-25 N/A	Complete
Audit Wales	Structured Assessment 2024 (issued Nov 24)	Closed	AW_SA2024_HDU HB_003	R3. To ensure the sustainable development principle is central to its long-term vision, the Health Board should review its well-being objectives as part of its planned long-term strategy refresh (see paragraph 69).	The well-being objectives will be reviewed as part of the long-term strategy refresh	Executive Director of Public Health	Mar-26	Mar-26	Complete
Audit Wales	Structured Assessment 2025 (issued October 2025)	Closed	AW_SA2025_HDU HB_001	R1. The Health Board should hold a briefing session with Independent Members to clarify the 'Triple A' (Alert, Advise, Assure) process	To hold a session at an Independent Member Development Session on the correct and consistent use of the 'Triple A' assessments at meetings. To include the 'Triple A' criteria on Chair's Briefs as a prompt for Chairs to make an assessment at the end of each agenda item.	Director of Corporate Governance	Jan-26	Jan-26 N/A	Complete
Audit Wales	Structured Assessment 2025 (issued October 2025)	Closed	AW_SA2025_HDU HB_002	R2. The Health Board should update the Board Assurance Framework Dashboard to include committee oversight arrangements	Committee oversight arrangements of the BAF have been included in the supporting information on the BAF Dashboard to the Board in November.	Director of Corporate Governance	Nov-25	Nov-25 N/A	Complete

3.4

10:15, 15 Mins

3.4 - Review of the Management of Outpatients

*Anne Beegan,
Urvisha Perez,
Andrew Carruthers
(Hywel Dda UHB -
Chief Operating
Officer), Paula Goode
(Hywel Dda UHB -
Service Director for
Planned and
Specialist Care), Lisa
Humphrey (Hywel
Dda UHB - General
Manager)*

| For assurance

Attachments

[3.4 HDUHB Review of the management of outpatient appointments FINAL.pdf](#)

[3.4 HDUHB Outpatients Management Response Form \(Final\).pdf](#)

Managing outpatients

Hywel Dda University Health Board

January 2026

About us

We have prepared and published this under section 61(3) (b) of the Public Audit Wales Act 2004.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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Audit snapshot

What we looked at

- 1 Our review assessed whether Hywel Dda University Health Board (the Health Board) has effective arrangements in place to manage its outpatient appointments. In doing so, we assessed progress in implementing recommendations made in our 2015 and 2017 follow-up outpatient reviews.

Why this is important

- 2 Outpatient services perform a critical role in a patient's health journey, supporting more patients than any other hospital department. Follow-up outpatient appointments make up the largest element of outpatient activity. These appointments are typically used to review a patient's condition after surgery or a procedure, administer medication, manage pain levels and chronic conditions, or monitor signs of deterioration.
- 3 During 2014-15, the Auditor General reviewed the management of follow-up outpatients across all health boards in Wales. Our 2015 Review of Follow-up Outpatient Appointments at the Health Board found that information on the scale of delayed follow-up outpatient appointments was unreliable and the Health Board was not doing enough to assess clinical risk or prioritise outpatient service modernisation.
- 4 We made nine recommendations, which focused on:
 - outpatient services transformation;
 - data quality;
 - follow-up outpatient reporting; and
 - clinical risk assessment.

- 5 Our 2017 progress review found the Health Board had made slow progress in addressing our recommendations. We also made two new recommendations on data quality.
- 6 In April 2020, NHS Wales published a strategy and action plan called Transforming the way we deliver outpatients in Wales, which was refreshed in 2023. The strategy sets out the need to accelerate the development of new ways of working, the adoption of new technologies, the self-management of stable long-term conditions, as well as the importance of sharing best practice.

What we have found

- 7 The Health Board has significantly reduced the number of patients waiting over one year for a first outpatient appointment, meeting the Welsh Government target by March 2025. However, the focus on first outpatient appointments has affected its ability to reduce the number of patients experiencing delayed follow-up outpatient appointments, with numbers continuing to increase. In October 2025, approximately 17,000 patients were waiting twice as long as they should be for a follow-up outpatient appointment.
- 8 The Health Board clearly understands the barriers to improving outpatient services and is taking steps to modernise and improve service efficiency. In October 2025, over half of patients were discharged at the first outpatient appointment or referred to a self-management pathway. However, Did Not Attend (DNA) rates are still high. In October 2025, the DNA rates were 7.2% for new outpatient appointments and 6.0% for follow-up outpatient appointments. The Health Board does not have a long-term plan to address challenges and develop sustainable outpatient services for the future.
- 9 Board oversight of outpatient performance is strong, and operational arrangements are improving. However, Board level reporting of harm caused by long outpatient waits needs strengthening. While validation processes are in place, they focus only on patients with very long waits. Improvements are needed in clinical validation and proactive harm identification.

What we recommend

10 We have made two new recommendations to the Health Board, these focus on:

- developing a long-term plan for outpatient services; and
- improving clinical and administrative validation.

Key facts and figures

Of the ten outstanding recommendations from our 2015 and 2017 reviews, five are complete, four are in progress and one is superseded.

Under the Welsh Government's escalation and intervention arrangements the Health Board is at Level 3 for planned care.

The Health Board met Welsh Government's target of zero patients waiting over a year for a first outpatient appointment by March 2025. Since then, performance has slightly deteriorated with 190 patients waiting more than a year in August 2025.

In October 2025, 72,025 patients were waiting for a follow-up outpatient appointment, compared to 108,089 patients at the time of our 2017 review (February 2017).

In October 2025, 16,558 patients waiting for a follow-up outpatient appointment were delayed twice as long as they should be, compared to 16,481 patients in October 2024 and 15,571 in October 2023.

In October 2025, Did Not Attend (DNA) rates were 7.2% for new outpatient appointments, above the Wales average of 6.7%, and 6.0% for follow-up appointments, below the Wales average of 6.3%.

The services with the highest waits for follow-up outpatients' appointments are ophthalmology, urology, dermatology, ear, nose and throat, rheumatology and paediatric.

Our findings

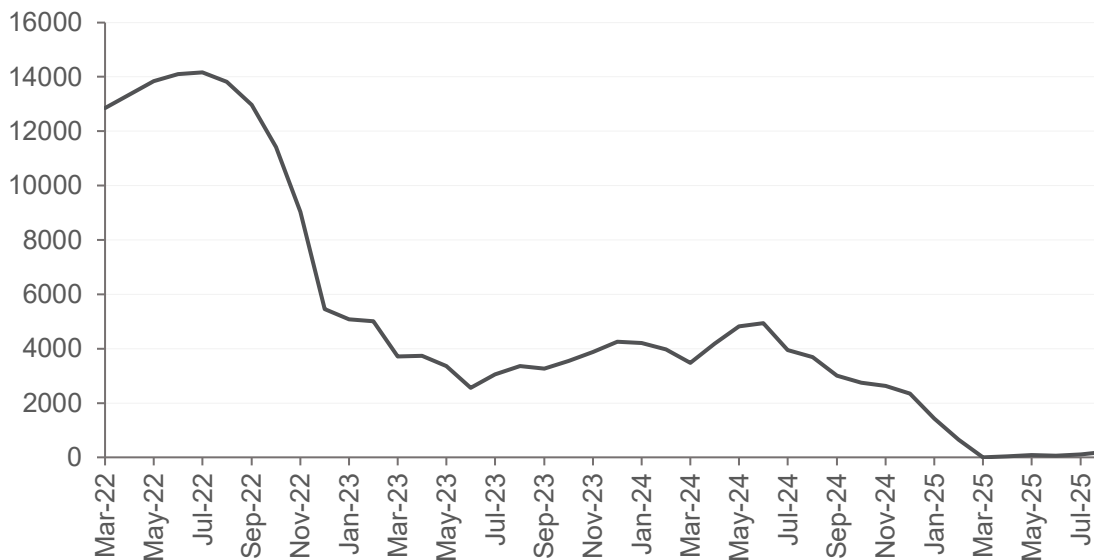
Outpatient performance

While long waits for first outpatient appointments have improved, the Health Board is still missing targets for delayed follow-up appointments

- 11 The COVID-19 pandemic had a significant impact on planned care service delivery with the total number of patients:
 - on the Health Board waiting list rising from 56,313 in March 2020 to 86,829 in March 2022;
 - waiting for a new outpatient appointment rising from 37,170 in March 2020 to 59,374 in March 2022; and
 - waiting longer than a year for a new outpatient appointment rising from 2 in March 2020 to 12,852 in March 2022.
- 12 In April 2022, the Welsh Government set a requirement that no-one should be waiting more than a year for their first outpatient appointment in most specialties by Spring 2025.
- 13 Since December 2022, the Health Board has significantly reduced the number of patients waiting more than a year for their first outpatient appointment, meeting the target of zero by March 2025 (**Exhibit 1**).
- 14 The Health Board was only one of three health boards to meet the target. Performance has slightly deteriorated since March with 190 patients waiting more than a year in August 2025. These patients relate to four specialties¹, the majority of which are waiting for an appointment in geriatric medicine.

¹ Geriatric medicine, ophthalmology, general medicine, and dermatology

Exhibit 1: number of patient pathways² waiting over 12 months for first outpatient appointment (by provider) – March 2022 to August 2025



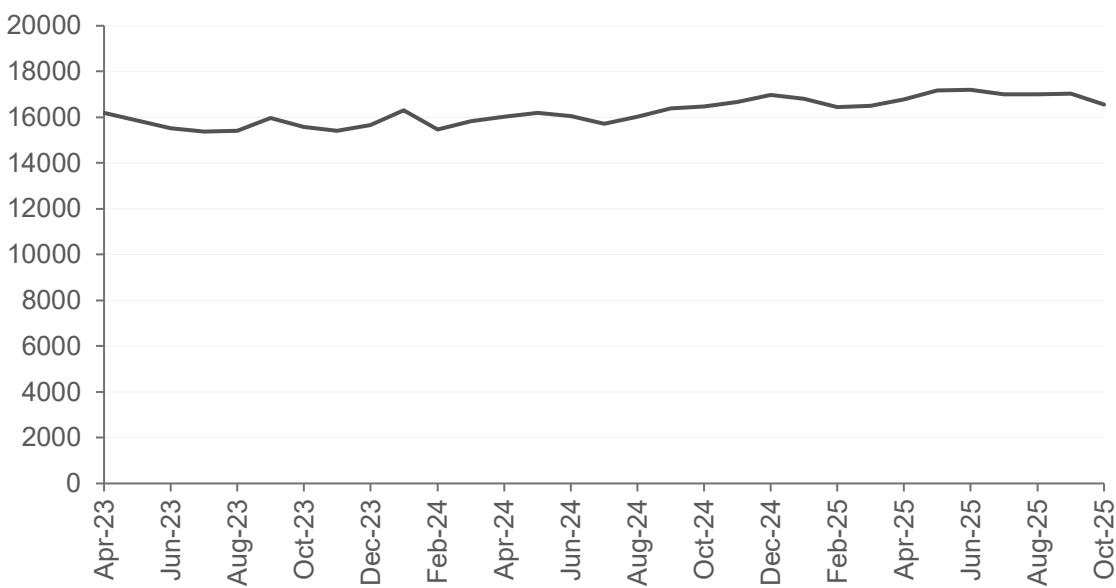
Source: Referral to treatment times, Welsh Government

- 15 The number of patients waiting for a follow-up outpatient appointment has decreased since the pandemic. At the time of our 2017 review, the number of patients waiting for a follow-up outpatient appointment was 108,089 (February 2017), compared to 72,025 in October 2025.
- 16 In February 2017, the Health Board reported 25,089 patients waiting for a follow-up appointment which is delayed. However, at that time, the Health Board was only reporting patients who did not have a booked appointment. The total number of patients delayed is likely to have been significantly higher. In October 2025, the Health Board reported a total of 29,129 patients waiting for a follow-up appointment which is delayed.

² Data is based on patient pathways. Each pathway represents a patient waiting but patients may have more than one health condition and therefore be on the waiting list more than once.

- 17 In April 2022, the Welsh Government also reset a requirement for NHS bodies to reduce the number of patients waiting for a follow-up outpatient appointment who are delayed by over 100% (that is, they are waiting twice as long as they should). This is an issue because the longer a patient waits, the higher the chance of harm, especially for serious health conditions.
- 18 In February 2017, we reported that just over 15,000 patients were delayed twice as long as they should be, although this figure excluded patients who had a booked appointment. In April 2023, the total number of patients delayed twice as long was reported as 16,181. While this number reduced during 2023, the number of patients delayed twice as long has been steadily increasing since July 2024, rising to 16,558 in October 2025 (**Exhibit 2**).

Exhibit 2: number of patients waiting for a follow-up outpatient appointment twice as long as they should be – April 2023 to October 2025



Source: Welsh Government

- 19 Many of the patients (44%) waiting for a follow-up outpatient appointment delayed twice as long as they should be, relate to ophthalmology. This is a high-risk specialty with a greater risk of harm to patients because of delayed treatment.
- 20 The total number of patients on the follow-up list and the number delayed however is the second lowest in Wales.

Outpatient services transformation

While the Health Board is working to modernise outpatient services, it lacks a long-term plan for service transformation

- 21 The Health Board clearly understands the barriers to improving outpatient services. These include outdated facilities, geographically dispersed services, staffing shortages and waiting list backlogs in some areas. There is also resistance to change, for example adopting virtual appointments.
- 22 However, the Health Board does not have a long-term plan to address these challenges and develop sustainable outpatient services for the future. Our [2025 Planned Care Review](#) also highlights the lack of long-term plans for planned care. In the medium term, the Health Board is working to modernise outpatient services for some specialties through its Clinical Services Plan. However, the plan only focuses on the most fragile services³, with plans currently in the development phase⁴. There are also digital projects which feed into outpatient transformation.
- 23 The Health Board recognises the importance of modernising its approach to managing outpatient care, adopting national strategies⁵ and Clinical Implementation Network (CIN) guidance for service transformation. The Health Board's 2025–26 Annual Plan sets out a range of measures to improve service efficiency, promote self-management pathways and address long waiting times.
- 24 The Health Board is starting to move away from issuing routine follow-up appointments. Where clinically appropriate, it discharges patients after their first outpatient appointment or puts them on a self-management pathway.

³ The Clinical Services Plan covers the following services: Critical Care, Dermatology, Emergency General Surgery, Endoscopy, Ophthalmology, Orthopaedics, Radiology, Stroke, and Urology.

⁴ The public consultation for the Clinical Services Plan ended on 31 August 2025.

⁵ Outpatient transformation as set out in Welsh Government's [Our programme for transforming and modernising planned care and reducing waiting lists in Wales \(April 2022\)](#).

- 25 The Health Board is starting to see some success. In October 2025, 39% of new outpatients were discharged after their first appointment. This approach is well used in specialties such as general surgery, gynaecology, and ear, nose, and throat. In addition, 15% of new outpatients were discharged to See on Symptom (SOS) or Patient Initiated Follow-Up (PIFU) pathways. Our analysis also indicates that there is a steady increase in the use of PIFU and SOS pathway for follow-up outpatients.
- 26 This approach ensures the prudent use of follow-up appointments and minimises the follow-up backlog from growing. The Health Board appointed a project lead responsible for collecting and analysing SOS and PIFU data. This enables clinicians and senior managers to review performance on a weekly basis and make data-driven decisions. It is also monitoring outpatient clinic start and finish times to improve operational efficiency across departments. However, there is no reporting on the use of virtual appointments.
- 27 The Health Board is not having as much success in reducing its Did Not Attend (DNA) rates. In October 2025, the Did Not Attend (DNA) rate for new outpatient appointments was 7.2%, which is higher than the Wales average of 6.7%. For follow-up appointments, the DNA rate was 6.0%, although lower than the Wales average of 6.3%. The cost of appointments lost to DNA in October 2025 was equivalent to £132,690⁶. The Health Board is working to digitalise its appointment letters, as one of the reasons patients miss appointments is because appointment letters arrive too late. This is part of wider plans to develop a digital patient service centre, allowing patients to manage their own appointments.

⁶ Based on an average cost of £120 for a new outpatient appointment, and £90 for a follow-up appointment.

- 28 Since September 2025, the Health Board has focused on reducing outpatient waits over 26 weeks, as part of the Welsh Government's Planned Care Improvement Recovery Plan⁷ to cut 200,000 waits by March 2026. The Health Board aims to deliver over 15,000 additional appointments through insourcing, starting with ophthalmology, trauma and orthopaedics, and urology.
- 29 While the Health Board's current actions are practical given the scale of waiting list challenges, they are short-term in nature. A longer-term outpatient plan is needed, with a clear vision and roadmap aligned to the Health Board's long-term strategy and enabling plans, such as digital and estates⁸.

⁷ The Welsh Government's Planned Care Improvement Recovery Plan for 2025-26 is a national strategy aimed at reducing waiting times and improving access to planned care services across NHS Wales.

⁸ The Health Board is currently refreshing its long-term strategy and digital and estates plans.

Oversight and monitoring

Board oversight of outpatient services is strong, and operational arrangements are improving, but Board level reporting of harm caused by long waits needs strengthening

- 30 The Health Board is working to improve leadership and accountability for outpatient services.
- 31 The Chief Operating Officer oversees planned care, including outpatient services. In April 2025, the Health Board introduced a new operational structure, placing outpatient services within the Planned and Specialist Clinical Care Group. This group is led by a newly appointed leadership team that provides both clinical and operational oversight. However, the structure is still being set up, and the structures below the leadership level are currently unclear. The new structure also includes a programme lead for planned care transformation.
- 32 Previously, the Clinical Director of the Planned Care Directorate also served as Deputy Clinical Lead for the NHS Wales Planned Care Programme, which helped apply Clinical Implementation Network guidelines across specialties.
- 33 Executive and operational oversight of outpatient performance is improving. Performance is routinely reviewed through:
 - Executive Improving Together Sessions;
 - Integrated Quality, Finance, Performance and Delivery Group;
 - Referral to Treatment (RTT) optimisation meetings (previously Watchtower meetings); and
 - Planned and Specialist Clinical Care Group Integrated Governance meetings.

- 34 The fortnightly integrated governance meetings are new, and the agenda alternates between finance and performance, and quality and safety. However, it is unclear where outpatient transformation activities are reported operationally.
- 35 The Health Board is now reporting the numbers of booked and un-booked follow-up outpatients with a target date to Welsh Government. This was an issue highlighted in our earlier reports. However, in October 2025, 38,514 patients were not booked, of which 21,410 patients were delayed. Positively, all patients on the follow-up list have a target date. Our previous reviews also highlighted variation between monthly data submissions to Welsh Government and internal reports. The Health Board has since strengthened the reporting process to improve consistency across reports.
- 36 There is good Board level oversight of outpatient performance. Both the Board and the Finance and Performance Committee regularly receive the Integrated Performance Assurance and the Escalation Oversight and Highlight reports. These reports track key metrics such as long waits for first appointments, delayed follow-ups, and eye care measure performance. They also explain the challenges and outline actions being taken to improve service performance, including efforts to modernise.
- 37 The Digital, Data and Innovation Committee and the Quality, Safety and Experience Committee also receive updates on key areas, such as progress with digital outpatient appointment letters and the Welsh Government's Planned Care Improvement Plan. However, without a long-term outpatient plan, most updates focus on short-term actions to reduce waiting lists.
- 38 Our 2025 planned care review found that the Health Board needs to strengthen Board level reporting on actual harm resulting from long planned care waits. We made a similar recommendation in our 2015 outpatient follow-up review. A report on the impact of long waits was expected to go to the Quality, Safety and Experience Committee in October 2025, but this has been delayed.

- 39 The Health Board reported that risks from delayed follow-up appointments are not recorded on its operational risk register. While there is a corporate risk linked to meeting Ministerial priorities for planned care recovery, this does not cover follow-up appointments because most fall outside the referral-to-treatment pathway. As a result, the risk of failing to reduce the number of patients waiting twice as long as they should for follow-up care is not captured.

Clinical risk assessment

While some validation processes are in place, they focus on long waits. Improvements are needed in clinical validation and proactive harm identification

- 40 Validating the outpatient waiting list enables the Health Board to better understand and manage service demand. It is a key process to ensure patients are seen on time, reducing the risk of avoidable harm. Some clinical conditions require more urgent attention, so regular administrative and clinical validation of waiting lists is essential to keep patients safe.
- 41 In 2015, we recommended implementing systems to identify patients at risk of irreversible harm from delayed follow-ups and develop targeted interventions to mitigate these risks. Our 2017 progress review found that despite identifying high-risk patients and updating clinical outcome forms, poor compliance and system limitations hindered timely follow-ups. Risks of harm remained due to inconsistent data capture and slow clinical validation.
- 42 Since our previous reviews, 21 specialties have adopted the updated clinical outcome forms. Each specialty now monitors its own forms and uses sample audits to check accuracy and compliance. While the forms help services to identify high-risk patients, it is unclear how the Health Board uses this information to prioritise patients at risk of irreversible harm from delays.
- 43 For example, the Health Board has the poorest performance against the Welsh Government's eye care measure. In October 2025, only 37.5%⁹ of patients with the highest risk category (R1)¹⁰ were waiting within their target date or within 25% beyond it.

⁹ The national target is for 95% of patients on the Eye Care Measure waiting list to be seen by their target date or within 25% beyond their target date.

¹⁰ The highest risk is known as Risk Factor 1 or R1. The R1 category is for patients assessed as being at risk of irreversible harm or significant adverse outcome should their target date be missed.

- 44 Additionally, as highlighted in **paragraph 19**, many ophthalmology follow-up appointments are delayed twice as long as they should be. This presents a significant risk of avoidable harm to patients. The Health Board acknowledges this issue, and ophthalmology is one of the fragile services being address through its Clinical Services Plan.
- 45 The Health Board has two administrative validation teams, looking at new and follow-up appointments. Following CIN guidelines to ensure data quality, the team conduct twice yearly validation of patients delayed by more than 100%. The Health Board reports that on average, through validation, about 20% of patients are removed from the waiting list or directed to self-management pathways. However, it is unclear how high-risk patients with shorter delays are monitored to ensure they are not coming to harm.
- 46 The Waiting List Support Service allows patients to self-report issues, but the service is not integrated into the validation process.
- 47 The team shares data from the validation exercise with specialties for clinical validation. The Health Board reported that clinical engagement in validation varies across specialties, though CIN guidelines have helped increase participation. There is currently no benchmark for clinical validation. Work is underway through a national transformation workstream to engage clinicians in clinical validation and introduce it into consultant job plans.
- 48 Our 2025 planned care review found that while the Health Board uses the Datix system to record clinical risks from treatment delays, there is no consistent approach across specialities for assessing and reporting risk of harm. We made a recommendation that the Health Board develop and implement a consistent methodology for assessing the risk of harm to patients caused by long waits across specialities.

- 49 Our previous reviews highlighted issues with data quality. We recommended identifying and addressing waiting list errors, including providing feedback to those involved in data entry to support learning. Weekly meetings with the follow-up validation team now help identify recurring issues and error patterns, with feedback shared via the validation manager or directly with specialties. Since June 2024, defined administrative validation outcomes, including reasons for removal and error details, are also tracked, reported, and shared as relevant to support continuous improvement.
- 50 However, issues can still arise due to system upgrades to WPAS, which may inadvertently introduce new errors. More broadly, the Health Board has a focus on improving the quality and use of data. As part of this work, it is conducting a series of data quality deep dives, including a review of current processes and validity of RTT waiting times.

Recommendations

51 We have made two recommendations; one replaces a recommendation from our 2015 and 2017 work.

52 The status of the 2015 and 2017 recommendations is set out in **Appendix 2**.

R1 The Health Board should develop a longer-term outpatient plan to address current and future service challenges. The Health Board should ensure the plan is (**paragraph 29**):

- aligned with its long-term strategy and enabling plans such as digital and estates;
- based on current and projected future demand for services;
- costed, at minimum for the medium term (3-5 years);
- supported by resource plans i.e. financial, workforce and infrastructure;
- supported by clear delivery actions and milestones; and
- approved by the Board.

R2 The Health Board should improve the quality of its information and reduce harm by embedding a programme of regular participation of clinical validation across all specialties (**paragraph 47**).

Appendices

1 About our work

Scope of the audit

We looked at whether the Health Board has effective arrangements in place to manage its outpatient appointments. We also assessed the extent to which the Health Board has addressed audit recommendations from our follow-up outpatient reviews in 2015 and 2017.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the Health Board have realistic plans to improve outpatient and follow-up outpatient services?
- Does the Health Board have appropriate leadership arrangements to drive improvements in outpatient services and address barriers that might inhibit progress?
- Does the Health Board have good quality information to effectively manage its outpatient service and reduce the risk of patient harm?

Criteria

In gathering evidence against the above questions, we were looking for the Health Board to demonstrate that it had:

- made the expected progress in implementing our 2015 and 2017 follow-up audit recommendations (set out in **Appendix 2**) to address the issues and concerns identified in the audits.
- current and longer-term plans in place to manage outpatient services.

Methods

We undertook our audit work between March and October 2025.

We reviewed the following key documents:

- Outpatient services transformation and improvement plans;
- Operational and executive level groups papers related to outpatient transformation;
- Outpatient programme governance and oversight arrangements;
- Performance dashboard for outpatient services;
- Board and committee papers;
- Operational and corporate risk registers; and
- Procedures for clinical assessment of patients waiting for a new or follow-up outpatient appointment.

We interviewed the following:

- Chief Operating Officer;
- Service Director for Planned and Specialised Care;
- General Manager for Cancer and Planned Clinical Care Group;
- General Manager Scheduled Care; and
- Validation Manager.

We also asked the Health Board to complete and submit a self-assessment, setting out its view of progress against the 2015 and 2017 recommendations. The Health Board submitted a completed self-assessment on 21 March 2025.

2 Previous recommendations

Our 2017 progress review found that eight of the nine recommendations made in our 2015 Review of Follow-up Outpatients Appointments were outstanding. We also made two new recommendations (recommendations 10 and 11). Below is the status of these recommendations based on our review.

Outpatient services transformation

R8 Develop and implement lean clinical condition pathways to improve quality, safety, and efficiency of service (**In progress, paragraph 23**).

R9 Plan for longer-term modernisation of outpatient services by taking stock of: (**Superseded by 2025 R1**)

- clinical resources, including medical, nursing, and allied health practitioners, required;
- the change capacity and skills required; and
- internal and external engagement with stakeholders.

Data quality

R1 Identify and address the cause of errors on the waiting list to prevent future reoccurrence, improve data accuracy, and minimise the need for ongoing validation (**Complete, paragraph 49**).

R10 As part of the administrative validation process, ensure that there is a process in place to feedback the causes of errors to those involved in the data entry process, to ensure that learning takes place and that action is taken to reduce the same errors occurring again in the future (**Complete, paragraph 49**).

R11 Embed a programme of clinical validation across all specialties to ensure that patients waiting on the follow-up list are appropriate and to identify opportunities for managing this cohort of patients differently (**In progress, paragraph 47**).

Follow-up outpatient reporting

R2 Identify the reasons for inconsistencies in waiting list numbers and improve reporting processes to ensure information is accurate and reliable (**Complete, paragraph 35**).

R3 Comply with Welsh Government reporting requirements by reporting on the numbers of both booked and un-booked follow-up outpatients, in line with the revised all-Wales template (**Complete, paragraph 35**).

- R4** Ensure that there is sufficient information on delayed follow-up outpatient appointments, including clinical risks, and that this is reported to relevant subcommittees so that the Board can take assurance from monitoring and scrutiny arrangement (**In progress, paragraph 38**).

Clinical risk assessment

- R6** Put in place systems and processes that will allow the Health Board to identify patients with conditions where they could come to irreversible harm if delays occur in follow-up appointments (**Complete, paragraph 42**).

- R7** Develop targeted interventions to minimise the risk to patients with conditions where they could come to irreversible harm if delays occur in follow-up appointments (**In progress, paragraph 42**).

3 Key terms in this report

Term	Description
100% delayed	100% delayed” means the patient’s planned care activity (such as a follow-up or treatment) has been delayed by twice the target time set for that activity.
Administrative Validation	Administrative validation is the process of verifying that non-clinical data—such as patient demographics, appointment details, or waiting list entries—is accurate and correctly recorded in administrative systems.
Clinical Validation	Clinical validation is the process of checking that a documented diagnosis is supported by clear clinical evidence in the patient’s record to ensure accuracy and compliance.
Clinical Implementation Networks	Clinical Implementation Networks (CIN) are collaborative groups established under the National Clinical Framework to implement evidence-based clinical improvements.
DNA rate	Did Not Attend (DNA) rate, refers to instances where a patient fails to attend a scheduled appointment without prior notice.
Executive Improving Together	Executive Improving Together in Hywel Dda is a framework where the Executive Team leads continuous improvement by aligning goals, using data dashboards, and fostering a culture of problem-solving and innovation to deliver better outcomes.
IQFPD	Integrated Quality, Finance, Performance and Delivery (IQFPD) Group is an executive

governance group within Hywel Dda University Health Board. Its role is to oversee and coordinate the delivery of the Health Board's Annual Plan, ensuring alignment across quality, finance, performance, and operational delivery, while managing risks and supporting Welsh Government improvement requirements.

Patient Initiated Follow-Up

Patient Initiated Follow-Up (PIFU) gives patients the flexibility to arrange their follow-up appointments only when they feel they need them, rather than being scheduled for routine check-ups at fixed intervals.

Referral to Treatment

Referral to Treatment (RTT) is the time from when a patient is first referred for specialist care to when they start their treatment, covering all steps like consultations, tests, and pre-treatment processes.

See on Symptom

See on Symptom (SOS) is an outpatient care model that allows patients to self-refer for follow-up only if symptoms reappear or worsen, rather than attending routine scheduled appointments.

WPAS

Welsh Patient Administration System (WPAS) is the largest IT system in NHS Wales. It is designed to manage patient administrative data across secondary care settings.

About us

The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

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We welcome correspondence and
telephone calls in Welsh and English.

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

Management response form



Audited body	Hywel Dda University Health Board
Audit name	Review of the Management of Outpatients
Response received	9 February 2026

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	The Health Board should develop a longer-term outpatient plan to address current and future service challenges. The Health Board should ensure the plan is (paragraph 29):	HDUHB Outpatient Annual Plan (2026/27) is in development but is reliant on service specific demand and capacity planning. The annual plan for OPD is being developed in partnership with digital, estates, finance, and workforce. This comprises of the following elements which will be delivered over the course of the 4 quarters of the year 2026/7. By the end of Q4 (2025/26) the longer-term plan for Outpatients into 26/27 will be drawn together using all components as noted below:	31/3/2026 31/3/2026	Planned Care and specialist services Director of Planning and Performance

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		- Capacity and demand planning will underpin required models of OPD delivery including use of digital technology and WG mandated use of CIN pathways Q2 - All estate plans completed and costed, and funding routes identified - Workforce training needs analysis completed and initiated - Alternative models of delivery becoming embedded into systems Q3 - Review of all key components to be scoped and any remedial actions taken on failure to deliver Q4 - Clinical Services Plan initiation particularly in fragile services	31/03/2026 - 30/06/2026 30/06/2026 30/06/2026 30/06/2026 01/07/2026 - 30/09/2026 31/03/2027	

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		- Scoping of completed extended practice roles and how they can support delivery 2027/28 - Continued use of digital frameworks to support delivery of Outpatients services All these key actions will be underpinned by the progressive transformation of delivery including and not exclusive to improvements in DNA, SOS/PIFU usage, clinic utilisation improvements, OPD booking model being digitalised and improved use of Health Care pathways.	31/03/2027 31/07/2026 31/01/2027	
R2	The Health Board should improve the quality of its information and reduce harm by embedding a programme of regular participation of clinical validation across all specialties (paragraph 47).	The Health Board currently undertake ad-hoc clinical validation. All long waiting patients (104 weeks RTT & Delayed Follow ups) are validated. This is by administrative staff who manually interrogate the WPAS system. Most specialties undertake clinical validation of referrals as part of their on-call session. HDUHB routinely return 30% of referrals with advice & guidance.		General Manager (LH) Clinical Director (MH)

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		To implement a regular clinical validation requires changes to job plans which will take time to embed. This means that F2F clinic appointments will be reduced freeing up job plan time to clinically validate into practice. An enabling action that will support resource re-allocation is the elimination of longest waiting follow up patients. Historic follow ups (i.e. over 2 years) are being moved over to SOS/PIFU pathways (as per Clinical Implementation Guidelines). Stepped timeframe as noted in Date column Step 1. This supports the timeframe for the enabling actions to be completed regarding the transfer of historic follow ups and recruitment into admin validation and training. Step 2 Supporting all Clinical validation to be factored into job plan consolidating work already being undertaken.	Initial completion date 30th June 2026 Further date of 31st July 2026	

3.5

10:30, 0 Mins

3.5 - Review of Radiology Services

*Anne Beegan,
Urvisha Perez*

DEFERRED to 23 June 2026 meeting

| For assurance

3.6

10:30, 0 Mins

3.6 - Review of Investment in Digital Systems

***Anne Beegan,
Urvisha Perez***

DEFERRED to 7 May 2026 meeting

| For assurance

4 - NWSSP – Audit and Assurance Services - Internal Audit

4.1

10:30, 5 Mins

4.1 - Internal Audit Plan Progress Report

James Johns
(NWSSP - Internal Audit)

| For assurance

Attachments

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

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



PWYLLGOR ARCHWILIO A SICRWYDD RISG AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	14 April 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 and from the outcomes of the finalised audit reports. The Audit & Risk Assurance Committee is asked to approve the updates to the plan.

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

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

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

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

Enw Da: Reputational:	n/a.
Gyfrinachedd: Privacy:	n/a.
Cydraddoldeb: Equality:	n/a.

Hywel Dda University Health Board

Audit & Risk Assurance Committee

April 2026

Audit & Assurance Services Internal Audit Progress Report

CONTENTS

1. Introduction
2. Outcomes from Finalised Audits
3. Delivery and Planning Update
4. Internal Audit Plan 2026/27

Appendix A - Assignment Status Schedule



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

Please note

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

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

1. Introduction and Background

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

2. Outcomes from Finalised Audits

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

ASSIGNMENT	ASSURANCE RATING
Internal Escalation - Level 3-4	 Limited
Operational Governance	 Limited
Shadow IT Management	 Reasonable
HTA follow up	n/a
Space utilisation	n/a

3. Planning and Delivery Update

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

Audit	Current status	Current Position / comments
Infection Prevention and Control	WIP	Additional work required to resolve queries, which will determine assurance being provided.

- 3.3** As a result of ongoing planning discussions with the Health Board, including with the Director of Corporate Governance, we have been asked to defer three audits Theatre Stock system, Cleanliness Standards and ED Data follow up. The Committee is asked to approve the amendments to the plan.
- 3.4** Regular meetings with the Director of Corporate Governance have continued, along with meetings taking place with Executive Directors and senior managers in relation to audits currently being planned and delivered. The UHB Board meetings and some Committees and board meetings have been observed. Ongoing liaison meetings with Counter Fraud, Audit Wales and Health Inspectorate Wales have also continued.

4. Internal Audit Plan 2026/27

- 4.1** The Internal Audit Plan 26/27 has been developed, with the draft plan on the agenda for the Committee's approval.

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

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

Audit & Risk Assurance Committee Progress Report

Commissioning – Third Sector	Q3/4	May	Chief Operating Officer	wip			
Decision making for high-cost drugs	Q2/3	Feb	Finance	wip			
GP Out of Hours	Q3/4	Apr	Chief Operating Officer	planning			
Corporate Risk Ophthalmology	Q1/2	Aug	Chief Operating Officer	Final	Reasonable	-	2
Vaccination & Immunisation	Q1/2	Oct	Public Health	Final	Limited	5	4
Patient Experience	Q3/4	Feb	Nursing, Quality Safety & Experience	Final	Reasonable	1	4
Infection Prevention & Control	Q3/4	Apr/may	Nursing, Quality Safety & Experience	QA			
Theatre Stock System Implementation	Q3	Apr	Chief Operating Officer	defer			
Human Tissue Authority	Q2	Oct	Allied Health Professionals & Health Science	Final	Limited	2	4
Medical Devices Regulations	Q2/3	Dec	Chief Operating Officer	Final	Substantial		1
Managed Practices	Q1/2	Dec	Chief Operating Officer	Final	Reasonable	2	4
Follow up and agreed Action Implementation Tracking -			Corporate Governance	wip			
ED Data Validation re audit	Q4		Chief Operating Officer	defer			
Human Tissue Authority – recommendation follow up	Q4	Apr	Allied Health Professionals & Health Science	FINAL	n/a		

Sickness Management - recommendation follow up	Q4		Nursing/Workforce	planning			
Cyber Security	Q2/3	Dec	Finance	FINAL	Substantial		1
Departmental /Shadow IT systems management	Q3	Feb	Finance	FINAL	Reasonable	2	1
Estates Assurance - Space Utilisation	Q2/3	Feb	Strategy & Planning	FINAL	Advisory		
Major Infrastructure Investment Plan (MIIP)	Q3/4	April	Strategy & Planning	WIP			
Control of Contractors	Q1/2	Oct	Chief Operating Officer	Final	Advisory	-	-
Capital Governance	Q1	Oct	Strategy & Planning	Final	Advisory	-	-
Integrated Audit & Assurance Plans (SSU)- Withybush General Hospital Fire – Phase 2.	IAAPs		Strategy & Planning				



Office details: Audit & Assurance Services West Team

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

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

4.2

10:35, 5 Mins

4.2 - Internal Audit Plan 2026/27

*James Johns
(NWSSP - Internal
Audit)*

| For approval

Attachments

[4.2 SBAR IA Plan Mandate & Charter 2026-27.pdf](#)

[4.2 Internal Audit Plan & Charter 2026-27.pdf](#)



PWYLLGOR ARCHWILIO A SICRWYDD RISG AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	14 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit & Assurance Services - Internal Audit Plan, Mandate & Charter 2026-27
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Head of Internal Audit
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Internal Audit

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

ADRODDIAD SCAA SBAR REPORT
<u>Sefyllfa / Situation</u> Audit & Assurance Services has, following the annual planning process and in accordance with the requirements of the new Global Internal Audit Standards, prepared the Internal Audit Plan for the year 2026/27. The plan sets out our risk-based programme of work and also contains the Internal Audit Mandate and Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service. The new Standards require that a risk based internal audit plan is created that supports the achievement of the organisation's objectives. The Plan will be delivered in accordance with the Internal Audit Mandate and Charter and the agreed KPIs, which are monitored and reported to the Health Board and Audit & Risk Assurance Committee. All Internal Audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP). The plan covers the whole of the 2026/27 audit year, however, will be subject to regular on-going review and adjustment as required to ensure that the audits reflect the Health Board's evolving risks and changing priorities and therefore providing effective assurance. <u>Cefndir / Background</u> The NHS Wales Shared Services Partnership (NWSSP) Audit and Assurance Service provides an Internal Audit service to the Hywel Dda University Health Board (UHB). It is a requirement of the Global Internal Audit Standards to establish risk-based plans. The plan is presented to the Audit & Risk Assurance Committee for approval. The plan sets out the programme of work for the year ahead, covering a broad range of organisational risks. The full document also describes how we deliver that work in accordance with professional standards. The plan has been prepared following discussions with Chair of the Audit & Risk Assurance Committee, Chief Executive, a number of Executive Directors and Senior Managers and the Director of Corporate Governance.

Asesiad / Assessment

The report provides the Committee with a level of assurance that an appropriate Internal Audit Plan, Mandate and Charter have been prepared for the 2026/27 year, in the with the requirements of the Global Internal Audit Standards, which covers a broad range of organisational risks and will allow for an appropriate annual opinion to be delivered.

Argymhelliad / Recommendation

The Audit & Risk Assurance Committee is asked to Approve the Internal Audit Plan, Mandate and Charter for 2026/27.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

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

Quality and Engagement Act (sharepoint.com)	
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Global Internal Audit Standards. Information gathered as part of the delivery of audits, the annual Internal Audit planning process, including meetings with Executive Directors, Chair of ARAC and Director of Corporate Governance. Health Board documents, risk registers and Board Assurance Framework. Internal Audit Plan & Charter Outcomes from individual Internal Audit reports
Rhestr Termiau: Glossary of Terms:	Contained within the reports.
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Audit & Risk Assurance Committee Chair Director of Corporate Governance Chief Executive and Executive Directors

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	n/a
Ansawdd / Gofal Claf: Quality / Patient Care:	n/a

Gweithlu: Workforce:	n/a
Risg: Risk:	n/a
Cyfreithiol: Legal:	n/a
Enw Da: Reputational:	n/a
Gyfrinachedd: Privacy:	n/a
Cydraddoldeb: Equality:	n/a

Internal Audit Plan & Charter 2026/27

Hywel Dda University Health Board

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1. Introduction

This document sets out the Internal Audit Plan for 2026/27 (the 'Plan') detailing the audits to be undertaken and information of the corresponding resources. It also contains the Internal Audit Mandate and Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit and Risk Assurance Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the key findings and agreed actions from internal audit reviews may be used by Hywel Dda University Health Board's (UHB) management to improve governance, risk management, and control within their operational areas.

The Global Internal Audit Standards (the 'Standards') require that a risk based internal audit plan is created that supports the achievement of the organisation's objectives.

Accordingly, this document sets out the risk-based approach and the Plan for 2026/27. The Plan will be delivered in accordance with the Internal Audit Mandate and Charter and the agreed KPIs, which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by other organisations on behalf of NHS Wales. These are: Digital Health and Care Wales (DHCW); NHS Wales Shared Services Partnership (NWSSP); and the NHS Wales Joint Commissioning Committee (JCC). These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for the JCC), but the results, as in previous years, are reported to the relevant health organisations and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Global Internal Audit Standards

The Plan has been developed in accordance with Principle 9: Plan Strategically, which includes Standard 9.4 – Internal Audit Plan, of the Standards, and the accompanying Application Note, which provides public sector interpretations and additional requirements for the Standards, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals.
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks.
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work.
- confirmation of the audit resources required to deliver the Internal Audit Plan.
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning considers the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place. In addition, the Plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit and Risk Assurance Committee (ARAC) in line with the Internal Audit Mandate and Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the 'audit universe'). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Director of Corporate Governance (Board Secretary) and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our Plan is made up of several key components:

- 1) Consideration of key governance and risk areas: We have identified several areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover the Governance, the Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management, and an overall assessment of Digital and Information Technology. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.
- 2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the corporate risk register, together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.
- 3) Follow up - this is follow-up work on previous 'limited' and 'unsatisfactory' assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.
- 4) Work agreed with the Directors of Corporate Governance, Directors of Finance, other executive peer groups, or Audit & Risk Assurance Committee Chairs in response to common risks faced by several organisations. This may be advisory work to identify areas of best practice or shared learning.
- 5) The impact of audits undertaken at other NHS Wales bodies that may impact on HEIW, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), and the Joint Commissioning Committee (JCC).
- 6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the final business case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to Hywel Dda UHB's systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; therefore, we have considered the following:

- A review of Hywel Dda UHB's vision, values and forward priorities as outlined in the Integrated Medium Term Plan (IMTP).
- An assessment of The UHB's governance and assurance arrangements and the contents of the corporate risk register.
- Risks identified in papers to the Board and its Committees in particular the Audit and Risk Assurance Committee and the Quality, Safety & Experience Committee.
- Key strategic risks identified within the corporate risk register and assurance processes.
- Discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility, including compliance and ethics programmes.
- Cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions).
- New developments and service changes.
- Legislative requirements to which the organisation is required to comply.
- Planned audit coverage of systems and processes provided through NWSSP, DHCW, and the JCC.
- Work undertaken by other supporting functions of the Audit and Risk Assurance Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV), where appropriate.
- Work undertaken by other review bodies, including Audit Wales.
- Coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with the Chief Executive, members of the executive team, Director of Corporate Governance and Chair of the Audit & Risk Assurance Committee to discuss current areas of risk and related assurance needs.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and corporate risk register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also considers corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2026/27

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan refers to key strategic risks identified within the corporate risk register and related systems of assurance, together with the proposed audit response within the outline scope.

When developing the audit scope, in discussion with the responsible executive director(s) and operational management, the scope, objectives and audit resource requirements, and timing will be refined in each area.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit and Risk Assurance Committee will be kept apprised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit and Risk Assurance Committee meeting.

Most of the audit work will be undertaken by our regionally based teams with support from our national capital and estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of information governance, IT security and digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the executive team

and endorsed by the Audit and Risk Assurance Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit and Assurance Committee for approval.

Regular liaison with Audit Wales, as your External Auditor, will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The Plan has been put together based on the planning process described in this document. The Plan includes sufficient audit work to be able to give an annual Head of Internal Audit opinion in line with the requirements of Standard 11.3 – Communicating Results, and Application Note 10B – Overall conclusions and annual reporting.

Audit & Assurance Services confirms that it has the necessary human, financial and technological resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit and Risk Assurance Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by Hywel Dda, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

Included with the plan are audit assignments delivery by our Specialist Services Unit team in relation to Estates and Capital. The current recharge for the Estates & Capital audit work is xxxxxxxxx. In addition, any capital audit work in relation to specific projects will be charged for separately on the basis of a separately agreed Integrated Audit & Assurance Plan. Where this is the case, a provision for this work would have been included by Hywel Dda in its business case submission.

6. Action required

The Audit and Assurance Committee is invited to consider the Internal Audit Plan for 2026/27 and:

- approve the Internal Audit Plan for 2026/27;
- approve the Internal Audit Mandate and Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

James Johns

Head of Internal Audit

NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2026/27

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Corporate Risk Register (CRR)] / Rationale	Executive Lead/Responsible Director	Planned start
1. Hywel Dda University Health Board (HDdUHB) and Swansea Bay University Health Board (SBUHB) Regional Joint Committee: Work Programme Delivery (Assurance) Following the joint advisory review undertaken in Q4 25/26 to assess the adequacy and clarity of governance structures, roles, responsibilities, and the early operational functioning of the Regional Joint Committee, a subsequent joint review will focus on progress in delivering the Joint Committee's work programme and the operational implementation of its decisions. This review may include the pathology service as a tracer area to test how governance and delivery arrangements are working in practice across both organisations.	Joint SBUHB	Chief Executive	Q3/4
2. Operational Governance Arrangements – (Assurance) Review implementation of updated governance arrangement to support new CCG operational structures, aligned to agreed actions from the previous audit review.	UHB Priority	Chief Operating Officer	Q3
3. Financial management – Undertake a review of the financial Grip and Control assessment	1199	Finance	Q1
4. Cost Management and Savings Schemes (inc CCGs) – Review of identification and delivery of schemes.	1199	Finance	Q2/3
5. Cleanliness Standards – (Assurance) – To assess implementation of agreed actions from the previous internal audit report	UHB Priority	Allied Health Professionals & Health Science	Q3/4
6. <i>Organisational Change Process Operational Structure (Advisory) Provide assurance over implementation, timeline, costs and lessons learned.</i>		Chief Operating Officer	Q2

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Corporate Risk Register (CRR)] / Rationale	Executive Lead/Responsible Director	Planned start
7. Health & Safety - - (Assurance) – Assess controls in place over key risk areas, including arrangements and processes in place within the Health Board managing Health & Safety including agreed actions from previous audit and recorded H&S risks.	H&S Risks	Allied Health Professionals & Health Science	Q3
8. Workforce Planning - (Assurance) – Review of arrangements particularly covering (AHP, Physio and Medical & Dental.	1978	Workforce & OD	Q2/3
9. Staff Experience / Wellbeing (Assurance) – To provide assurance over the arrangements established with the UHB for ensuring staff wellbeing and improving experience.	1821	Workforce & OD	Q2
10. Complaints – (Assurance) Assess controls in place over key risk areas, including arrangements and processes in place within the Health Board managing complaints including new regulations and feedback	UHB priority WG/TI.	Nursing, Quality Safety & Experience	Q3
11. Quality Management System (Assurance) To provide assurance over the controls in place and governance arrangements.		Nursing, Quality Safety & Experience	Q2
12. Rostering (Assurance) – Review arrangements in place for the utilisation of rostering systems.		Workforce & OD	Q2
13. Management of Service change (e.g. PPH MIU and UEC) - To provide assurance over the progress with implementation and governance arrangements.		Chief Operating Officer	Q3
14. Validation of Emergency Departments performance and waiting time data - (Assurance) – Re-Audit to assess implementation of agreed actions from the previous internal audit report	1027	Chief Operating Officer	Q1/2
15. Business continuity – review arrangements for escalation and de-escalation of business continuity arrangements including authority to and governance.		Chief Operating Officer	Q1/2

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Corporate Risk Register (CRR)] / Rationale	Executive Lead/Responsible Director	Planned start
16. Primary Care Prescribing (Assurance) – Provide assurance over the adequacy of arrangements in place.		Chief Operating Officer	Q2
17. Delayed Pathways of Care (Discharges) Assurance. Review systems in place for the management of patient discharges including a focus on arrangements implemented after previous audit review.		Chief Operating Officer	Q2
18. IRMER – (Assurance) Assess controls in place for the management of required arrangements and compliance.	Exec priority	Allied Health Professionals & Health Science	Q2/3
19 Continuing Healthcare (Assurance) – Review arrangement in place for direct payments.	2190	Chief Operating Officer	Q2/3
20. Capital Equipping - Review controls and governance arrangements in place.	Exec priority	Finance	Q1/2
21.Theatre Stock System Implementation (Assurance)– Review robustness of system controls and operation.	New System	Chief Operating Officer	Q4
22. Patient Demographic Information (Assurance) – Review arrangements in place to address the risk associated with Patient Demographic Information.		Finance	Q2/3
23. Primary Care Community by Design (Assurance) – To provide assurance over the progress with implementation and governance arrangements.		Chief Operating Officer	Q4
24.Vaccination & Immunisation - (Assurance) Re-Audit Assess implementation of agreed actions from the previous internal audit report,	Re-Audit /1194	Public Health	Q4
25.Follow up and agreed Action Implementation Tracking -Review status of agreed action implementation and supporting evidence.	Action Tracking	Corporate Governance	Q2-4

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Corporate Risk Register (CRR)] / Rationale	Executive Lead/Responsible Director	Planned start
26.Digital /IT – Digital Partner Contract- Review arrangements in place for contract management and governance.	1352	Finance	Q2/3
27.Digital /IT – Artificial Intelligence and Robotic Process Automation (Assurance) – To provide assurance that appropriate governance, controls and processes are in place to minimise risks and maximise benefits arising from the use of evolving technologies, including artificial intelligence and robotic process automation. There is also the potential for this audit to be undertaken as a joint piece with Swansea Bay University Health Board.	Joint SBUHB	Finance	Q3
28. - Radiology Informatics System Programme – (Assurance) Looking at the implementation, lessons learned, uptake and effectiveness.		Finance	Q2
29.Heath records management. looking at current situation, plans to improve, the proposed approach and development for the digitised record.		Finance	Q3
30.Estates Assurance – Control of Contractors (Assurance) - To assess the systems and controls in place within the UHB to measure the efficiency and effectiveness.	1745	Strategy & Planning	Q2/3
31 Capital Systems - Targeted Estates Funding	1745	Strategy & Planning	Q3/4
Integrated Audit & Assurance Plans	1745	Strategy & Planning	IAAP

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2026/27
Audit plan 2026/27 agreed/in draft by 30 April	✓	To deliver plan
Audit opinion 2025/26 delivered by 31 May	✓	To deliver opinion
Audits reported versus total planned audits, and in line with Audit & Risk Assurance Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	✓	95%
Report turnaround management response to draft report [15 working days maximum]	✓	85%
Report turnaround draft response to final reporting [10 working days]	✓	95%

Appendix C: Internal Audit Mandate and Charter

1 Introduction

1.1 This Mandate and Charter is produced and updated annually to comply with the Global Internal Audit Standards (introduced from 1 April 2025 for the UK Public Sector). The Standards (with specific reference to Standard 6.1 Internal Audit Mandate and 6.2 Internal Audit Charter) require the production and maintaining of an Internal Audit Mandate and Charter that, at a minimum, sets out:

- The purpose of Internal Auditing;
- a commitment to adhere to the Global Internal Audit Standards;
- the Mandate, including the scope and types of services to be provided, and the Board's responsibilities and expectations regarding management's support of the internal audit function; and
- the organisational position and reporting relationships, including Independence.

The Mandate and Charter are complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Mandate and Charter:

- Board means the Board of Hywel Dda University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit & Risk Assurance Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Hywel Dda University Health Board. The Chief Executive has made arrangements within this Mandate and Charter for an operational interface with internal audit activity through the Director of Corporate Governance (Board Secretary).

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Hywel Dda University Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

- 2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit & Risk Assurance Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.
- 2.3 The organisation's risk management, internal control and governance arrangements comprise:
- the policies, procedures and operations established by the organisation to ensure the achievement of objectives.
 - the appropriate assessment and management of risk, and the related system of assurance.
 - the arrangements to monitor performance and secure value for money in the use of resources.
 - the reliability of internal and external reporting and accountability processes and the safeguarding of assets.
 - compliance with applicable laws and regulations; and
 - compliance with the behavioural and ethical standards set out for the organisation.
- 2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

- 3.1 Independence is described in the Global Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit & Risk Assurance Committee and Accountable Officer.
- 3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit & Risk Assurance Committee on behalf of the Board. Such functional reporting includes the Audit & Risk Assurance Committee:
- approving the internal audit mandate and charter.
 - approving the risk based internal audit plan.
 - approving the internal audit resource plan.
 - receiving outcomes of all internal audit work together with the assurance rating. and

- reporting on internal audit activity's performance relative to its plan.
- 3.3 While maintaining effective liaison and communication with the organisation, as provided in this Mandate and Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.
- 3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.
- 3.5 This Mandate and Charter make appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.
- 3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

- 4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit & Risk Assurance Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.
- 4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.
- 4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Global Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.
- 4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit & Risk Assurance Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit & Risk Assurance Committee and the Chair of the organisation if deemed necessary.
- 4.5 The Audit & Risk Assurance Committee approves all Internal Audit plans and may review any aspect of its work. The Audit & Risk Committee also has regular private meetings with the Head of Internal Audit.
- 4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any

committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

- 5.1 In terms of normal business the Accountable Officer has determined that the Director of Corporate Governance will be the nominated lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.
- 5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Director of Corporate Governance in planning its work programme.
- 5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.
- 5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.
- 5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.
- 5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, the Joint Commissioning Committee.
- 5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.
- 5.8 The Audit & Risk Assurance Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit & Risk Assurance Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

- 6.1 Internal Audit must comply with the Global Internal Audit Standards and the UK Public Sector Application Note in discharging its responsibilities.
- 6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2024) and associated performance standards agreed with the Audit & Risk Assurance Committee and the Shared Services Partnership Committee. The Service Level Agreement includes several Key Performance Indicators, and we will agree with each Audit Risk Assurance

Committee which of these they want reported to them and how often.

7 Scope

- 7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:
- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information.
 - reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance.
 - reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets.
 - reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice.
 - reviewing operations or programmes to ascertain whether results are consistent with the organisation's objectives and goals and whether the operations or programmes are being carried out as planned.
 - reviewing specific operations at the request of the Audit & Risk Assurance Committee or management, this may include areas of concern identified in the corporate risk register.
 - monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance.
 - ensuring effective co-ordination, as appropriate, with external auditors and other regulators. and
 - reviewing the Annual Governance Statement prepared by senior management.
- 7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.
- 7.3 If the Head of Internal Audit or the Audit & Risk Assurance Committee consider that the level of audit resources or the Mandate and Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

- 8.1 To ensure delivery of its scope and objectives in accordance with the Mandate and Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales equirements of the Mandate and Charter
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives priorities and risk assessment
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

- 8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.
- 8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Standards and facilitate:
- the provision to the Accountable Officer and the Audit Risk Assurance Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement.
 - audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks.
 - improvement of the organisation's risk management, control and governance by providing management with

constructive recommendations arising from audit work.

- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan'.
- effective co-operation with external auditors and other review bodies functioning in the organisation. and
- the allocation of resources between assurance and consulting work.

- 8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.
- 8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.
- 8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.
- 8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit & Risk Assurance Committee on behalf of the Board.
- 8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.
- 8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead and will also be copied to the Director of Corporate Governance.

9 Reporting

- 9.1 Internal Audit will report formally to the Audit & Risk Assurance Committee through the following:
- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
 - The Head of Internal Audit opinion will:
 - a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes.
 - b) Disclose any qualification to that opinion, together with the reasons for the qualification.
 - c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies.

- d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement.
- e) Compare work undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria. and
- f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit & Risk Assurance Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit & Risk Assurance Committee requirements; and
- The Audit & Risk Assurance Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage.
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director.
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The draft report will also indicate priority ratings for individual report findings and recommendations.
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken.
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate, or disagreement remains then the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit & Risk Assurance Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit & Risk Assurance Committee Chair to ensure that the issues raised in the report are addressed appropriately.
- Reminder correspondence will be issued after the set response date where no management response has been

received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit & Risk Assurance Committee where no management response is forthcoming.

- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary, return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
 - Specific
 - Measurable
 - Achievable
 - Relevant / Realistic
 - Timely.
- The relevant Executive Director, Director of Corporate Governance and the Chair of the Audit & Risk Assurance Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Director of Corporate Governance and placed on the agenda for the next available Audit & Risk Assurance Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access is granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

- 11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.
- 11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.
- 11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

- 12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Global Internal Audit Standards, is being achieved.
- 12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit Risk Assurance Committee.
- 12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit & Risk Assurance Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

- 13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.
- 13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Mandate and Charter

14.1 This Internal Audit Mandate and Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit & Risk Assurance Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
March 2026

Disclaimer & Public Sector Internal Audit Standards

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 Mandate and Charter as approved by the Audit & Risk Assurance 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 regarding the advice and information contained.

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

Public Sector Internal Audit Standards



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

4.3

10:40, 10 Mins

4.3 - BREAK

4.4

10:50, 20 Mins

4.4 - Operational Governance Arrangements (Limited Assurance)

*James Johns
(NWSSP - Internal
Audit), Andrew
Carruthers (Hywel
Dda UHB - Chief
Operating Officer)*

| For assurance

Attachments

[4.4 Operational Governance Arrangements Final IA Report.pdf](#)

Operational Governance Arrangements

Final Internal Audit Report 2025/26

Hywel Dda University Health Board



Limited Assurance

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Executive Sign Off

Audit Committee

Executive Lead

Audit Team

HDU-2526-02

November 2025 – February 2026

2 April 2026

April 2026

Andrew Carruthers, Chief Operating Officer

James Johns, Head of Internal Audit

Sophie Corbett, Deputy Head of Internal Audit

Executive Summary

Purpose

In April 2025 the Health Board implemented a new Clinical Care Group (CCG) model aimed at enhancing integration and ensuring consistency and clarity in service planning, delivery and monitoring. This audit has reviewed implementation of governance arrangements to support the new operational structure.

Overview

Operational governance arrangements are generally well designed but are not operating as intended:

- CCGs report directly to IQFPD and are therefore held to account by the Executive Team rather than the Chief Operating Officer.
- The associated administration of the meeting rhythm is onerous and there is insufficient governance resource assigned to facilitate it effectively. Whilst all CCGs have adopted the model arrangements, application is inconsistent. We experienced difficulty in accessing meeting papers, inconsistent record keeping arrangements and lack of transparency regarding discussion and coverage of key operational domains.
- Whilst CCGs do regularly report to IQFPD, items escalated via the AAA exception reports were not always documented within CCG meeting records due to gaps in meeting records. There is a risk of premature, inaccurate or unnecessary escalation which undermines the effectiveness of the governance structure. We also identified examples of delayed reporting/escalation to IQFPD due to CCG meetings not following the prescribed rhythm.
- There is duplication of reporting between operational governance structures and the internal escalation process, driven by the same domains being monitored through two separate frameworks. Links between escalation levels, associated actions and monitoring within the operational governance structure are unclear.

There is opportunity to streamline operational governance arrangements and escalation processes, place greater reliance on available dashboards to spotlight areas requiring focus and prioritisation, and as a source of assurance for areas not deemed as high risk/priority.

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

The findings of this review need to be considered in conjunction with the findings of the separate internal audit review of Internal Escalation: Level 3/4 Functions (ref HDU-2526-03).

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	Governance structures are clearly defined		1, 4	Reasonable
2	Governance arrangements are consistently applied and operating as intended		2, 3	Limited
3	Issues arising within key operational domains are appropriately monitored and addressed		3, 4	Limited
4	Information flows from the IGGs to the IQFPD and Health Board committees are timely, accurate and support escalation and assurance.		1, 2, 3	Limited

Management Actions



High Priority



Medium Priority

Themes



■ Governance

Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Financial Loss

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: Governance structures are clearly defined

Reasonable

Operational Structure

A new operational structure was implemented in April 2025 with the establishment of six Clinical Care Groups (CCGs). The five clinical based groups have a triumvirate leadership model consisting of a Service Director, Associate Medical Director and Assistant Director of Nursing. The non-clinical group (Estates and Facilities CCG) has a Service Director and head of service. The structure was refined in November 2025 with the Primary Care CCG being amalgamated into the Community & Integrated Medicine (CIM) CCG.

Services are structured as Clinical Service Groups (CSGs) within each CCG, with a triumvirate leadership model consisting of a Clinical Director, Service Group General Manager and Head of Nursing. The new structure is set out within a framework document formally communicated to CCG Service Directors by the Chief Operating Officer in February 2025. To equip Service Directors in their new roles, the Corporate Governance Team developed an Operational Governance Standard Operating Procedure for each CCG (and their underpinning CSGs) setting out the operational structure and responsibilities of the triumvirate.

At the end of 2025 the operational structure was refined, with Primary Care CCG to become a CSG of the Community & Integrated Medicine CCG. We understand that further changes are expected in relation to Estates and Facilities.

Governance Arrangements

The Health Board’s expectations of the governance arrangements that will need to be put in place to support the establishment of the new operational structure were communicated in the Chief Operating Officer’s email to Service Directors.

Each CCG was required to establish an Integrated Governance Group (IGG) with a fortnightly meeting rhythm to focus on (i) Business, Planning, Performance (incl. finance) & People (BPPP); and (ii) Quality, Health & Safety (QHS). This same structure should be replicated at CSG level, reporting into the CCG IGG, which in turn reports into the Integrated Quality, Finance & Performance Delivery (IQFPD) Group – a group of the Executive Team. The arrangements have been clearly documented in a process map and schedule, and suite of templates developed to support consistent implementation and operation of the governance arrangements across all CCGs.

By design, the CCGs report directly to the IQFPD and are therefore held to account by held to account by IQFPD members (Executive Team) instead of the Chief Operating Officer (COO). **[Finding 1]**

The Health Board has a separate internal escalation process designed to drive improvement across seven key domains. There is significant overlap between the internal escalation process and operational governance arrangements resulting in duplication of reporting via both mechanisms. **[Finding 4]**

Key Findings		Risk & Impact	Agreed Management Action
1	CCG Accountability By design, the CCGs report directly to the IQFPD and are therefore held to account by held to account by IQFPD members (Executive Team) instead of the Chief Operating Officer (COO). Senior Operational Leadership Team meetings are held monthly, these are operationally focused, sit outside the established CCG governance framework and do not align to the fortnightly CCG to IQFPD reporting rhythm. As a result, CCGs are escalating	Ineffective governance arrangements potentially resulting in delayed escalation of issues and concerns and/or failure to detect and	Agreed Action: Review of COO Operating System, Governance Arrangements and alignment to escalation policy to be undertaken Expected Evidence of Implementation:

	matters to IQFPD before they have been considered through the COO's senior leadership forum.	address poor performance.	Revised COO Operating System Agreed at Formal Executive Team and Implemented
		High Priority	Officer: Chief Operating Officer
	Theme: Governance	Control Design	Target Implementation Date: 31 st May 2026

Objective 2: Governance arrangements are consistently applied and operating as intended

Limited

All CCGs have established an IGG and adopted the model Terms of Reference.

Meeting Rhythm

Guidance suggests that meetings be held on the Tuesday of week 1 (BPPP) and week 3 (QHS) to report into IQFPD on the Wednesday of week 2 (BPPP) and week 4 (QHS). Whilst all CCGs broadly follow a fortnightly rhythm many meetings were out of sequence resulting in delayed reporting / escalation to IQFPD. Some CCGs hold their IGG meetings on a Thursday allowing less than 24hrs for submission of papers for the next IQFPD. Nevertheless, there is evidence of regular reporting by each CCG to IQFPD. **[Finding 2]**

Meeting Administration

Meeting administration arrangements are inconsistent. Teams channels are successfully utilised for Executive Team groups - this approach has been adopted by the MHL D and Primary Care CCGs both of which demonstrated good organisation and accessibility of meeting records. We experienced significant difficulties in obtaining meeting papers for P&SC and to a lesser extent CIM in part due to the lack of central repository for meeting records and reliance on Service Director PAs for meeting administration rather than a dedicated governance resource. **[Finding 3]**

The model agenda templates are comprehensive serving as an aide memoire of all possible topics to be covered at BPPP and QHS, for CCGs to draw upon as appropriate. The templates have been adopted by AH&HS, CIM, P&SC and MHL D CCGs, but not by Primary Care or Estates & Facilities to which the standard areas are less applicable. In some cases the full model agenda template is used for every meeting and not tailored to reflect the actual agenda for the meeting. In such instances the actual content of the meeting wasn't always clear, particularly where there were no papers certain items or minutes to demonstrate items discussed. **[Finding 3]**

Some IGGs have a significant volume of papers – sometimes more than 30 items per meeting (twice monthly). We also observed examples of remarkably lengthy papers – slide packs and exception reports in excess of 30 pages. There is opportunity to improve efficiency and release resource through better use of live dashboards at IGG meetings. **[Finding 3]**

The approach to documenting IGG meetings is inconsistent both between and within CCGs. We observed a mixture of minutes, action notes, high level notes captured on agendas and in some cases no record at all. Guidance isn't prescriptive, although an action notes template has been provided and there is no specific requirement for minutes. Even where the action notes template was used it was rarely completed consistently and concisely. In some cases, it is used to capture a high-level summary of discussion of some but not all agenda items, regardless of whether there were any associated actions. **[Finding 3]**

Review of meeting notes/minutes (where available) also noted issues with attendance of core members (as identified within the respective terms of reference) with frequent apologies.

Key Findings		Risk & Impact	Agreed Management Action
2	Fortnightly Meeting Rhythm The process map and schedule suggest that CCG IGG meetings are held on a Tuesday afternoon with submission of AAA reports by Friday for IQFPD on the following Wednesday. Whilst this arrangement is designed to facilitate rapid reporting and escalation of issues, the rigidity of the schedule restricts flexibility around operational pressures. Primary Care CCG combines the BPPP and QHS agendas into a single monthly meeting meaning that the BPPP report to IQFPD is always one month late (note that Primary Care is now a CSG of the CIM CCG, so future reporting will be via the CIM CCG IGG). Planned and Specialist Care meetings have been more erratic with meeting dates not in line with the IQFPD reporting schedule, two meetings not held, and a two BPPP and QHS meetings combined into monthly meetings, resulting in consistently delayed reporting to IQFPD.	Ineffective governance arrangements potentially resulting in delayed escalation of issues and concerns and/or failure to detect and address poor performance.	Agreed Action: Review of COO Operating System, Governance Arrangements and alignment to escalation policy to be undertaken
			Expected Evidence of Implementation: Revised COO Operating System Agreed at Formal Executive Team and Implemented
	Theme: Governance	High Priority Control Operation	Officer: Chief Operating Officer Target Implementation Date: 31 st May 2026
3	Meeting Administration We experienced issues in accessing meeting papers for two CCGs due to a lack of central repository (such as SharePoint or Teams) for meeting papers. We were unable to obtain papers for five meetings (1 CIM, 4 P&S). Whilst model agenda templates had been adopted in most cases, in many cases they were not tailored to reflect the actual agenda for the meeting. Coupled with the absence of meeting minutes/notes and in some cases papers, it wasn't always clear which agenda items had/hadn't been covered in the meeting. Some IGGs have a significant volume of papers – in excess of 30, with many of those particularly lengthy – consuming significant resource in meeting preparation.	Ineffective governance arrangements potentially resulting in delayed escalation of issues and concerns and/or failure to detect and address poor performance.	Agreed Action: An updated SOP to support a revised operating system will be developed and implemented to provide clarity on the expectation.

The approach to documenting meetings is also inconsistent, with a mixture of minutes, action notes, high level notes captured on agendas and in some cases no record at all. It was often not clear what (if any) actions were arising from meetings, and what items (if any) were to be escalated to the IQFPD via AAA reporting.		Expected Evidence of Implementation: Updated SOP to support new Operating System
Theme: Governance	High Priority Control Operation	Officer: Deputy Chief Operating Officer Target Implementation Date: 31st May 2026

Objective 3: Issues arising within key operational domains are appropriately monitored and addressed

Limited

The model agenda templates for BPPP and QHS meetings are designed to ensure coverage of key operational domains. CIM, P&SC, AH&S and MHL D CCGs have all adopted the standard agenda. However, issues with the availability of meeting papers and consistency and completeness of meeting records (see objective 2) impedes our ability to give assurance that all issues arising within key operational domains are appropriately monitored and addressed. **[Finding 3]**

Where actions were identified within the action notes template, they were seldom SMART in nature and sometimes difficult to trace through to completion. The template is intended to be a cumulative/rolling record, but we identified examples where not all meetings were captured, and where actions had been removed from subsequent iterations. **[Finding 3]**

[Links to Internal Escalation Processes](#)

The Health Board's internal escalation process focuses on CCG performance across seven key domains – quality & safety, governance, workforce, finance, strategy planning & fragile services, population health and performance. Domains in escalation level 3+ require targeted action to address issues identified. The internal escalation review found that links between operational governance arrangements and escalation were not clear – there was little evidence of monitoring at IGGs of escalation levels, actions and trajectories to address issues and achieve de-escalation. **[Finding 4]**

Key Findings	Risk & Impact	Agreed Management Action
4 Internal Escalation As of December 2025, four of the six CCGs were in level 3 escalation for at least four of the seven domains (including finance, performance, strategy planning & fragile services, performance, quality & safety) necessitating monthly reporting on those domains to the Executive Recovery Meetings. This is separate and in addition to the fortnightly IGG meetings, which also cover those domains under the standard agenda template. Consequently, there is duplication of reporting to Executive Team via both mechanisms.	Ineffective governance arrangements potentially resulting in delayed escalation of issues and concerns and/or failure to detect and address poor performance.	Agreed Action: Review of COO Operating System, Governance Arrangements and alignment to escalation policy to be undertaken Expected Evidence of Implementation:

Links between operational governance arrangements and escalation are not clear – there is little evidence of monitoring at IGGs of escalation levels, actions and trajectories to address issues and achieve de-escalation.		Revised COO Operating System Agreed at Formal Executive Team and Implemented
	High Priority	Officer: Chief Operating Officer
Theme: Governance	Control Design	Target Implementation Date: 31 st May 2026

Objective 4: Information flows from the IGGs to the IQFPD and Health Board committees are timely, accurate and support escalation and assurance

Limited

As highlighted under objective 2, whilst all CCGs broadly follow a fortnightly rhythm many meetings were out of sequence resulting in delayed reporting / escalation to IQFPD. Furthermore, the Chief Operating Officer's senior leadership team meetings do not align to the fortnightly CCG to IQFPD reporting rhythm resulting in CCGs reporting directly to IQFPD and being held to account by IQFPD members (Executive Team). **[Finding 1 & 2]**

Reporting to IQFPD is via AAA (alert, advise, assure) exception reporting. Items for reporting should be identified as such within the action notes template. Two CCGs do not use the action notes template, and one had not updated the template to reflect recent meetings. Where the template had been used the AAA field had often not been properly completed to indicate whether an item was for reporting under AAA or not applicable. The template also includes a section to summarise items for escalation to IQFPD, but this was also often not completed.

Nevertheless, there is evidence of regular reporting by each CCG to IQFPD. Review of AAA reports confirmed that items are included on the exception reports even where they are not highlighted for reporting/escalation within meeting records. Whilst it is reassuring that items are being escalated despite poor meeting records, there is a risk that items are reported prematurely or unnecessarily in haste due to the rapid reporting schedule. **[Finding 3]**

Assurance reporting to Health Board committees is as determined, and following scrutiny of reports, by the IQFPD instead of directly from the service. This should ensure quality and appropriateness of reporting.

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

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4.5

11:10, 20 Mins

4.5 - Internal Escalation: Level 3 & 4 Functions
(Limited Assurance)

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

| For assurance

Attachments

[4.5 Internal Escalation L3 & 4 Functions Final IA Report.pdf](#)

Internal Escalation: Level 3 & 4 Functions

Final Internal Audit Report 2025/26

Hywel Dda University Health Board



Limited Assurance

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Audit Committee

Executive Lead

Audit Team

HDU-2526-03

October - November 2025

21 March 2026

April 2026

Huw Thomas, Executive Director of Finance

James Johns, Head of Internal Audit

Sophie Corbett, Deputy Head of Internal Audit

Executive Summary

Purpose

The overall objective of the review was to assess the actions undertaken by CCGs / Executive Directorates ("functions") to facilitate improvement in their internal escalation levels.

Overview

The *Our Improving Together Framework* is a structured, data-driven approach to driving performance improvement across the organisation, focusing on seven key domains to enhance outcomes for patients, staff, and the wider population. Whilst the design of this process is generally robust some gaps were identified, it is resource intense and over-reliant on the Performance Team, and there is little evidence to demonstrate that the process is operating as intended or driving performance improvement.

We have concluded **Limited** assurance overall with seven findings requiring management action – these are summarised below with full details provided in the Findings & Agreed Action Plan on page 5:

1. Actions to address reasons for escalation and achieve de-escalation are not formally documented in a single, central (per function) repository which impedes oversight, traceability and monitoring. We are unable to confirm that sufficient and appropriate actions have been identified for all areas in L3 escalation.
2. Actions for L3 domains assessed as 'Alert' (and therefore discussed at Executive Recovery meetings) are documented within the meeting slide packs. Sample review confirmed that these were generally SMART in nature, although instances were identified where actions had either not been identified or did not sufficiently address the stated reasons for escalation.
3. Internal Recovery meetings (function level) are not taking place. Whilst operational governance structures cover all seven domains, links with escalation were not clear - there was little evidence of monitoring of escalation levels, the reasons for escalation, actions and trajectories to address issues and achieve de-escalation.
4. The Executive Improving Together Sessions for Community & Integrated Medicine do not include the Quality & Safety domain. The reason for this was unclear.
5. Executive Recovery meetings are not taking place every month where functions have assessed L3 domains as Alert, with officers citing difficulty in scheduling meetings due to availability of senior leadership and the impact of service pressures.
6. The 3A assessment is replicated at Executive Recovery meetings, but the escalation route for areas assessed as Alert was not clear.
7. A significant proportion of actions arising from EITS and Executive Recovery meetings remain open/ongoing with some dating back to late 2024/early 2025.

The findings of this review and corrective actions need to be considered the context of the Health Board's operational governance arrangements, which are subject to an ongoing, separate internal audit review to be reported in due course.

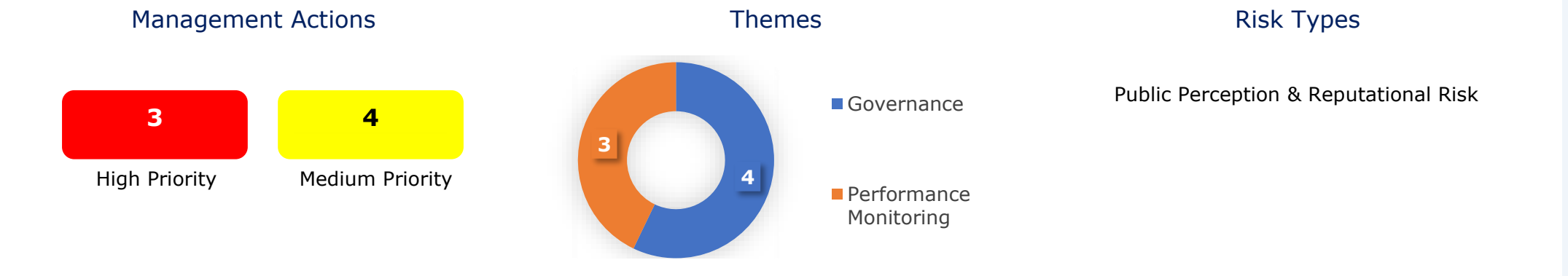
There is opportunity to better integrate and streamline the Our Improving Together escalation process with existing operational governance arrangements. The structure of the Integrated Governance Group (IGG) meetings could be more domain-focused and escalation levels assessed and determined by the function directors and subsequently agreed with the domain lead, which may improve engagement and ownership within the function.

A consolidated (per function) repository of key actions to improve performance (at all levels of escalation) clearly aligned to domains, escalation status and reasons for escalation (where applicable), would allow greater oversight of the issues to be addressed, and assurance that actions have been identified by the function to resolve them and are being progressed. This could be monitored via the IGG with onward assurance/escalation via 3A assessment arrangements.

The 3A assessment could be undertaken at a 'reason for escalation' or action (rather than domain) level, which would spotlight the specific areas requiring Executive support. There may also be merit in exploring whether the role of the EITS and Executive Recovery meetings could also be incorporated into the existing operational governance structure (noting overlap of domain coverage and group membership). Streamlining would reduce the administrative/governance burden on functions, many of which are already dealing with significant service pressures, allowing them to focus on operational priorities.

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	Functions at escalation level 3 / 4 have identified sufficient and appropriate actions to deliver sustained improvement in performance and achieve de-escalation, and there are appropriate governance arrangements in at service level to monitor this.	1, 2, 3	Limited
2	Functions at level 3 / 4 are subject to regular review, oversight and support to drive continuous improvement.	4, 5, 6	Limited



At a Glance

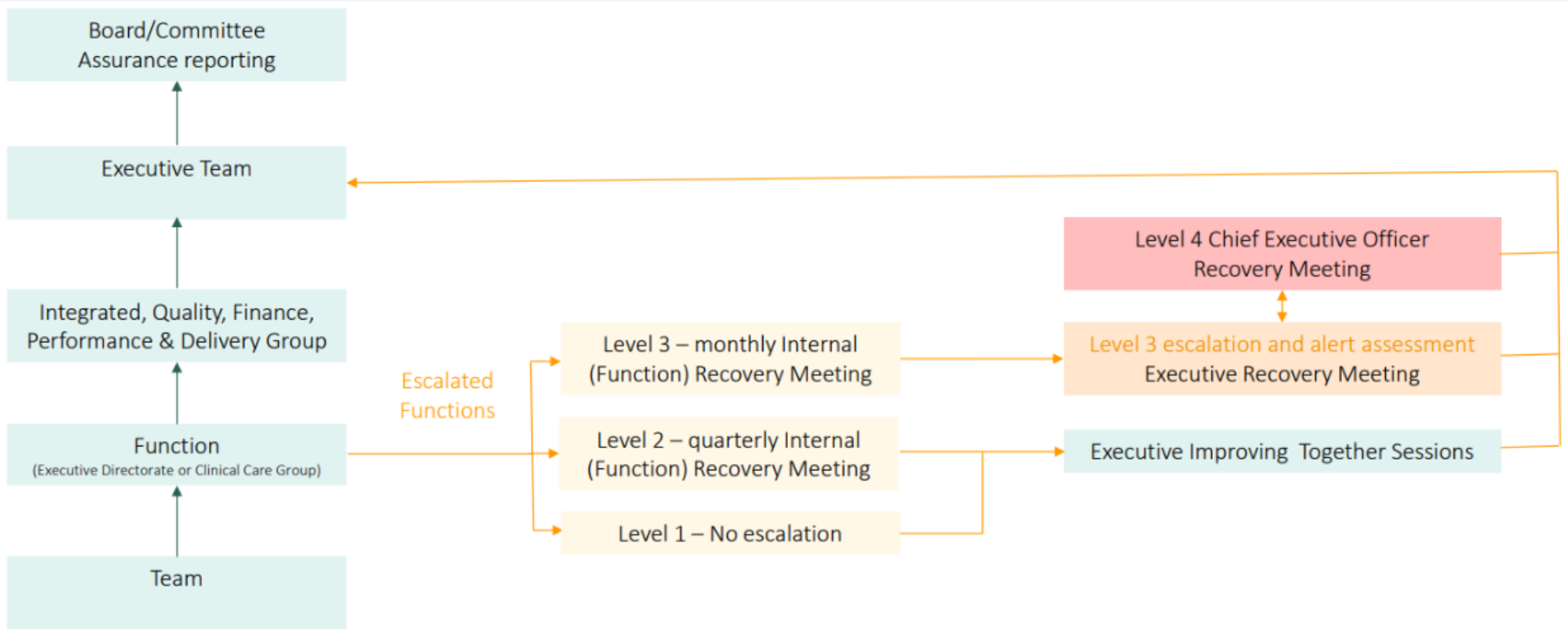
Escalation Status by Function and Domain [December 25]

Function	Quality & Safety	Governance	Workforce	Finance	Strategy, Planning and Fragile Services	Population Health	Performance
Chief Operating Officer Management	1	2	2	2	1	3	n/a
Community and Integrated Medicine	3	3	2	3	3	3	3
Estates and Facilities	2	1	2	3	1	3	3
Executive Director of Allied Health Professions and Health Sciences	1	1	n/a	1	1	2	n/a
Executive Director of Finance	1	2	1	1	1	2	n/a
Executive Director of Nursing, Quality and Patient Experience	1	2	2	1	1	3	3
Executive Director of Public Health	1	1	2	1	1	2	2
Executive Director of Strategy and Planning	1	1	1	1	1	3	n/a
Executive Director of Workforce and Organisational Development	1	1	1	1	1	2	n/a
Governance and Communication	1	1	1	1	1	2	n/a
Long Term Agreements (LTAs)	n/a	n/a	n/a	2	n/a	n/a	n/a
Medical	1	1	2	1	1	3	n/a
Mental Health and Learning Disabilities	3	1	2	3	2	3	3
Operational Allied Health and Health Sciences	2	1	2	3	3	3	3
Pharmacy and Medicines Management	1	1	2	2	2	3	n/a
Planned and Specialist Care	2	2	2	3	3	3	3
Primary Care	2	2	1	2	2	3	3

Escalation Levels



Escalation Governance Arrangements



Findings & Agreed Action Plan

The following five functions were sampled based on the number of domains in L3 escalation (there were no domains in level 4 at the time of audit fieldwork):

- Community & Integrated Medicine (CIM)
 - Allied Health & Health Sciences (AH&HS)
 - Mental Health & Learning Disabilities (MHLD)
- Planned & Specialist Care (P&SC)
 - Estates & Facilities (E&F)

Objective 1: Functions at escalation level 3 / 4 have identified sufficient and appropriate actions to deliver sustained improvement in performance and achieve de-escalation, and there are appropriate governance arrangements in at service level to monitor this

Limited

Adequacy of Actions

Escalation status, reasons for escalation and criteria for de-escalation for each function are set out within the Our Performance dashboard. The functions reviewed do not maintain a single record of actions to achieve de-escalation. We were directed to the Executive Recovery meeting slide packs as the primary source of actions for L3 domains, although these focus only on areas assessed as 'Alert' by the service director, so do not cover all areas in L3 escalation. For the areas sampled, 70% of the domains in L3 escalation (as at September 2025) were assessed as Alert and escalated to ER meetings. Actions for other areas not assessed as Alert are captured at source (e.g. function governance meetings) and not identifiable as internal escalation actions. Consequently, whilst we observed actions for most domains, we are unable to confirm that sufficient and appropriate actions have been identified for *all* areas in L3 escalation. **[Finding 1]**

The actions within the Executive Recovery slide packs for the sampled functions were generally considered sufficient and appropriate to achieve the stated de-escalation criteria and were SMART in nature, although some gaps were identified. Furthermore, the absence of single records of escalation actions coupled with variability in the format of actions in earlier slide packs and gaps in meetings impedes traceability of actions. **[Finding 2]**

We identified good practice in the stipulation of expected impact for formal actions within the slide packs, which supports SMART principles and encourages focus on the outcome and effectiveness of actions.

Internal Recovery Meetings

The *Our Improving Together Framework* requires monthly Internal Recovery meetings to be held within the function for all L3 domains. These can be held as separate meetings or integrated into the existing governance arrangements. None of the five functions reviewed hold separate meetings. Guidance states that the Function Director is expected to ensure that service leads are aware of their escalation levels, reasons for escalation, have actions in place to address the issue(s) and trajectories for resolving. The Integrated Governance Group meeting documentation for the sampled functions did not clearly demonstrate that this is taking place. **[Finding 3]**

Key Findings		Risk & Impact	Agreed Management Action
1	Central Record of Actions The functions reviewed do not maintain central records of actions to achieve de-escalation. Whilst actions for many L3 domains are captured in the Executive Recovery meeting slide packs, we are unable to confirm that sufficient and	Insufficient actions identified to achieve de-escalation.	Agreed Action: We have created "Our Actions" dashboard to ensure that actions are consistently captured and tracked across the organisation.

	appropriate actions have been identified for all areas in L3 escalation. The absence of a central record impedes oversight, traceability and monitoring. There is a risk that gaps or duplication may not be identified and addressed.		Expected Evidence of Implementation: Our Actions dashboard
		High Priority	Officer: Head of Performance
	Theme: Performance Monitoring	Control Design	Target Implementation Date: Completed
2	Sufficient & Appropriate Actions The five functions sampled collectively had 17 domains in in L3 escalation as at September 2025. Review of the Executive Recovery meeting slide packs confirmed that all 12 domains assessed as Alert were included for discussion at the October 2025 meetings. We identified four instances where actions had either not been identified within the slide pack or did not sufficiently address the stated reasons for escalation. Actions were generally considered to be SMART in nature although some exceptions were identified.	Insufficient actions identified to achieve de-escalation.	Agreed Action: Following a review of activity, we have agreed to move to monthly touchpoints with escalated CCGs and build into the Improving Together Executive Collaboration approach. The Terms of Reference will include this requirement.
			Expected Evidence of Implementation: Terms of Reference for ITEC
		Medium Priority	Officer: Director of Finance
	Theme: Performance Monitoring	Control Operation	Target Implementation Date: 31 March 2026
3	Internal Recovery Meetings We were advised that the internal recovery meetings form part of the function's Integrated Governance Group (IGG) meetings, although this was not explicitly evident from the IGG agendas and action notes. The IGG model agendas cover all seven domains and there was evidence of general review and performance monitoring in relation to these domains. However, links with escalation were not clear - there was little evidence of monitoring of escalation levels, reasons for escalation, actions and trajectories to address issues and achieve de-escalation.	Actions are not monitored through to implementation potentially resulting in de-escalation criteria not being achieved.	Agreed Action: As for Recommendation 1.
			Expected Evidence of Implementation: Our actions dashboard.
		High Priority	Officer: Head of Performance
	Theme: Performance Monitoring	Control Operation	Target Implementation Date: Completed

Performance review and escalation arrangements are set out within the *Our Improving Together Framework* - see organogram on page 4.

Escalation Level Review

On a monthly basis the lead Executive Director (or nominated deputy) for each domain reviews the progress of each CCH/Executive Directorate against the key improvement metrics for that domain and assign the appropriate escalation level. These are submitted to the Performance Team for collaborative review with the Director of Delivery and Deputy Director of Finance and once agreed, the escalation levels are updated in the *Our Performance Dashboard*.

Executive Improving Together Sessions [EITS]

EITS are held bi-annually and provide a structured forum for CCGs and executive directorates to review progress against all domains, key priorities, identify challenges, and agree on support required. These sessions are intended to ensure alignment with the annual plan, promote collaborative problem-solving, and use data insights to monitor performance. EITS meetings were held in June and November 2025 for all sampled functions. Review of EITS slide packs noted that for Community & Integrated Medicine the Quality & Safety domain is excluded – the reason for this was unclear. **[Finding 4]**

Executive Recovery Meetings

These meetings are intended for functions at L3 escalation and assigned an Alert assessment as notified by the Function Director to the Performance Team. The 3A assessments had been completed and submitted for the sampled functions for five sampled months (June – December). However, we identified gaps with Executive Recovery meetings not always taking place where domains had been assessed as Alert. Furthermore, at the time of reporting no meetings had been held since October 2025. **[Finding 5]**

The Chair of the meeting is required to complete a 3A assessment for each area reviewed, this is captured on the Escalation Meetings Action Tracker. However, it is not clear and we were unable to determine the escalation route for domains assessed as Alert. **[Finding 6]**

Actions arising from EITS and Executive Recovery Meetings

Actions arising from Executive Recovery meetings are comprehensively captured on a tracker with actions assigned a unique ID for traceability. These actions are generally administrative or supplementary in nature rather than formal actions to directly address reasons for escalation, but nonetheless contribute to the escalation governance and performance improvement process. As of 25 November 2025, a large number of open actions remain in both the Executive Recovery (level 3&4 actions) and EITS (level 1&2 actions) trackers, with some dating back to late 2024/early 2025. Furthermore, observation of an EITS meeting noted that actions on the EITS tracker were not reviewed or discussed during the meeting. **[Finding 7]**

An *Our Actions* tracker and dashboard are currently in development and will bring together actions from Board, Committees, EITS, Executive Recovery, Integrated Quality, Finance, Performance & Delivery (IQFPD) and other related groups. This is expected to be implemented in February 2026.

Key Findings		Risk & Impact	Agreed Management Action
4	Gap in Domain Review at EITS Review of EITS slide packs noted that for Community & Integrated Medicine the Quality & Safety domain is excluded – we were advised that this is being managed via the CCG Integrated Governance Group meetings (which by design cover	Poor performance is not managed effectively or addressed, potentially impacting on the quality and safety of	Agreed Action: As for Recommendation 2.
			Expected Evidence of Implementation: Terms of Reference for ITEC

	all seven domains regardless). The reason for this variation was not clear.	services to patients or the financial position.	
	Theme: Governance	Medium Priority Control Operation	Officer: Director of Finance Target Implementation Date: 31 March 2026
5	Gaps in Executive Recovery Meetings Executive Recovery meetings should take place monthly where the function has assessed one or more domains as Alert. Across the five functions reviewed, 23 Executive Recovery meetings should have been held during the period July – December 2025*. Only 12 meetings actually took place. The Performance Team, responsible for facilitating the meetings, cited difficulty in scheduling meetings due to availability of senior leadership at both Executive at function level. Furthermore, no meetings had been held since October 2025 (reviewing August/September data) due to EITS in November and service pressures in December, although meetings are scheduled for January/February 2026. <i>*excluding June & November where EITS took place instead</i>	Poor performance is not managed effectively or addressed, potentially impacting on the quality and safety of services to patients or the financial position.	Agreed Action: As for Recommendation 2. Expected Evidence of Implementation: Terms of Reference for ITEC
	Theme: Governance	High Priority Control Operation	Officer: Director of Finance Target Implementation Date: 31 March 2026
6	Escalation Route for Alerts The Chair of the meeting is required to complete a 3A assessment for each area reviewed, this is captured on the Escalation Meetings Action Tracker. However, it is not clear and we were unable to determine the escalation route for domains assessed as Alert.	Poor performance is not managed effectively or addressed, potentially impacting on the quality and safety of services to patients or the financial position.	Agreed Action: As for Recommendation 2. Expected Evidence of Implementation: Terms of Reference for ITEC
	Theme: Governance	Medium Priority Control Operation	Officer: Director of Finance Target Implementation Date: 31 March 2026

7	ERM and EITS Escalation Action Trackers As at 25 November 2025, 149 actions were open on the ERM tracker (125 overdue, 7 with no due date), and 251 actions are open on the EITS tracker (140 overdue, 51 with no due date). The high volume of overdue and undated actions— some dating back to late 2024/early 2025 —reduces assurance over progress and accountability, indicating gaps in action planning, deadline setting, and governance.	Poor performance is not managed effectively or addressed, potentially impacting on the quality and safety of services to patients or the financial position.	Agreed Action: As for Recommendation 1.
			Expected Evidence of Implementation: Our Actions tracker.
	Theme: Governance	Medium Priority Control Operation	Officer: Head of Performance Target Implementation Date: Completed.

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

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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/NHS Trust. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

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



4.6

11:30, 10 Mins

4.6 - Estates Assurance – Space Utilisation
(Advisory Report)

*James Johns
(NWSSP - Internal
Audit), Lee Davies
(Hywel Dda UHB -
Executive Director of
Strategy and
Planning), Paul
Williams (Hywel Dda
UHB - Head of
Property
Performance),
Sharon Hughes
(Hywel Dda UHB -
Principal Programme
Manager
Transformation)*

| For assurance

Attachments

4.6 Space Utilisation Final IA Advisory Report.pdf

Space Utilisation

Final Advisory Report

2025/26

Hywel Dda University Health Board

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

HDU-SSU-2526-29

October-November 2025

March 2026

14th April 2026

Lee Davies, Executive Director of Strategy & Planning

Huw Richards, Deputy Director, SSu

Melanie Goodman, Audit Manager

Executive Summary

Purpose

Optimising space utilisation within NHS Wales is crucial to support improved efficiency, cost reductions and to benefit patient care.

This advisory review sought to evaluate the effectiveness of the management and control of space utilisation within the University Health Board (UHB), share learning across NHS Wales organisations at which this review is taking place, and where possible provide best practice guidance and suggested opportunities for improvement.

The review originated from the 2025/26 internal audit plan, agreed with management, and approved by the Audit Committee.

Overview

The UHB's established controls for management of space utilisation compare favourably with both published guidance and findings from the other NHS Wales organisations reviewed. However, it is recognised that NHS Wales (including Hywel Dda) is in a limited position in terms of available data and processes by which to drive effective space utilisation. The UHB has recognised this challenge and established foundations, including strategic plans, governance structures and procedures, to take this forward.

The governance structure and processes considered at this review are focused on the management of office space, and do not currently involve consideration of clinical or primary care accommodation. Whilst therefore the management considerations raised at this report are directed towards office space, a wider challenge remains for the Health Board to develop improved understanding of clinical space requirements to feed into overarching strategies.

Whilst a relatively small number of space utilisation surveys have been undertaken to date within the UHB, they have found an average rate of only 45% utilisation in the areas surveyed, indicating opportunities for significant benefits from estate rationalisation should these findings be replicated elsewhere. Noting the significant level of backlog maintenance costs identified within the UHB, and continuing pressure on limited Welsh Government capital funds, Hywel Dda UHB, along with the rest of NHS Wales, should aim to prioritise increased understanding of space utilisation to drive strategic planning and improved utilisation of the existing estate going forward. The scale of the challenge ahead is recognised, noting the size of the estate and relatively limited progress made to date in obtaining utilisation data.

Noting the advisory nature of the review, we have not provided assurance ratings or recommendations but have identified several areas for management consideration.

Scope & Assurance Summary

Objectives

Related
Considerations

1	Strategy and Governance: To consider whether the UHB's strategy for space utilisation across its estate is adequately defined and approved. That measurable targets and objectives have been established for the short, medium and long term. That there are supporting policies and procedures in place. That appropriate governance arrangements have been defined and are operating effectively.	1,2,3
2	Data Capture and Monitoring: That a robust baseline for space occupancy and associated costs has been established, together with robust ongoing monitoring mechanisms. Processes are in place for the ongoing monitoring of space utilisation, to provide up to date data to enable monitoring against performance targets, inform decisions, e.g. via surveys, audits, monitoring software etc. Demonstration that evaluation data is collated from post-completion project reviews to confirm whether new build spaces are being utilised in accordance with the agreed business case objectives. Assess the utilisation of monitoring tools to track space utilisation.	4,5,6
3	Management and Compliance: Review processes and technological tools for managing space utilisation, including compliance with policies and procedures for space allocation, changes in use, surplus space management, and decision-making around leasing/SLAs to enable optimisation of space. Evaluate the integration of cost considerations in decisions and the assessment of available space in project planning stages.	7,8
4	Performance Evaluation and Reporting: Assess how space utilisation data is used to monitor performance against established targets. Assess how data informs strategic planning for the estate. Evaluate the effectiveness of reporting mechanisms, including actions taken to address under-utilisation.	1,3,5

Management Considerations

8

Themes



Risk Types

Financial Loss

Quality or Safety Issues

Public Perception & Reputational Risk

Findings & Management Considerations

Objective 1: Strategy & Governance

Overview / Summary of Observations

The UHB’s strategic approach to space utilisation is set out in the following formally approved documents:

- Property Asset Strategic Plan;
- Agile Working Plan; and
- Decarbonisation Delivery Plan.

The plans set out a direction of travel for the UHB in terms of utilisation of its estate. We have suggested below that the strategic approach could be strengthened by inclusion of measurable targets against which performance can be measured, but recognise this may be difficult at this time, until the UHB increases its available utilisation data to fully understand the baseline position and scope for improvement.

A robust governance structure was in place to deliver the aims of the strategic plans, including executive leadership from the Executive Director of Strategy & Planning and oversight from the Strategic Property & Environment Taskforce Group (SPETFG) (chaired by the executive lead). Clear roles and responsibilities had been assigned, with operational activity led by the Head of Property Performance, and with dedicated management resource from the Principal Programme Manager (Transformation).

Recognising siloed and varying practices previously operating across the UHB in the management of space, the process was centralised during 2025 under the remit of the newly formed Central Accommodation Group (CAG), supported by the *‘Space Utilisation Principles & Framework’* document. The new process has established robust principles to support consistent and transparent data-based decision making (in line with strategic aims) when considering requests for accommodation changes across the estate.

We have suggested a number of potential enhancements to the above foundations, to support the processes moving forward.

Management Consideration 1: Space Utilisation Targets

The existing strategic plans and *‘Space Utilisation Principles & Framework’* could be strengthened by inclusion of measurable targets for office space utilisation, against which performance can be monitored and reported.

Management Response:

The Central Accommodation Group will implement a Corporate/Office Space KPI Table with the following RAG rated KPI’s - **Green 70%+, Amber 30-70% Red Under 30%** - this will be documented within the Space Utilisation Principles & Framework document

Target Implementation Date:

June 2026

Management Consideration 2: Formalisation of Procedures

The '*Space Utilisation Principles & Framework*' may benefit from formalisation either as a stand-alone policy or by inclusion within existing strategic plans, to increase visibility and authority.

Management Response:

We will develop a Space Utilisation Policy for the health board, which aligns to what other public sector bodies have implemented and the recommendations identified via the Corporate Landlord Project, which will ensure appropriate controls and delivery of the agreed principles and plans.

Target Implementation Date:

March 2027

Management Consideration 3: Team Plan

A team 'work plan' could be produced, centralising detail such as goals, targets, timeframes, planned activities etc. across a specific time-period e.g. annual. This may assist in the prioritisation of activities, identification of any additional resource requirements etc. and may aid in the monitoring and reporting of progress/achievements of the team.

Management Response:

We will transition the current pipeline of moves/timetable (excel spreadsheet) into a more comprehensive annual project plan/project pipeline.

Target Implementation Date:

March 2027

Objective 2: Data Capture & Monitoring

Overview / Summary of Observations

The risk of under-utilisation of non-clinical space post-Covid was recognised by Welsh Government, who, in their August 2023 letter to NHS Wales organisations (*'Estate Rationalisation of non-clinical space'*), requested that organisations reviewed their utilisation of the estate and exploit rationalisation opportunities. The UHB reflects these objectives in their Property Asset Strategic Plan.

The availability of space utilisation data across the NHS Wales estate is however a barrier to effective planning. Recognising the limited data held by NHS Wales organisations (including Hywel Dda), NWSSP: Specialist Estates Services (SES) were asked by Welsh Government to assist organisations in obtaining useable data, via application of the OccupEye monitoring system. The service is provided free of charge to NHS Wales organisations, and from 2024 onwards, it was pleasing to note that Hywel Dda UHB had made use of the offering, undertaking 14 monitoring projects in conjunction with SES (representing nearly a quarter of all projects undertaken across NHS Wales during this period).

OccupEye projects completed to date have identified significant under-utilisation, with utilisation rates averaging 45% in the areas surveyed: highlighting the potential for significant benefits if these findings are replicated in other areas and improvements made.

It is acknowledged by the Property team that early activities have focused on the “low hanging fruit” of office accommodation. Going forward, the UHB has prepared prioritised plans for future roll-out of OccupEye monitoring, ensuring data is obtained in the highest risk / most beneficial areas at the earliest opportunity. Plans also included survey of non-clinical services operating from acute sites, that could potentially be relocated to free up space for clinical services. Future considerations could also include utilisation of Primary Care premises.

The UHB is also progressing through the early stages of its Corporate Landlord Model project, a first within NHS Wales, which aims to centralise all estates budgets, costs, decision-making and activities and support strategic planning. The UHB was working with a local authority who had already successfully implemented the model, to ensure the UHB project was appropriately informed by lessons learnt and also recognised future opportunities to share learning across the wider NHS Wales as the project progresses.

Whilst recognising the early stages of the UHB's data capture and monitoring processes, firm plans were in place to expand on this, with clear links to the strategic plans. Additional areas to be considered are set out below.

Management Consideration 4: Centralised Data Repository

As available data increases, there is benefit to gathering and bringing data sources together. This may include lease data, floor areas, current usage, space potential, costs etc. The team may wish to assess their current and planned data sources and consider options for data management solutions.

Management Response:

This is a longer-term objective to fully realise and requires identification of investment into the appropriate digital systems to bring disparate information together into one system to streamline reporting and create an integrated performance dashboard. HDUHB commit to this being a key output of the HDUHB Corporate Landlord project and will feature a key objective and essential output within the health board's Corporate Landlord Outline Business Case and Implementation Plan.

Target Implementation Date:

August 2026

Management Consideration 5: Reporting of benefits achieved from OccuEye monitoring

Whilst recognising that outcomes from OccuEye monitoring have been centrally reported to internal forums, the team may wish to prepare more detailed individual reports detailing the learning, actions taken and benefits achieved, resulting from the data obtained. NWSSP Specialist Estates Services (SES) have expressed a desire to receive more detailed feedback of the benefits achieved from the OccuEye projects completed with their support, to assist in the promoting of benefits across NHS Wales (with details to be suitably anonymised), and the report could therefore benefit both internal reporting and the sharing of benefits more widely.

Management Response:

Evidence of activity and success is more valuable and actionable if in a real-life case study, setting out the practical and methodical approach to achieving the desired space utilisation / rationalisation goals. Therefore, we will produce case studies, publicise/communicate them internally and share with NWSSP to highlight the good practice and results achieved.

Target Implementation Date:

March 2027

Management Consideration 6: Post-completion review of the benefits achieved from capital projects

The team could liaise with the Capital Planning team, to determine opportunities for involvement in post-project reviews, in terms of assessment of space utilisation and achievement of the intended space-related benefits from capital investment.

Management Response:

In agreement/collaboration with the Capital Planning Team, the health board aims to conduct post occupation audits/reviews following the first 12 months of the full occupation date, as defined within business case documentation and from installing Occupeye to monitor plan versus reality and against agreed space utilisation targets.

Target Implementation Date:

August 2027

Overview / Summary of Observations

Application of the '*Space Utilisation Principles & Framework*' document was managed by the Central Accommodation Group (CAG), with an electronic proforma to be completed for accommodation requests, and a spreadsheet to record requests and outcomes. Outcomes were reported routinely to the Strategic Property & Environment Taskforce Group (SPETFG). The new proforma ensured the provision of a sufficient range of information to support consideration of the requests, however we noted there could be improved clarity (and audit trail) in the recording of outcomes at the spreadsheet. The centralised process has been robust to date in its repudiation of requests which do not support the aims of the UHB's strategic plans.

A robust process was also in place for the central management of lease arrangements via the CAG, linked to the prioritised objectives for lease rationalisation set out within the Property Asset Strategic Plan. The Property Team have noted significant improvements in lease management activity arising from the new governance structure and centralised process, with staff across the UHB now aware that lease agreements need to be centrally approved. This has reduced the ad-hoc arrangements previously seen, which did not always necessarily align with the UHB's strategic plans.

A recent successful project supported by the Property Team and using OccupEye data to support the business case, has seen the re-location of office staff to a modern, centralised corporate hub in Carmarthen, leased from the Welsh Government at zero cost. This has enabled the termination of three leases and one freehold disposal in existing older properties, and has also freed up space at acute sites, in line with the aims of the Property Asset Strategic Plan in rationalising the estate.

We note a further opportunity for the Property Team to increase their involvement in the development of new capital projects (in conjunction with the Capital Planning team), bringing their data-based decision-making disciplines around space requirements to the planning of potential new capital investments.

Management Consideration 7: Accommodation Requests Spreadsheet

The Accommodation Requests Spreadsheet could be enhanced to provide greater clarity and audit trail of the outcomes of the accommodation requests received.

Management Response:

The Spreadsheet template in situ will be enhanced to include a outcomes/output column for each accommodation request and the output/decision will be recorded here so that it is clearly evidenced.

Target Implementation Date:

March 2026

Management Consideration 8: Involvement in the planning of new projects

Aligned to *Management Consideration 6*, the team could liaise with Capital Planning to determine opportunities for involvement, at a sufficiently early stage in the planning process, in new capital projects. This could benefit the process for determining space requirements, potentially supported by OccupEye data where feasible, and ensure business cases can provide a clear justification for the level of investment requested.

Management Response:

Where appropriate/possible, we will use Occupeye data and actual staff working patterns (not headcount) to inform the planning of capital projects and ensure business cases and investment is justified and offers value for money. We will promote the Hywel Dda Agile Working Strategic Plan in capital planning and workforce planning groups to underpin effective workforce planning based on true modern-day working patterns and agile working arrangements.

Target Implementation Date:

March 2027

Overview / Summary of Observations

As discussed in *Objective 2*, the UHB had limited SMART (specific, measurable, achievable, realistic, timely) data on space utilisation (to use as a benchmark against which to monitor and report performance), and as such targets had not yet been determined and included in the strategic plans (see *Management Consideration 1*). Once targets have been developed, reporting can be enhanced to incorporate data-based measurement of performance via OccupEye results and other processes.

We have also already noted the potential benefit of developing a central team plan for space utilisation activities, against which delivery can be monitored and reported to appropriate forums, e.g. CAG and SPETFG (see *Management Consideration 3*), and the opportunity for more detailed analysis and reporting of the benefits derived from OccupEye projects, for reporting internally and also for sharing more widely with NWSSP:SES (*Management Consideration 5*).

Notwithstanding these opportunities for improved reporting, we otherwise evidenced a robust range of reporting of space utilisation activities and performance, against the approved strategic plans, to appropriate forums in line with the defined responsibilities set out in the terms of reference. Recent examples have included reporting of delivery against the Property Asset Strategic Plan, of progress made using the data derived from OccupEye projects and of lease arrangements. Routine highlight reporting from the CAG to SPETFG included accommodation request decisions, top risks and mitigations.

Noting the previously referenced Management Considerations, no further actions have been suggested in this section.

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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4.7

11:40, 10 Mins

4.7 - Human Tissue Authority Follow-up (Review)

*James Johns
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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

[4.7 HTA Follow-up Final IA Report.pdf](#)

HTA (Follow Up)

Final Internal Audit Report

2025/26

Hywel Dda University Health Board

Contents

Executive Summary 1

Status of Previously Agreed Management Actions 2

Appendix A 7

Review Reference	HDU-2526-12
Fieldwork	February-March 2026
Executive Sign Off	April 2026
Audit Committee	April 2026
Executive Lead	James Severs, Director of Allied Health Professions & Health Science
Audit Team	James Johns, Head of Internal Audit Sophie Corbett, Deputy Head of Internal Audit

Executive Summary

Purpose

The overall objective of this follow-up review was to assess the progress in implementing the actions agreed with management to address the issues identified in the previous Human Tissue Act audit (HDT-2526-21). This review focuses on progress made on the implementation of actions and is not a full re-audit of the topic area; therefore, an assurance rating has not been assigned.

Overview

The agreed management actions raised in the original Human Tissue Authority report were reviewed and a summary of their status is noted in the table below:

Ref.	Matter Arising	Priority Rating	Implemented	Partially Implemented	Not Implemented
1	Standardisation of SOPs and Forms	Medium	✓		
2	Staff Training	Medium	✓		
3	Central Record of Tissue Samples	Medium	✓		
4	Missing/Incomplete Traceability Documentation	High	✓		
5	Delayed Disposals/Prolonged Retention of Tissue	High	✓		
6	Mortuary Services Risk Register	Medium	✓		

Our follow-up review confirms that significant progress has been made in addressing the issues identified in the previous Human Tissue Act audit, with all actions now fully implemented. The standardisation of SOPs and Forms is considered implemented, and duplications and discrepancies have been identified and an action plan with timescales developed, however it should be noted that amendments to the documents are not due to be completed until the end of 2026.

Further details on each recommendation are provided below.

Status of Previously Agreed Management Actions

Ref	Original Key Finding	Original Responsibility & Timescale	Priority Rating	Status
1	Standardisation of SOPs and Forms A legacy of site-specific SOPs and documentation has resulted in multiple versions and inconsistencies. Now that all postmortems are undertaken on one site a review to consolidate and standardise SOPs, forms and documents needs to be completed to simplify naming and referencing and remove duplication and also standardise processes where practicable as part of the regional mortuary with SBUHB. This will be a significant undertaking and there is no plan in place setting out how and when this will be achieved.	Hannah Albery, Pathology Quality Manager 31 December 2025	Medium Priority	Implemented An action plan with timescales for achievement and an initial review of documents has been done to identify those that can be merged or are obsolete, however amendments to the documents are not due for completion until 31/12/26.
2	Staff Training Training records for a sample of six (of 16) mortuary staff were reviewed to ensure completion of training competency forms had and accurate recording on the Q-Pulse system. Five competencies were reviewed for each employee – a total sample of 30 competencies. We identified: • Seven instances where the employee had not signed and dated the competency form. • Three instances where the assessor had not signed or dated the competency form to confirm achievement of competency. • Eight instances where there was a significant period (more than two months) between the employee and assessor signed dates, including four instances of 12 months+	Cathy Cenayko, Mortuary Manager 31 December 2025	Medium Priority	Implemented We verified that a gap analysis has been undertaken to identify where records have not been uploaded to the QMS and where records have not been fully completed. Training and competence plans in Q-Pulse have been refreshed with target dates for all outstanding training and competences completed so that ongoing compliance can be monitored. We confirmed that a competency compliance target has been set at 85% (in line with the HB's target for mandatory training compliance) and saw evidence that this is being monitored via the Quality Management meetings, the HTA operational group and the HTA assurance group. A review of papers highlighted that compliance has improved month on month and achieved 69% in December 2025.

Ref	Original Key Finding	Original Responsibility & Timescale	Priority Rating	Status
	• Eight instances where the competency had not been recorded on the individual's training history record on Q-Pulse. • Inconsistency in the use of the employee and assessor signed date as the competency completion date on Q-Pulse which, given the time lapse between the two, could impact on competency renewal dates. The overall compliance position for mortuary staff training was 51% as at 22 August 2025.			
3	Central Record of Tissue Samples The central tracking spreadsheet does not provide oversight of tissue location, and it was not always clear at what stage of the process the active cases were. Sample testing also identified instances where the data held in the spreadsheet was incomplete or inaccurate including incorrect PM date, incorrect number of slides recorded as disposed, items recorded as disposed but still retained.	Yasmin Brown, Regional Mortuary Manager 31 December 2025	Medium Priority	Implemented We confirmed that a flowchart of the traceability process has been created and the central tracker spreadsheet has been reviewed and updated to ensure full traceability of all samples. We noted that columns have also been added to record details and dates of contact with HMC/other external stakeholders to facilitate chasing outstanding paperwork. We reviewed the new template for the tissue traceability audit and verified that it has been updated to include reconciliation of case records to the central tracker which will enable the identification and correction of discrepancies.

Ref	Original Key Finding	Original Responsibility & Timescale	Priority Rating	Status
4	Missing/Incomplete Traceability Documentation Sample testing of 15 active and 15 closed (disposed) cases identified: • Five instances where form LFMOR613 Tissue Blocks Retained Record was not on file, so there was no itemised list of tissue blocks retained (although the total number of blocks is documented elsewhere). • Two instances where form LFMOR416 Mortuary Specimen Transfer Record was not on file, so there was no record of the transfer of tissue from the mortuary to histology. • Five instances where form LFMOR415/13 Retained Histology Block Transfer Log was incomplete so there was no record of the transfer of tissue from histology to the mortuary. • One instance where form LFMOR409 Release & Disposal of Tissue was incomplete with details of disposal missing (although high level disposal information was recorded elsewhere), and one instance where form LFMOR640 Disposal Form did not record the pathologist details.	Hannah Albery, Pathology Quality Manager 31 December 2025	High Priority	Implemented Mortuary staff are required to acknowledge that they have received and read any newly issued procedures via the QMS system. Although we verified that the 'Standards of record keeping and good documentation practice' instructions document has been recirculated to all staff via Q-Pulse, the Pathology Quality Manager advised us that staff have confirmed that they have read them, noting the exception of staff off work at the time. We reviewed the audit template for the HTA Standards: Traceability Horizontal audit and verified that it has been updated and understand that the audit frequency will be increased to twice yearly for all sites. A review of Monthly Quality Management Meeting papers confirmed that audit findings and non-conformances are discussed at the meetings.

Ref	Original Key Finding	Original Responsibility & Timescale	Priority Rating	Status
5	Delayed Disposals / Prolonged Retention of Tissue Sample testing of 15 active and 15 closed cases identified: One active case (i.e. tissue samples held in the mortuary) where the Coroner's investigation had concluded in March 2024 and therefore the tissue should have been disposed of in June 2024. • One closed case (i.e. tissue samples disposed) where tissues had been recorded as disposed but some of the samples were still present in the mortuary. • Six instances where the Coroner's expiry date (i.e. disposal due date) had been miscalculated, posing a risk of premature or delayed disposal. • Ten instances of delayed disposal (for the purpose of this test we have deemed this to be more than one month after the 14-week expiry date), with one case disposed of three years after closure of the Coroner's investigation. The delayed disposals and instances of retained tissue identified have not been reported as incidents, either internally via Datix or externally to the HTA as reportable incidents (HTARIs). We were advised that confirmation of investigation closure is often not received from the Coroner in a timely manner and although the team will request updates from the Coroner's Office where capacity allows, this is outside the role of the mortuary and not documented.	Craig Baker, Cellular Pathology Service Delivery Manager 31 December 2025	High Priority	Implemented We obtained evidence that the tissues being held without consent have been disposed of correctly and that these incidents have been reported via Datix. It was determined by the Designated Individual however that these instances don't constitute HTARIs (HTARI Guidance for Establishments stating that discovery of an organ or tissue, including tissue blocks and slides, retained following post-mortem examination when they should have been disposed of are classed as HTARIs) and a professional judgement was taken to report internally and to discuss this issue at the next HTA visit. We reviewed the central tracker spreadsheet to confirm it has been updated to auto calculate the retention expiry date based on the Coroner's investigation closed date. A review of a sample of case files confirmed that the date of receipt of correspondence from HMC is now being recorded and details of follow up correspondence and updates are being noted on an action log. We confirmed that the central tracker spreadsheet now contains a column to record the date that the confirmation of investigation closure was received by the mortuary. Work is currently underway to review the tissue traceability system in collaboration with HM Coroner. The Regional Mortuary Manager engaged with key personnel at the Coroner's Office in October 2025 and has held several follow-up meetings since. These discussions have resulted in progress and an agreement to revise existing processes. Implementation of the revised processes is pending the return of key HMC staff who are currently absent. The Mortuary Service deems that inadequate communication from the understaffed Coroner's office presents a risk of breaching the HTA licence and we verified that this has been added to the operational risk register.

Ref	Original Key Finding	Original Responsibility & Timescale	Priority Rating	Status
6	Mortuary Services Risk Register Risks on the operational risk register require review (due June/July 2025) and updating to record progress in implementing the identified actions, any consequent impact on the risk scores and any further action required.	Craig Baker, Cellular Pathology Service Delivery Manager 31 December 2025	Medium Priority	Implemented We obtained the latest risk register and confirmed that risks have been reviewed, and the risk register updated accordingly. The Mortuary Manager has been provided with training by the DATIX risk team so that she can now access and update the risk register. We also evidenced that risks are being reported to and reviewed at the HTA assurance group.

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

Disclaimer

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

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

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

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

Public Sector Internal Audit Standards

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



4.8

11:50, 0 Mins

4.8 - Infection Prevention & Control

James Johns
(NWSSP - Internal
Audit)

DEFERRED to 7 May 2026 meeting

| For assurance

4.9

11:50, 0 Mins

4.9 - GP Out of Hours

***James Johns
(NWSSP - Internal
Audit)***

DEFERRED to 7 May 2026 meeting

| For assurance

4.10

11:50, 0 Mins

4.10 - Major Infrastructure Investment Plan

James Johns
(NWSSP - Internal
Audit)

DEFERRED to 7 May 2026 meeting

| For assurance

4.11

11:50, 0 Mins

4.11 - Decision Making for High Cost Drugs

James Johns
(NWSSP - Internal
Audit)

DEFERRED to 7 May 2026 meeting

| For assurance

4.12

11:50, 0 Mins

4.12 - Wellsky System

***James Johns
(NWSSP - Internal
Audit)***

DEFERRED to 7 May 2026 meeting

| For assurance

4.13

11:50, 0 Mins

4.13 - Joint Committee with SBUHB

James Johns
(NWSSP - Internal
Audit)

DEFERRED to 23 June 2026 meeting

| For assurance

4.14

11:50, 0 Mins

4.14 - Medical Workforce Stabilisation

James Johns
(NWSSP - Internal
Audit)

DEFERRED to 23 June 2026 meeting

| For assurance

4.15

11:50, 0 Mins

4.15 - Theatre Stock System Implementation

James Johns
(NWSSP - Internal
Audit)

DEFERRED to 2026/27 IA Plan

| For assurance

5 - Clinical Audit

5.1

11:50, 10 Mins

5.1 - Clinical Audit Update

Mark Henwood
(Hywel Dda UHB -
Executive Medical
Director), Sharon
Daniel (Hywel Dda
UHB - Executive
Director of Nursing,
Quality & Patient
Experience), Ian
Bebb (Hywel Dda
UHB - Clinical Audit
Manager)

| For assurance

Attachments

[5.1 Clinical Audit Update ARAC April 2026.pdf](#)

[5.1 Appendix 1 - National Clinical Audit and Outcome Review Programme 2026-27.pdf](#)

[5.1 Appendix 2 - Clinical Audit Programme Letter 2026-2027.pdf](#)

[5.1 Appendix 3 - Clinical Audit Programme 2025-2026 \(October-March\).pdf](#)



PWYLLGOR ARCHWILIO A SICRWYDD RISG AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	14 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Clinical Audit Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mark Henwood, Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Ian Bebb, Clinical Audit Manager

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

This report seeks to provide the Committee with assurance on the performance, risks and impact of the Health Board's Clinical Audit function, including national audit compliance, progress in implementing the Audit Management and Tracking (AMAT) system, levels of engagement across services and key improvements delivered during 2025-26.

Cefndir / Background

During 2025-26, significant structural and digital changes have helped reshape the Clinical Audit function, including the roll-out of AMAT, integration with Clinical Care Groups and improved alignment with strategic priorities. These changes enable a more consistent tracking, stronger re-audit cycles and clearer visibility of risk areas.

The Health Board delivers an annual Clinical Audit Programme (CAP) that is aligned to organisational priorities and directly supports assurance on the quality and safety of clinical care. The programme sets out a targeted suite of audit projects selected to address key areas of clinical risk, variation, and improvement, and is delivered operationally through Clinical Care Groups and relevant services. In addition to locally-defined priorities, the CAP incorporates all mandatory audits required through the National Clinical Audit and Outcome Review Plan (NCAORP) and other national bodies, ensuring full compliance with external standards. Participation in these audits enables the Health Board to benchmark performance nationally, identify variations in clinical practice, and access advanced analysis that informs improvement actions and strengthens overall governance.

National Clinical Audit

The National Clinical Audit and Outcome Review Plan (NCAORP) is a mandatory audit programme in Wales.

Non-participation in mandatory national clinical audits presents a material risk to the Health Board, as it prevents us from benchmarking our clinical practice against other organisations and limits our ability to evidence compliance with key professional standards and national guidelines. While non-participation does not, in itself, indicate deficiencies in clinical care, it

creates a gap in the assurance available to the Board by reducing the breadth and depth of comparative data.

The Health Board does utilise a wider range of quality and safety intelligence – such as Quality Improvement activity, the Safety Dashboard, performance indicators, National Institute for Health and Care Excellence (NICE) compliance processes and service evaluations – to assess the overall health of services. However, national audits remain a critical component of our assurance framework, providing external comparison, independent scrutiny, and visibility of variation that cannot be replicated through local mechanisms alone.

Some specialties have identified that full participation in all mandatory national audits is not achievable without additional investment. Where this is the case, the Health Board has taken proactive steps to ensure that risks are understood, owned, and mitigated. Services are required to assess the impact of limited participation and incorporate the associated risks into their specialty risk registers, business cases, and annual planning objectives.

Clinical Care Groups and the Clinical Audit Team are working with these specialties to prioritise audit participation based on clinical risk, patient outcomes, and national expectations. This includes agreeing phased engagement plans, identifying resource gaps, and ensuring that areas with the greatest potential quality benefit are supported first.

This approach enables the Health Board to continue demonstrating the value of audit participation – through targeted improvements, clearer visibility of variation, and strengthened assurance – while ensuring that constraints are actively managed rather than becoming barriers to clinical quality improvement.

Key finding from 2025-26:

- 316 standard audits completed via AMAT, representing a significant increase in transparency and re-audit opportunities
- 2000 completed improvement actions and 700 in progress, evidencing operational update of audit findings from the Nursing Audit Programme
- Re-audit doubled year on year, strengthening assurance that improvements are embedded.
- Full or near-full participation in most mandatory National Clinical Audits, with clear escalation processes developed for exceptions
- Improved clinical leadership capacity following new appointments in Diabetes and Care of the Elderly
- Clinical Care Group escalation has seen an increase in the submission of clinical audit action plans. However, a number of projects have delayed submissions for action plans and a small number of projects remain significantly behind

Asesiad / Assessment

Audit Management and Tracking (AMAT) Software

The Ward & Area module continues to expand, with a current total of 21 active audits that are being carried out Health Board wide. The software acts as a data collection platform and audit results and actions can be tracked through dashboard displays with instant outputs. These audits all fall primarily under the nursing remit. Outputs are monitored through various groups and actions are embedded within AMAT and are being carried out regularly. Additional audits are being planned.

Audit activity has provided consistent assurance for several projects that have maintained high levels of compliance e.g.:

- Bare below the elbows 98.9%
- Hand hygiene 94.2%
- Personal Protective Equipment 99.3%
- Positive Patient Identification 95.6%
- Controlled Drugs 100%

Other audit activity has provided opportunities for improvement, and the Health Board can evidence patient safety improvements e.g.:

- NEWS 2 and the Burden of Illness 67.5% increased to 82.1%
- Fluid Balance Chart Audit 72.7% increased to 86.2%

The system will help ensure that these trends are continued and track the actions assigned to these audit projects e.g. there are currently 247 improvement actions aligned with the NEWS2 audit.

Across these Ward based audits there have been approximately 2000 improvement actions completed since roll out began in May 2025. A further 700+ improvements are being progressed. Whilst each action may only have a small (or varying) impact, this does represent 2000 instances of safer, timely or effective care for patients. Evidence for these actions has also been uploaded to the AMAT system. Once the programme has been fully rolled out this number will increase significantly.

Specific examples of improvements across the portfolio of audits include:

- Lying and standing BP carried out post fall
- Identification of child risk (Health visiting)
- Recording of IV fluid rate
- Increase in paediatric observation frequency (when required)
- Restrictive Practice Care Plan and Risk Assessment completion

All actions on the Ward module are tracked to a specific Ward Area and improvements are highly targeted. Areas of poor compliance are easily identified utilising this software and the system will automatically highlight low compliance.

Participation remains below expected levels, with an average participation across the 21 projects of 32.7%. The Clinical Audit Department have met several times with Senior Nursing representatives, who have agreed to focus on participation levels for the current portfolio of audits to ensure Health Board wide consistency, assurance and improvement.

A total of 316 “standard” clinical audits haven been completed on the system since it was implemented. All this information is available for all users to view and learn from as the system offers high levels of transparency. This allows the Health Board to focus more on re-audits in needed areas as opposed to “orphan” (e.g. single cycle) projects. The number of re-audits more than doubled from 2024-25 to 2025-26.

National Clinical Audit

Hywel Dda continues to meet the majority of national audit participation requirements. The Health Board has seen an increase in engagement and the completion of clinical audit improvement plans. The main areas requiring strengthened engagement in 2026/27 are Planned Care and Specialist Services, Care of the Elderly and Diabetes. Improvement plans have not yet been agreed for all areas, and the Clinical Audit Department continue to escalate

exceptions through standardised processes. More engagement will be required if the Health Board is to be compliant with the National Clinical Audit Programme.

A full list of national audits can be found in the accompanying attachment (Appendix 1).

Any exceptions to expected participation or good practice have been:

- Escalated to senior management within the respective services
- Reported to the relevant Clinical Care Group(s)
- Reviewed at the Clinical Audit Scrutiny Panel (CASP)
- Escalated to Effective Clinical Practice Advisory Panel
- Continually monitored

Discussions with audit and service leads are underway for all areas where low participation or engagement has been identified. Where participation shortfalls are identified and not mitigated, services are asked to include details within the relevant risk register. Services also have the option of applying to the Quality Impact Assessment Panel for further support.

All audits that are currently not being contributed to are on the respective services risk register.

The recent appointment of new Clinical Leads will support the appointment of Audit Leads for several key areas such as Diabetes and Care of the Elderly.

National audit findings have driven targeted improvements across multiple specialties, sites and for many patient groups. Examples of some of these improvements are:

- We now have a dedicated triple diagnostic assessment for every patient with a breast problem (National Cancer Audit Collaborating Centre (NATCAN) - Breast Cancer)
- Initiation of an acute asthma care bundle (National Adult Asthma Audit)
- Improved oxygen prescribing (National Chronic Obstructive Pulmonary Disease)
- Hywel Dda has adopted widespread use of cgm technology. Hywel Dda has higher numbers of women hitting Hba1c targets before and during pregnancy because of this (National Pregnancy in Diabetes)

More detailed information about the status of each registered audit is available on request.

Clinical Audit Programme (CAP) 2026/27

A new approach to compiling the CAP is being undertaken in 2026/27. This new approach is designed to further align the programme with Strategic/Organisational objectives. The Clinical Audit Department have written letters to the Quality, Safety and Experience Committee as well as this Committee. The Committees, and members thereof, are being asked to consider projects for inclusion. The letter has been provided as a separate attachment (Appendix 2).

The new CAP methodology ensures that projects are explicitly linked to strategic risks, clinical variation, and priority areas identified through performance dashboards. This supplements the committee-driven model and ensures greater organisational alignment.

A large portion of the audits now on the CAP are “continuous” in nature or are regular re-audits. This holds a lot of value, as the audit cycles will be repeated and improved upon.

The current programme is attached for information (Appendix 3).

Shared Learning

The CAD are continuing to hold Whole Hospital and Whole Health Board Audit meetings. They also contribute to other Medical Directorate forums, newsletters etc. as well as Enabling Quality Improvement in Practice (EQlIP), Clinical lead forums etc.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to:

- **NOTE** the performance improvements evidenced through the Audit Management and Tracking (AMAT) system and the volume of completed improvement actions
- **TAKE ASSURANCE** that services with low national audit engagement are implementing agreed improvement plans
- **TAKE ASSURANCE** from the continuation of most mandatory national audits and the processes followed for escalation
- **DISCUSS** the development of the 2026/27 April-September programme
- **TAKE ASSURANCE** from the continued shared learning through Whole Hospital Audit Meetings (WHAM) and other activities
- **ENDORSE** the revised Clinical Audit Programme (CAP) prioritisation approach to strengthen alignment with organisational risk

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference:
Cyfeirnod Cylch Gorchwyl y Pwyllgor:

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

3.9 Provide assurance with regard to the systems and processes in place for clinical audit, and consider recommendations from the Effective Clinical Practice Working Group on suggested areas of activity for review by internal audit.

3.20 The Audit and Risk Assurance Committee and the Quality, Safety and Experience Committee both have a role in seeking and providing assurance on Clinical Audit in the organisation. The Audit and Risk Assurance Committee will seek assurance on the overall plan, its fitness for purpose and its delivery. The Quality, Safety and Experience Committee will seek more detail on the clinical outcomes and improvements made as a result of clinical audit. The internal audit function will also have a role in providing assurance on the Annual Clinical Audit Plan.

Cyfeirnod Cofrestr Risg Datix a Sgôr
Cyfredol:

Audit specific risks are included and owned by the Services and will feature on other risk registers.

Datix Risk Register Reference and Score:	
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)	3. Data to knowledge 4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Striving to deliver and develop excellent services
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	National Clinical Audit and Outcome Review Programme Hywel Dda UHB Forward Clinical Audit Programme
Rhestr Termiau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Not applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	The principals of audit imply that quality/patient care will be impacted. However, no specific audit results are called out within this report.
Gweithlu: Workforce:	Workforce engagement in Clinical Audit provides an understanding of the impact of quality of service and clinical care delivery, and is a key driver for appraisal for medical staff and professional practice development in all clinical disciplines.

Risg: Risk:	Audit specific risks are contained within service/specialty specific risk registers. This includes non-participation with mandatory national audits.
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	There is the potential for reputational impact when the Health Board does not participate in mandatory audit projects. None of the criteria in the impact assessment apply.
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	Not applicable

Mandatory National Clinical Audits 2026-27
National Clinical Audit and Outcome Review Plan (NCAORP)

National Audit Title	Expected Participation 2026-27
National Joint Registry	Yes
National Laparotomy Audit (NELA)	Yes
Case Mix Programme (ICNARC)	Yes
Major Trauma Audit (TARN)	Yes
National Early Inflammatory Arthritis Audit (NEIAA)	Yes
National Diabetes Paediatric Audit	Yes
National Adult Diabetes Audit (NDA)	TBC – On Risk Register
National Diabetes Core Audit (PC)	
NDA: National Diabetes Footcare	Yes
NDA: National Diabetes Inpatient Safety Audit (NDISA)	TBC – On Risk Register
NDA: National Pregnancy in Diabetes Audit (NPID)	Yes
NDA: National Integrated Specialist Survey	TBC – On Risk Register
NDA: Transition and Young Type 2 Audit	Yes
National Respiratory Audit Programme (NRAP)	Yes
COPD Secondary Care	
NRAP: Adult Asthma Secondary Care	Yes
NRAP: Paediatric Asthma Secondary Care	Yes
NRAP: Pulmonary Rehabilitation	Yes
NRAP: Wales Primary Care Audit	Yes
National Audit of Chronic Obstructive Pulmonary Disease (PC)	Yes
All Wales Audiology Audit	Yes
Stroke Audit (SSNAP)	Yes
National Audit of Inpatient Falls	Yes
National Hip Fracture Database	Yes
Fracture Liaison Service Database	Yes
National Audit of Dementia	Yes
National Audit of Cardiac Rehabilitation	Yes
National Cardiac Audit Programme (NCAP)	Yes
Myocardial Ischaemia National Audit Project (MINAP)	
NCAP: National Audit of Cardiac Rhythm Management (CRM)	Yes
National Heart Failure Audit	Yes
National Clinical Audit of Psychosis	Yes
National Audit of Metastatic Breast Cancer	Yes
National Audit of Primary Breast Cancer	Yes

National Bowel Cancer Audit (NBOCA)	Yes
National Oesophago-Gastric Cancer Audit (NOGCA)	Yes
National Lung Cancer Audit	Yes
National Prostate Cancer Audit	Yes
National Ovarian Cancer Audit	Yes
National Pancreatic Cancer Audit	Yes
National Non-Hodgkin Lymphoma Audit	Yes
National Kidney Cancer Audit	Yes
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy 12)	Yes
National Maternity and Perinatal Audit	Yes
National Neonatal Audit Programme	Yes
National Perinatal Mortality Review Tool (PMRT)	Yes
National Audit for the Care at the End of Life (NACEL)	Yes
Epilepsy 12 Children and Young People National Clinical Audit	Yes

MEMORANDWM / MEMORANDUM

I / To: Distribution list – see below

Oddiwrth / From: Mr Stefan Bajada
Clinical Director for Clinical Audit
Chair of the Clinical Audit Scrutiny Panel

Dyddiad / Date: 26.02.2026

Dear Colleagues,

The Clinical Audit Department will be collating a Health Board wide Clinical Audit Programme. This Programme will be a summary of planned clinical audit activity regularly updated and prioritised in accordance with Health Board strategy and policy.

We would like to invite you to consider what clinical audit projects might be beneficial to the organisation. As members of a Senior Organisational Committee, you will have a unique and overarching view of priorities and can support the alignment of clinical audits with organisational objectives.

Projects proposed for the programme are intended to be pre-defined, planned clinical audits that will be carried out within the next 6 months. As a committee, you may not be able to suggest something so specific and may wish to suggest “topics” or areas of concern instead. Discussing these projects/topics with the relevant operational team will be the most effective way of seeing these projects being implemented. The Clinical Audit Department can support this process by highlighting these projects to operational teams as a priority audit topic.

We would ask you to:

- Consider audit topics/projects for inclusion within the programme
- Notify the relevant Operational Team that you have highlighted this topic for inclusion
- Notify the Clinical Audit Department of this project/topic

Please note that all projects on the programme will still be required to go through the Health Board clinical audit proposal/approval process. When the audit is ready to be undertaken it will need to be registered on the AMAT system at that time.

To include proposed projects in the audit programme we will need to receive all responses by the 30th April 2026. Any project proposals submitted after this date will be required to go through additional processes for inclusion in the programme as existing audits will have been allocated a priority.

We look forward to hearing from you. In the meantime, if you have any questions, please contact the Clinical Audit Manager or Director for Clinical Audit. Additional information and contact details can be found below.

Yours Sincerely

S Bajada

Mr Stefan Bajada
Consultant Trauma & Orthopaedics

I J Bebb

Ian Bebb
Clinical Audit Manager



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Hywel Dda
University Health Board

Clinical Director for Clinical Audit
Chair, Clinical Audit Scrutiny Panel
Stefan.Bajada2@wales.nhs.uk

ian.bebb@wales.nhs.uk

Hywel Dda University Health Board Clinical Audit Programme 2026/27 (Apr – Sept)

Name of person completing submission: *E-mail:*.....

Name of committee or group this submission originates from:

Specialty	Audit Topic	Project Lead	Proposed Location	Reasons for Inclusion* (please see below)

**Reasons for inclusion - Please provide details of the following:*

- Details of the key objective, risk register reference etc. that the project is linked to
- Reference to the high priority nature of this project and other relevant details including consideration of why this project should be chosen over other audits

Projects that do not meet the criteria for inclusion cannot be added to the forward programme

Prince Philip
carol.williams10@wales.nhs.uk

☎ 01554 783699

Glangwilli
Liz.evans2@wales.nhs.uk

☎ 01267 229635

Bronglais
chloe.robertson-brock@wales.nhs.uk

☎ 01970 635617

Withybush
George.Ruloff@wales.nhs.uk

☎ 01437 773717

Additional Information

How we can support you

All clinical audit projects will be assigned a priority level based on the clinical audit proposal and supplementary information that we receive regarding the audit. The Clinical Audit Department aims to support clinical audit projects on the Health Board Wide programme. Support will be allocated based on priority and availability of Department resources.

The finalised programme will be available to view on the intranet, allowing all staff to view current/planned audit activity within the Health Board. All clinical audit activity is also viewable using the AMAT system and can be accessed by any AMAT user.

Why we are doing this

The Health Board needs to support effective clinical audit that leads to improvements in the quality of care that we provide. Audit projects should contribute to the achievement of Health Board priorities and be clear about how patient care will be improved. There is a need to adhere to all external mandatory priorities whilst continuing to support quality local audit activity related to Health Board priorities. With finite resources for audit activity there is a limited number of projects which can be supported by the Clinical Audit Department and the wider Health Board, therefore, it is vital that we have a robust system to prioritise, approve, and monitor audits.

It will be an annual programme broken down into two 6 monthly periods with reports produced each financial year.

Functions of the programme

The programme will fulfil several functions and allows us to:

- Meet the requirements for external priorities
- Monitor progress made in completing the programme
- Monitor the quality of clinical audit activity
- Monitor the impact of the programme
- Focus audit activity on quality improvement
- Identify specialties/departments with low levels of clinical audit activity

Priorities for inclusion in the programme

- National Clinical Audit and Outcome Review Plan - automatically included on the programme (**see below**)
- Patient Safety Issues
- NICE guidance
- Welsh Risk Pool required audits
- Audits associated with the risk register
- Complaints/Incidents/Litigation that require clinical audit
- Important local audit priorities

Re-audit, in order to identify the impact of change, will be a core part of the programme.

Mandatory National Clinical Audits Update for 2026

- **Acute**
 - National Joint Registry

- National Laparotomy Audit (NELA)
- Case Mix Programme (ICNARC)
- National Major Trauma Registry

- **Long Term Conditions**
 - National Core Diabetes Audit (Primary Care)
 - National Diabetes Footcare
 - National Diabetes Inpatient Safety Audit
 - National Gestational Diabetes Audit
 - National Pregnancy in Diabetes
 - National Paediatric Diabetes Audit
 - National Diabetes Prevention Programme Audit
 - National Diabetes Integrated Specialist Survey Audit
 - Transition (Adolescents and Young Adults) and Young Type 2 Audit
 - National Chronic Obstructive Pulmonary Disease (COPD)
 - National Pulmonary Rehabilitation
 - National Adult Asthma Audit
 - Wales Primary Care Audit (Asthma & COPD)
 - National Early Inflammatory Arthritis
 - All Wales Audiology Audit

- **Older People**
 - SSNAP (Stroke)
 - National Audit of Inpatient Falls
 - National Hip Fracture Database
 - Fracture Liaison Service Database
 - National Audit of Dementia

- **End of Life**
 - National Audit of Care at the End of Life (NACEL)

- **Heart**
 - National Heart Failure
 - Cardiac Rhythm Management
 - Myocardial Ischaemia National Audit Project (MINAP)
 - Cardiac Rehabilitation

- **Cancer**
 - National Lung Cancer
 - National Prostate Cancer
 - National Oesophago-Gastric Cancer Audit
 - National Audit of Metastatic Breast Cancer
 - National Audit of Primary Breast Cancer
 - National Bowel Cancer Audit
 - National Ovarian Cancer Audit
 - National Pancreatic Cancer Audit
 - National Non-Hodgkin Lymphoma Audit
 - National Kidney Cancer Audit

- **Women's and Children's Health**
 - National Neonatal Audit Programme
 - National Maternity and Perinatal
 - National Children and young people's asthma

- National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)
- **Mental Health**
 - National Clinical Audit of Psychosis

N.B. All projects listed above have the potential to run in the 2026/27 year, however most, but not all of them will do so.

Clinical Audit Programme (CAP) 2025-2026 (Oct-Mar)						
Audit Status	Originating Committee	Speciality	Audit Title	Registration Date	Audit Leads	Completion Date
In Progress	HDUHB RADAR	Cross Speciality Improvement	All Wales Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)	01/11/2025	David Wastell	31/3/26
In Progress	HDUHB RADAR	Cross Speciality Improvement	PEWS Audit	10/01/2025	David Wastell / Jenna Davies	Continuous
In Progress	HDUHB RADAR	Cross Speciality Improvement	NEWS2	10/01/2025	David Wastell	Continuous
In Progress	SNMT	Professional Standards Team	Bare Below the Elbows - All Wales Core	01/04/2025	Louise Mills	Continuous
In Progress	SNMT	Professional Standards Team	Continence Care Audit	01/04/2025	Louise Mills	Continuous
In Progress	SNMT	Professional Standards Team	Controlled Drugs Audit	11/01/2025	Louise Mills	Continuous
In Progress	SNMT	Professional Standards Team	Falls Extensive Check Audit	01/06/2025	Louise Mills	Continuous
In Progress	SNMT	Professional Standards Team	Hand Hygiene - All Wales Core Audit	01/04/2025	Louise Mills	Continuous
In Progress	SNMT	Mental Health & Learning Disabilities	Learning Disabilities Audit	01/01/2026	Louise Mills	Continuous
In Progress	SNMT	Professional Standards Team	Medicines Management Patient Audit - All Wales Core	01/04/2025	Louise Mills	Continuous
In Progress	SNMT	Professional Standards Team	Medicines Management Ward Audit - All Wales Core	01/04/2025	Louise Mills	Continuous
In Progress	SNMT	Professional Standards Team	Personal Protective Equipment (PPE) - All Wales Core	01/04/2025	Louise Mills	Continuous
In Progress	SNMT	Professional Standards Team	Positive Patient Identification Audit	09/01/2025	Louise Mills	Continuous
In Progress	SNMT	Professional Standards Team	Rostering Audit	01/05/2025	Louise Mills	Continuous
In Progress	HDUHB Cardiology Quality, Safety & Assurance	Cardiology	WHO Surgical and Safety Checks Audit	11/01/2025	Chris Soanes	Continuous
In Progress	Nutrition and Hydration Group	Nutrition & Dietetics	Meal Time Audit	12/01/2025	Lindsey Clark	Continuous
In Progress	Nutrition and Hydration Group	Nutrition & Dietetics	WAASP	12/01/2025	Lindsey Clark	Continuous
In Progress	Nutrition and Hydration Group	Nutrition & Dietetics	Fluid Balance	03/02/2026	Lindsey Clark	Continuous
In Progress	Respiratory Annual Forum	Respiratory	Acute NIV Health Board Wide	22/01/2025	Professor Keir Lewis	
In Progress	MH CAEG	Mental Health	Physical Health Monitoring on Adult Acute Psychiatric Wards of Hywel Dda University Health Board	11/11/2025	Ross Farrup	17/03/2026
In Progress	MH CAEG	Mental Health	Rapid Tranquilisation Monitoring Standards	17/10/2025	Sophie Jones	08/01/2026
In Progress	Care of the Elderly	Hywel Dda Palliative and End of Life Care Group	All Wales Care Decisions for the Last Days of Life (April 2024 - March 2025)	27.06.23	TBC	Continuous
In Progress	SNMT	Professional Standards Team	Maternity Record Keeping Audit: January 2025 - January 2026	09/01/2025	Faith Worrall	Continuous
In Progress	Thrombosis	Thrombosis	RE-AUDIT '25 - Venous Thromboembolism Inpatients Audit NICE QS 201 S1 - Cycle 4	21/05/2025	Emma Phillips	Continuous
In Progress	Thrombosis	Thrombosis	RE-AUDIT '25 - Venous Thromboembolism Lower Limb Immobilisation Audit NICE QS 201 S2 - Cycle 4	21/05/2025	Emma Phillips	Continuous
In Progress	Thrombosis	Thrombosis	RE-AUDIT '25 Venous Thromboembolism Radiology Referral USS Audit NICE QS 201 S3 (H61) - Cycle 2	21/05/2025	Emma Phillips	Continuous
Complete - Current Implementation	Planned Care	Critical Care	Rehabilitation After Critical Illness in Adults	8th July 2024	Manon Griffiths & Chloe Atkinson-Davies	25/11/2025
Complete Implemented	Planned Care	Critical Care	Central Line Care Bundle - A Clinical audit to Assess Compliance with the Completion of Care Bundles within Critical Care, HDUHB.	15th Feb 2024	Nerys Davies	31/12/2025
Complete Implemented	Planned Care	Critical Care	Ventilator Care Bundle - A Clinical audit to Assess Compliance with the Completion of Care Bundles within Critical Care, HDUHB.	8th Feb 2024	Nerys Davies	31/12/2025
Complete Implemented	Mental Capacity and Consent Group	Mental Capacity and Consent	Audit of Form 4: Treatment in Best Interests	14/03/2025	Stewart Mills Chris Sayer	17/03/2025

Complete Implemented	Nutrition and Hydration Group	Nutrition & Dietetics	Audit of Nasogastric Tube in HDUHB	24/04/2025	Health Board Wide	30/09/2025
Complete Implemented	Mental Capacity and Consent Group	Mental Capacity and Consent	Welsh Risk Pool All Wales Peer Review Consent Audit	11/09/2023	Chris Sayer	Audit extended
Complete Implemented	Public Health & Wellbeing QSE	Smoking Cessation & Wellbeing	Hywel Dda Inpatient Smoking Re-Audit	23/07/2024	Cath Eynon	20/10/2025
Complete Implemented	Nutrition & Hydration	Nutrition & Dietetics	An Audit of the Process of Care of Patients who Receive Parenteral Nutrition	02/10/2025	Kathryn Francis	14/01/2026
Complete Implemented	Thrombosis	Thrombosis	RE-AUDIT '25 - Venous Thromboembolism Outpatient Follow Up Audit NICE QS 201 S4 & S5 - Cycle 4	21/05/2025	Emma Phillips	07/11/2025
Planning	Care of the Elderly	Hywel Dda Palliative and End of Life Care Group	All Wales Care Decisions for the Last Days of Life (April 2025 - March 2026)	TBC	TBC	n/a
Planning	Thrombosis	Thrombosis	RE-AUDIT '25 Venous Thromboembolism Radiology Referral USS Audit NICE QS 201 S3 (H61) - Cycle 3	TBC	Emma Phillips	n/a
Planning	Thrombosis	Thrombosis	RE-AUDIT '25 - Venous Thromboembolism Outpatient Follow Up Audit NICE QS 201 S4 & S5 - Cycle 5	TBC	Emma Phillips	n/a
Planning	Thrombosis	Thrombosis	RE-AUDIT '25 - Venous Thromboembolism Lower Limb Immobilisation Audit NICE QS 201 S2 - Cycle 5	TBC	Emma Phillips	n/a
Planning	Thrombosis	Thrombosis	RE-AUDIT '25 - Venous Thromboembolism Inpatients Audit NICE QS 201 S1 - Cycle 5	TBC	Emma Phillips	n/a
Planning	Safeguarding Steering Group	Paediatrics	Female Genital Mutilation	TBC	Emma Appleton & Others	n/a
Planning	Safeguarding Steering Group	Sexual Health, Paediatrics	Child Sexual Exploitation Risk Questionnaire (CSERQ)	TBC	Judith Bowler	n/a
Planning	Safeguarding Steering Group	W&CH	Routine Enquiry	TBC	Kristy Hutch	n/a
Planning	SNMT	Professional Standards Team	Senior Peer Review/15 steps audit	TBC	Louise Mills	n/a
Planning	SNMT	Professional Standards Team	Record Keeping - Content	TBC	Louise Mills	n/a
Planning	SNMT	Professional Standards Team	Record Keeping - General	TBC	Louise Mills	n/a
Planning	SNMT	Professional Standards Team	Pressure Damage Management	TBC	Louise Mills	n/a
Planning	SNMT	Professional Standards Team	Mouthcare	TBC	Louise Mills	n/a
Planning	SNMT	Professional Standards Team	Infection Prevention & Control Management Audit	TBC	Rebecca Richards	n/a
Planning	HDUHB RADAR	Cross Speciality Improvement	Sepsis Medical Emergency	TBC	David Wastell	n/a
Planning	HDUHB RADAR	Cross Speciality Improvement	Medical Emergency Trolley Audit	TBC	David Wastell	n/a

6 - Financial Focus

6.1

12:00, 5 Mins

6.1 - Financial Assurance Report

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

| For assurance

Attachments

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

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

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

[6.1 Appendix 4a - Losses and Special Payments.pdf](#)

[6.1 Appendix 4b - WG Special Payment Form.pdf](#)

[6.1 Appendix 5 - Scheme specific limits.pdf](#)



PWYLLGOR ARCHWILIO A SICRWYDD RISG AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	14 April 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
<u>Sefyllfa / Situation</u> The Audit and Risk Assurance Committee (ARAC) requires assurance on a number of financial areas as outlined in the body of the report.
<u>Cefndir / Background</u> The Standing Orders require that ARAC provides assurance to the Board that the University Health Board's assurance processes are operating effectively. Critical to this is Financial Assurance, which cannot be measured only by the UHB's main finance report and requires further information in order to assess the control environment in place; the risk assessment and management process; and the control activities.
<u>Asesiad / Assessment</u> 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: - 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. - While the level of staff overpayments increased, the average recovery period has decreased from 14 to 7 months. Further details are provided on Schedule 3 of the Report. The target is to have no overpayments; however, the total overpaid during January and February 2026 represents 0.23% of the average monthly net pay costs (November and December 2025 – 0.22%).

- c) There were two individual losses exceeding £5,000 in January and February 2026 in respect of a written off debt (£7.9k) and wastage of a drug (£5.1k); 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 £26,234, a decrease 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.

To improve compliance across all aspects of the P2P process, a cohesive approach is undertaken between the Core Accounting Team, local Procurement team and NWSSP Accounts Payable to review and triangulate appropriate actions in conjunction with NWSSP's national IOH initiatives.

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

- b) Single Tender Actions (STAs) and contracts awarded are carefully controlled. No STAs have been made since March 2024.
- c) Schemes of Delegation reflect the requirement for individuals within the organisation to have the appropriate delegated powers. The Capital Scheme of Delegation has been amended replacing an Assistant Director of Finance with the Executive Director of Strategy and Planning for approval of requisitions up to £1m in respect of schemes that have already been agreed via the Capital approval process.

Other matters:

1. Special Payment (Healthcare Support Workers – Band 2/3)

Following a national review of HCSW's roles and responsibilities a Recognition payment of £3.4m was paid to 1,058 staff. WG approval is required for this Special payment. Further details are provided on Schedule 4b. Losses and Special Payments (continued) and in Appendix 4.

2. Capital Scheme of Delegation – specific to the Withybush Fire Scheme Phase 2 and Bronglais Fire Scheme

To ensure any variations to construction contracts are managed in a timely manner there is a requirement to specify limits of approval. These have been approved by the Executive Director of Strategy and Planning as Senior Responsible Office for the Project and are detailed in

Appendix 5 for noting. Approval is not required as this is not an amendment to the Scheme of Delegation per se, merely providing clarity in respect of limits of approval.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to:

- **SCRUTINISE** the award of contracts listed in Appendix 1a.
- **DISCUSS** the breaches of Standing Financial Instructions (SFIs) as detailed in Appendix 1b.
- **DISCUSS** the staff overpayments as detailed in Appendix 2 and seek assurance that actions to control them are sufficiently embedded.
- **DISCUSS** losses as detailed in Appendix 3 and **APPROVE** the losses in excess of £5,000.
- **APPROVE** The Capital Scheme of Delegation amendments replacing an Assistant Director of Finance with the Executive Director of Strategy and Planning for **RATIFICATION** by the Board.
- **NOTE** the requirement to specify limits of approval for the Capital Scheme of Delegation specific to the Withybush Fire Scheme Phase 2 and Bronglais Fire Scheme.
- **NOTE** the recognition payment the Health Board has made to eligible Health Care Support Workers and submission to Welsh Government for its' approval as a special payment.
- Take **ASSURANCE** from the actions taken to:
 - a) Improve Purchase To Pay (P2P) compliance
 - b) Manage Single Tender Actions (STAs) and
 - c) Update Schemes of Delegation as appropriate.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.4 The Committee's principal duties encompass the following: 2.4.2 Seek assurance that the systems for financial reporting to Board, including those of budgetary control, are effective, and that financial systems processes and controls are operating. 3.10 The Committee will be responsible for reviewing the UHB's Standing Orders and Standing Financial Instructions and Scheme of Delegation annually, (including associated framework documents as appropriate), monitoring compliance, and reporting any proposed changes to the Board for consideration and approval. 3.13 Approve the writing-off of losses or the making of special payments within delegated limits. 3.15 Receive a report on all Single Tender Actions and extensions of contracts.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	BAF SO9-PR20 BAF SO10-PR33
Parthau Ansawdd: Domains of Quality	Not Applicable

Quality and Engagement Act (sharepoint.com)	
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Monitoring returns to Welsh Government based on the Health Board's financial reporting system. Activity recorded in the AR and AP modules of the Oracle business system and activity recorded in the procurement Bravo system.
Rhestr Termiau: Glossary of Terms:	AP - Accounts Payable AR – Accounts Receivable BGH – Bronglais General Hospital CAT – Core Accounting Team CF – Counter Fraud COS – Contracted Out Service VAT EOY – End of Year ERs NI – Employers National Insurance GGH – Glangwili General Hospital HMRC – His Majesty's Revenue and Customs IFRS – International Financial Reporting Standards NWSSP – NHS Wales Shared Services Partnership PID – Patient Identifiable Data PO – Purchase Order POL – Probability of Loss PPH – Prince Philip Hospital PSPP – Public Sector Payment Policy SFI – Standing Financial Instructions SLA – Service Level Agreement STA – Single Tender Action VAT – Value Added Tax WGH – Withybush General Hospital WRP – Welsh Risk Pool

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	UHB's Finance Team UHB's Management Team

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



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6.1 Financial Assurance Report for the period 1 January to 28 February 2026 Audit and Risk Assurance Committee

14 April 2026

Compliance requirements for ARAC - Overview



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University Health Board

Requirement	Reporting	Frequency	Status	Reference
Scheme of delegation changes (non-Capital)	Exception reporting for approval	As appropriate	Compliant	Capital SoD change (Schedule 5)
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	Assure Committee	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 financial statements	Annually	Compliant	N/a – no changes

2a. Compliance with Purchase to Pay requirements

IOH

January and February 2026

No. 223; Value £1,357k

November and December 2025

No. 190; Value £1,262k

Cumulative to end February 2026

No. 224*; Value £1,219k

Cumulative to end of December 2025

No. 96; Value £350k

PSPP

Non – NHS (statutory target > 95%)

January 2026 – 97.0%

February 2026 – 96.2%

Cumulative to 28 February 2026

96.6%

NHS (no statutory target)

January 2026 – 85.5%

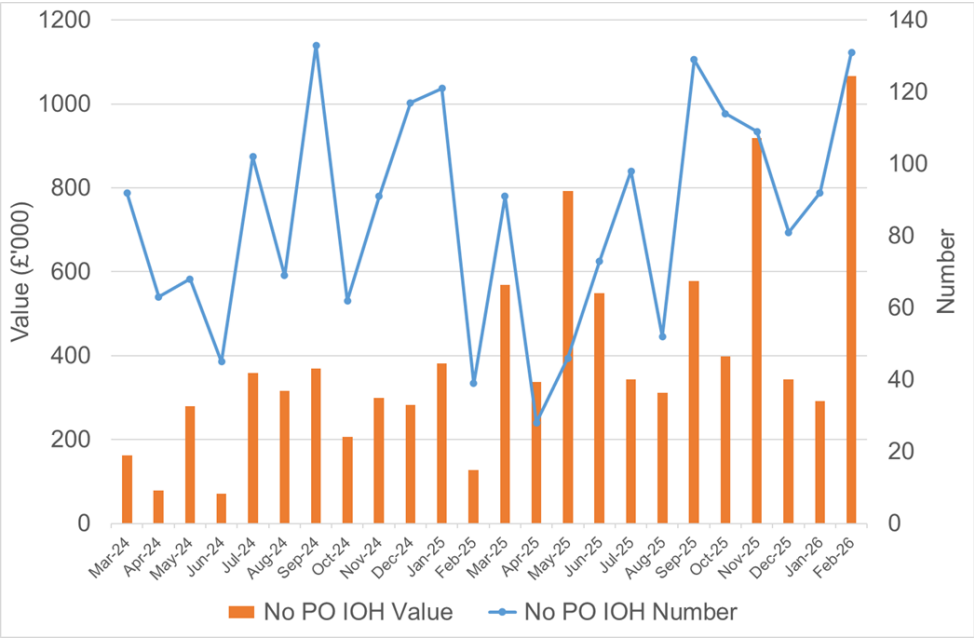
February 2026 – 73.6%

Cumulative to 28 February 2026

86.7%

*Significant increase due to Procurement resourcing constraints, which have now been resolved. Cumulative in month position to date (March 2026) has improved, reducing from 224 to 104.

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		
Healthcare Business Solutions (UK) Ltd	20	552,381
Softcat	1	183,153
Paul Sartori Foundation	3	59,476
Teifi Surgery	1	57,431
Health Board Non-Compliance exceeding £50,000:	No. of invoices	Value £
Clinical Care Groups/Executive function		
Planned and Specialist Care/Planned Care Management	21	565,279
Digital/IT and Information	7	267,826
Community and Integrated Medicine/Cered County Management	5	88,126
Community and Integrated Medicine/Pembs County Management	3	59,476

Improvements

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

2b. Compliance with Purchase to Pay requirements

STA

January and February 2026

No. 0; Value £0

November and December 2025

No. 0; Value £0

Tenders Awarded (>£25k)

January and February 2026

No. 15; Value £10,211,568

November and December 2025

No. 17; Value £5,443,422

Consultancy

January and February 2026

No. 0; Value £0

November and December 2025

Number = 0; Value = £0

Top 5 Tenders Awarded (>£25k)				Contracts awarded (>£25k) and breaches of SFIs			
Supplier	Description	Value £	Department	Contracts Awarded	Number	Value £	Details
Healios	Autism Diagnostic Assessments - Children	4,000,000	MH & LD	Post competitive tender	11	8,556,342	Appendix 1a
Part B Group Limited	Design Team for the BGH Fire Scheme	1,566,388	Capital Planning / Estates	Direct awards via Framework agreement	4	1,655,226	Appendix 1a
Softcat Plc	Citrix Hardware Replacement	995,094	Digital	VEAT	-	-	-
Norty Limited T/A T-Pro	NHS SBS Digital Dictation, Speech Recognition and Outsourced Transcription Framework Agreement	613,935	Digital	Total*	15	10,211,568	
Probrand Limited	Digital Carts on Wheels (COWs) Requirement	612,000	Operations	Consultancy Contracts	-	-	-
Total		7,787,417		Breaches of SFIs	7	138,996	Appendix 1b
				Contract Awards reported retrospectively	-	-	-
* Includes any contract awards reported retrospectively							

3. Compliance with Income to Cash

Salary
Overpayments

January and February 2026
No. 52; Value £48,610
(Appendix 2)

November and December 2025
No. 39; Value £39,373

Debt balance at 28 February
2026: £294k; average recovery
period of 7 months

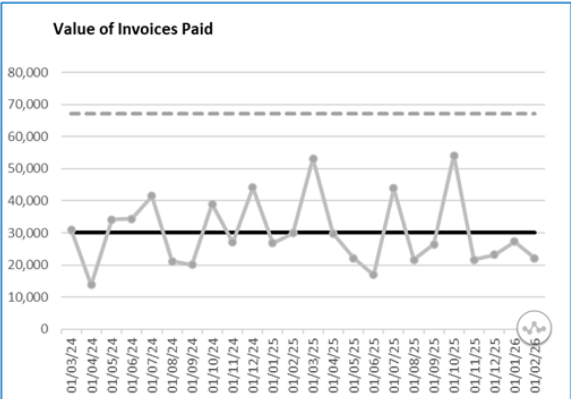
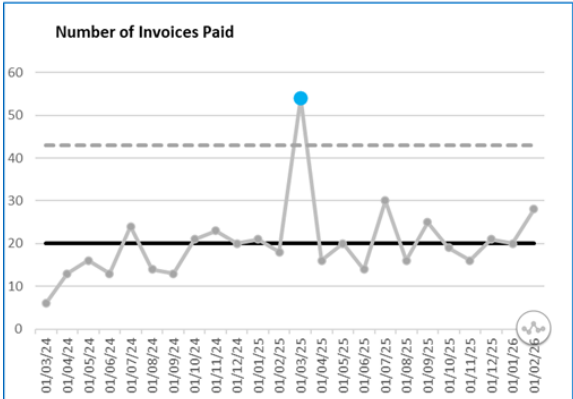
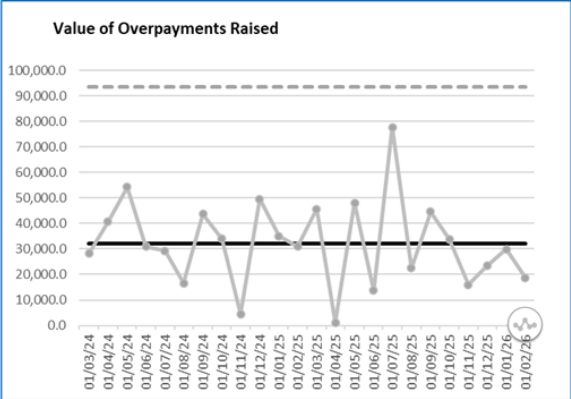
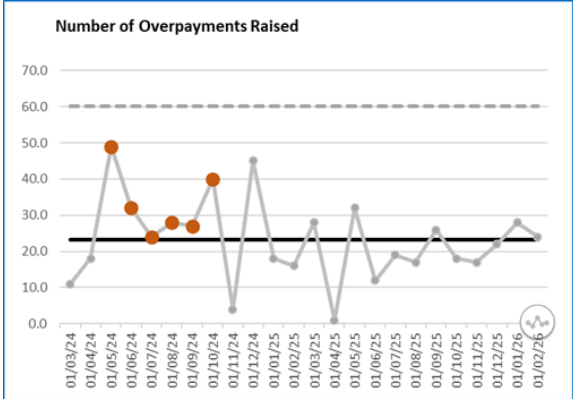
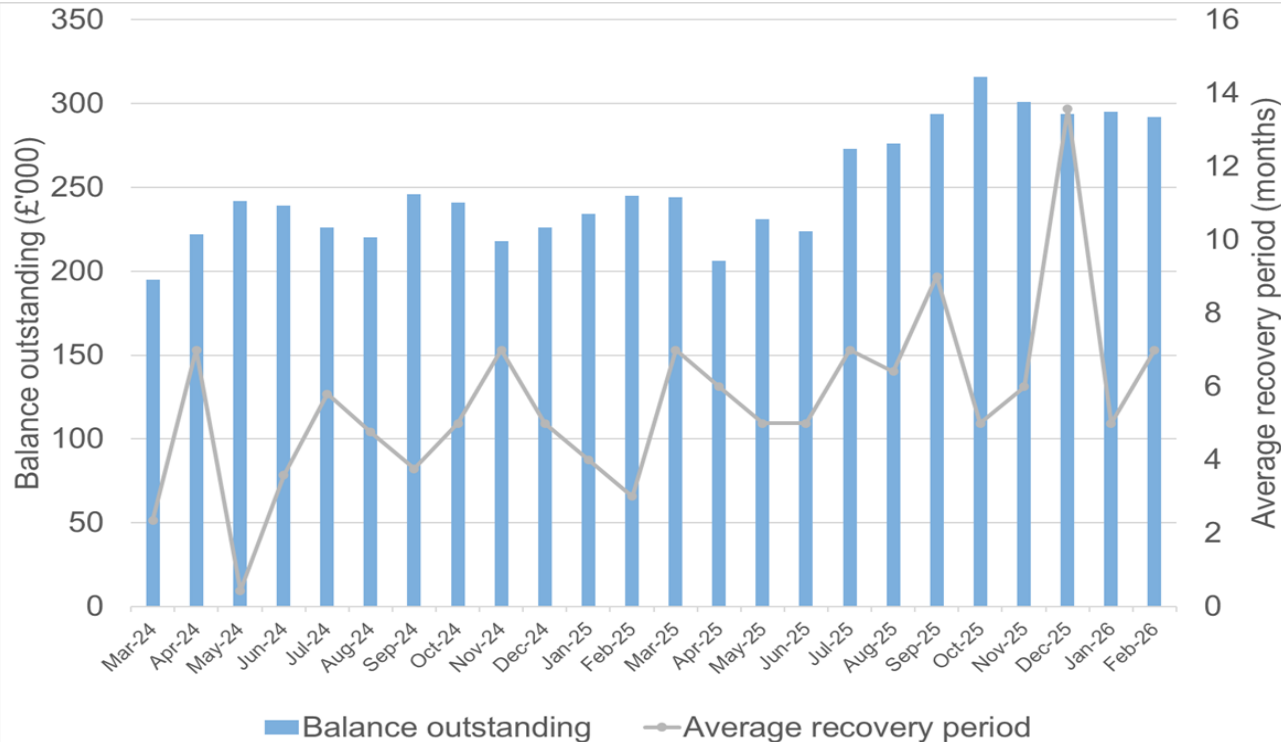
31 December: £292k; average
recovery period of 14 months

	Feb-26	Dec-25
Avg no of invoices raised	24	23
Avg value	£32k	£33.5k
Avg no paid	20	19
Avg value	£30k	£30k

Underpayments
January and February
2026 - £7,948

November and
December 2025 -
£22,511

Trend of aged overpayments and recoveries



4a. Losses and Special Payments



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

**Losses £5k and
over requiring
ARAC Approval**

**January and February 2026
£13,050**

*November and December 2025
£5,316*

**Losses under £5k
approved by DoF
and CEO**

**January and February 2026
£26,234**

(Appendix 3)
*November and December 2025
£27,590*

Losses – Requiring Approval from ARAC	£
Overseas Patient – collection efforts exhausted/legal recommendation to write off	7,950
Pharmacy wastage – WGH expired stock; change in treatment recommendation led to product being redundant (subsequently expired)	5,100
All Other Losses	
Ex gratia	244
Overpayments of salaries, salary sacrifice, accommodation, Wagestream, private patient income etc	7,631
4b Other causes* - expired stock, wastage, breakages	18,359
Total Losses	39,284

* 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

4b. Losses and Special Payments (continued)



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Special Payments – Ex Gratia (requiring Welsh Government approval)

Healthcare Support Workers (HCSW) – Band 2/3 status

The special payment relates to a national review of HCSWs focusing on their original Band 2 status and clinical work that may have been completed previously in line with Band 3 duties as per the Agenda for Change national profile for Band 3.

The Health Board engaged in All Wales discussions in respect of a framework agreement, recognising there would be a resulting liability to resolve the grievances raised, informed by latest national discussions and an initial local assessment of the workforce affected and principles to be applied.

The national discussions in respect of a framework agreement were subsequently developed to include both a Recognition payment and a Corrective payment, to be paid to all eligible staff. It is the Recognition payment that is deemed to be classified as a Special Payment, ex gratia.

Latest figures for Recognition payments are £3.4m, payable to 1,058 staff. The payment process is currently live with calculations and payments being processed by the NWSSP Payroll Team. The majority of staff affected were paid in February, with further payments in March and April. There is an ongoing review process as staff raise queries in respect of payments therefore the final position has yet to be finalised.

Further details are provided in **Appendix 4**.

5. Other Areas



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Compliance with Capital Requirements

Capital Scheme of Delegation - general

The Capital Scheme of Delegation reflects the requirement for the appropriate individual within the organisation to have delegated powers. In this instance, an amendment has been made to replace an Assistant Director of Finance with the Executive Director of Strategy and Planning. This is for the approval of requisitions up to £1m for schemes that have already been agreed via the Capital approval process and pre-approved by the Head of Capital Planning for assurance of their validity. All requisitions in excess of £1m require one-off limit increase approval by the Director of Finance. Approval by the Committee for ratification by the Board is required.

Capital Scheme of Delegation – specific to the Withybush Fire Scheme Phase 2 and Bronglais Fire Scheme

To ensure any variations to construction contracts are managed in a timely manner there is a requirement to specify limits of approval. These have been approved by the Executive Director of Strategy and Planning as Senior Responsible Office for the Project and are detailed in **Appendix 5** for noting.

Project Bank Account (PBA)

The Withybush Fire Scheme Upgrade Phase 2 project meets the criteria for use of a Project Bank Account (PBA). The contractor has set up an account with Barclays, which WG has confirmed is a compliant provider, and the first payment for the construction phase will be made in March 2026.

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 – the Financial Accounting Team is currently completing the draft Accounts for submission to WG by **1 May 2026**. The draft Accounts together with draft Remuneration Report, Accountability Report and Performance Report will be presented to ARAC on **7 May 2026**.

Audit Wales are proposing audit certification of the 2025/26 annual accounts on **26 June 2026**.



Appendices 1-3

Appendix 1a: Contracts awarded

Contracts Awarded Post Competitive Tender:

P Reference & Title	P0325 - Autism Diagnostic Assessments - Children (Ad Hoc)
Supplier	Healios
Contract Period	19/01/2026 to 18/01/2028
Value	£4,000,000.00
Department	Mental Health and Learning Disabilities
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	27/11/2025
Compliant	Y
Comment	Following a competitive tender, Healios were awarded a 24 month contract for Autism Diagnostic Assessments - Children (Ad Hoc). An option to extend the contract for a further 24 months is included in the award.

P Reference & Title	P0244CA - Design Team for BGH Fire Scheme
Supplier	Part B Group Limited
Contract Period	01/02/2026 to 31/08/2029
Value	£1,566,388.00
Department	Capital Planning / Estates
Professional Services (Yes/No)	Yes
Date of Board Approval (If Applicable)	27/11/2025
Compliant	Y
Comment	Following a competitive tender, Part B Group Limited were awarded a 42 month contract for a Design Team for the BGH Fire Scheme. This contract award does not allow for an extension.

P Reference & Title	P0432 – Citrix Hardware Replacement
Supplier	Softcat Plc
Contract Period	01/03/2026 to 31/10/2030
Value	£995,094.20
Department	Digital Services
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	29/01/2026
Compliant	Y
Comment	Following a competitive tender, Softcat Plc were awarded a 55 month contract for a Citrix Hardware Replacement. An option to extend the contract for a further 12 months is included in the award.

P Reference & Title	P0433 - Digital Carts on Wheels (COWs) Requirement
Supplier	Probrand Limited
Contract Period	16/02/2026 to 31/03/2029
Value	£612,000.00
Department	Digital Services
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Following a competitive tender, Probrand Limited were awarded a 36 month contract for a Digital Carts on Wheels (COWs) Requirement. An option to extend the contract for a further 12 months is included in the award.

P Reference & Title	P0355 - Project Manager for the Major Infrastructure Scheme at GGH
Supplier	Provelio Limited
Contract Period	01/03/2026 to 28/02/2030
Value	£450.111.06
Department	Capital Planning / Estates
Professional Services (Yes/No)	Yes
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Following a competitive tender, Provelio Limited were awarded a 48 month contract for a Project Manager for the Major Infrastructure Scheme at GGH. An option to extend the contract for a further 12 months is included in the award.

P Reference & Title	P0443 - Insourcing of Diagnostic Procedures
Supplier	ID Medical Group
Contract Period	09/02/2026 to 31/03/2026
Value	£400,000.00
Department	Scheduled Care
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Following a competitive tender, ID Medical Group were awarded a 2 month contract for the Insourcing of Diagnostic Procedures. An option to extend the contract for a further 12 months is included in the award.

P Reference & Title	P0154A - Cancer Services Hair Loss Support
Supplier	Caring Hair (Cancer Hair Care)
Contract Period	01/02/2026 to 31/01/2028
Value	£363,476.00
Department	Oncology
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Following a competitive tender, Caring Hair (Cancer Hair Care) were awarded a 24 month contract for Cancer Services Hair Loss Support. An option to extend the contract for a further 24 months is included in the award.

P Reference & Title	P0244D - Site Supervisor for the WGH Fire Scheme
Supplier	Drac Consulting Limited
Contract Period	09/02/2026 to 08/02/2028
Value	£90,914.85
Department	Capital Planning / Estates
Professional Services (Yes/No)	Yes
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Following a competitive tender, Drac Consulting Limited were awarded a 24 month contract for a Site Supervisor for the WGH Fire Scheme. This contract award does not allow for an extension.

Reference & Title	P0176A - Stakeholder Management Tool Renewal
Supplier	Tractivity Limited
Contract Period	30/03/2026 to 29/03/2028
Value	£27,500.00
Department	Digital Services
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Following a procurement exercise, Tractivity Limited were awarded a 24 month contract for a Stakeholder Management Tool Renewal. This contract award does not allow for an extension.

Reference & Title	P0377B - Bundle Docs Renewal
Supplier	Meditati Ltd T/A Bundledocs
Contract Period	06/02/2026 to 05/02/2029
Value	£25,858.44
Department	Digital Services
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Following a procurement exercise, Meditati Ltd T/A Bundledocs were awarded a 36 month contract for a Bundle Docs Renewal. This contract award does not allow for an extension.

Reference & Title	P0185 - Phlebotomy Booking Service Subscription
Supplier	BookingLab
Contract Period	01/03/2026 to 28/02/2028
Value	£25,000.00
Department	Digital Services
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Following a procurement exercise, BookingLab were awarded a 24 month contract for a Phlebotomy Booking Service Subscription. This contract award does not allow for an extension.

Direct awards via Framework Agreements:

P Reference & Title	P0109A - Digital Dictation Platform Renewal
Supplier	Norty Limited TA T-Pro
Framework Utilised	NHS Shared Business Services (SBS) Digital Dictation, Speech Recognition and Outsourced Transcription Framework Agreement (SBS/20/SM/WCC/9423)
Contract Period	26/04/2026 to 25/04/2028
Value	£613,934.64
Department	Digital Services
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	A direct award via the NHS SBS Digital Dictation, Speech Recognition and Outsourced Transcription Framework Agreement has been awarded to Norty Limited TA T-Pro for a Digital Dictation Platform Renewal for 24 months. An option to extend the contract for a further 12 months is included in the award.

P Reference & Title	P0434 - Wireless Access Points (WAP) Hardware Replacement
Supplier	Khipu Networks Limited
Framework Utilised	NHS SBS Digital Workplace Solutions 2 Framework Agreement (SBS10510)
Contract Period	30/03/2026 to 29/03/2029
Value	£541,453.70
Department	Digital Services
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	A direct award via the NHS SBS Digital Workplace Solutions 2 Framework Agreement has been awarded to Khipu Networks Limited for a Wireless Access Points (WAP) Hardware Replacement for 36 months. This contract award does not allow for an extension.

P Reference & Title	P0163A - Telephony Modernisation Subscription Based Model
Supplier	Maintel Europe Limited
Framework Utilised	Crown Commercial Services (CCS) Network Services Three (3) Framework Agreement (RM6116)
Contract Period	01/01/2026 to 30/09/2026
Value	£361,959.70
Department	Digital Services
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	A direct award via the CCS Network Services Three (3) Framework Agreement has been awarded to Maintel Europe Limited for a Telephony Modernisation Subscription Based Model for 9 months. This contract award does not allow for an extension.

P Reference & Title	P0442 - Simulation Suite Within Carmarthen Hwb
Supplier	Laerdal Medical Limited
Framework Utilised	NHS Supply Chain (NHSSC) Simulation Devices and Services Framework Agreement (2022/S 000-031912)
Contract Period	27/03/2026 to 26/03/2031
Value	£137,877.77
Department	Digital Services
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	A direct award via the NHSSC Simulation Devices and Services Framework Agreement has been awarded to Laerdal Medical Limited for a Simulation Suite Within Carmarthen Hwb for 60 months. This contract award does not allow for an extension.

Direct awards via VEAT/Transparency Process: None to report

Awards reported retrospectively: None to report

Appendix 1b: Breaches of SFIs

Title	Installation, Testing and Commissioning of Upgraded Medical Gas Pipeline System at Withybush General Hospital
Supplier	M&M Medical
Month/Year	January 2026
Value	£58,104.00
Spend classification	Capital Expenditure
Comment	In the month of January 2026, a retrospective purchase order was raised to M&M Medical for the Installation, Testing and Commissioning of Upgraded Medical Gas Pipeline System at Withybush General Hospital. The total value of the purchase order was £58,104.00. This breach of Standing Financial Instructions sits within the Capital Expenditure Directorate.
Action Taken	Escalated for Re-Education, and Relevant Director Informed for Awareness and Action

Title	Support the Development of an Addendum to the Original - A Healthier Mid and West Wales: Programme Business Case
Supplier	Strategic Healthcare Planning
Month/Year	February 2026
Value	£25,000.00
Department	Strategy and Planning Directorate
Comment	In the month of February 2026, a retrospective purchase order was raised to Strategic Healthcare Planning to Support the Development of an Addendum to the Original - A Healthier Mid and West Wales: Programme Business Case. The total value of the purchase order was £25,000.00. This breach of Standing Financial Instructions sits within the Strategy and Planning Directorate.
Action Taken	Escalated for Re-Education, and Relevant Director Informed for Awareness and Action

Title	Technically and Clinically Validated Deployment at a Test Site in West Wales to Demonstrate the Whyze Health AI Platform to Identify and Manage Cardiovascular Risk
Supplier	Whyze Health Limited
Month/Year	February 2026
Value	£20,000.00
Department	Medical Directorate
Comment	In the month of February 2026, a retrospective purchase order was raised to Whyze Health Limited for a Technically and Clinically Validated Deployment at a Test Site in West Wales to Demonstrate the Whyze Health AI Platform to Identify and Manage Cardiovascular Risk. The total value of the purchase order was £20,000.00. This breach of Standing Financial Instructions sits within the Medical Directorate.
Action Taken	Escalated for Re-Education, and Relevant Director Informed for Awareness and Action

Title	Prepare an Addendum to the Original - A Healthier Mid and West Wales: Programme Business Case
Supplier	Building Design Partnership Limited
Month/Year	February 2026
Value	£14,150.00
Department	Strategy and Planning Directorate
Comment	In the month of February 2026, a retrospective purchase order was raised to Building Design Partnership Limited to Prepare an Addendum to the Original - A Healthier Mid and West Wales: Programme Business Case. The total value of the purchase order was £14,150.00. This breach of Standing Financial Instructions sits within the Strategy and Planning Directorate.
Action Taken	Escalated for Re-Education, and Relevant Director Informed for Awareness and Action

Title	Installation and Refresh of Line Markings at Bronglais General Hospital
Supplier	Glamorgan White Lining
Month/Year	January 2026
Value	£9,350.00
Department	Community and Integrated Medicine Directorate
Comment	In the month of January 2026, a retrospective purchase order was raised to Glamorgan White Lining for the Installation and Refresh of Line Markings at Bronglais General Hospital. The total value of the purchase order was £9,350.00. This breach of Standing Financial Instructions sits within the Community and Integrated Medicine Directorate.
Action Taken	Escalated for Re-Education, and Relevant Director Informed for Awareness and Action

Title	Prepare Updated Cost Schedule for PBC Addendum
Supplier	Gleeds Cost Management Limited
Month/Year	February 2026
Value	£6,441.96
Department	Strategy and Planning Directorate
Comment	In the month of February 2026, a retrospective purchase order was raised to Gleeds Cost Management Limited to Prepare Updated Cost Schedule for PBC Addendum. The total value of the purchase order was £6,441.96. This breach of Standing Financial Instructions sits within the Strategy and Planning Directorate.
Action Taken	Escalated for Re-Education, and Relevant Director Informed for Awareness and Action

Title	Payment of Academic Tuition Fees 2025-2026
Supplier	Cardiff & Vale College
Month/Year	January 2026
Value	£5,950.00
Department	Workforce and Organisational Development Directorate
Comment	In the month of January 2026, a retrospective purchase order was raised to Cardiff & Vale College for the Payment of Academic Tuition Fees 2025-2026. The total value of the purchase order was £5,950.00. This breach of Standing Financial Instructions sits within the Workforce and Organisational Development Directorate.
Action Taken	Escalated for Re-Education, and Relevant Director Informed for Awareness and Action

Appendix 2: Overpayment of Salaries

	Period covered by this report: 1 January 26 – 28 February 26		
Ref	Reason for Overpayment	Value (£)	Number of invoices
1	Processing Error	1,819.67	4
2	Late Notification of Changes	14,416.57	22
3	Late Notification of Termination	29,091.63	21
4	Late Notification of Absence	2,011.40	3
5	No Notification of Return to Work	1,270.25	2
		48,609.52	52

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

2025/26 WRITE OFF LIST		
Period covered by this report:	1st January to 28 February 2026	
Losses and Special Payments Category	Value (£)	Explanation
OVERSEAS PATIENT	4,274.00	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
Total Write Off	4,274.00	
4b Other	1,256.53	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	1,336.50	P11-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	1,881.00	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
Total Other/Ex Gratia	4,474.03	
Total	8,748.03	

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

2025/26	WRITE OFF LIST		
Period covered by this report:		1st January to 28 February 2026	
Losses and Special Payments Category	Value (£)	Explanation	
OVERPAYMENT OF SALARY	0.01	UNDERPAID OF INVOICE	
OVERPAYMENT OF SALARY	0.02	UNDERPAID OF INVOICE	
OVERPAYMENT OF SALARY	0.02	UNDERPAID OF INVOICE	
OVERPAYMENT OF SALARY	0.02	UNDERPAID OF INVOICE	
LOCAL AUTHORITY	0.04	UNDERPAID OF INVOICE	
LOCAL AUTHORITY	0.04	UNDERPAID OF INVOICE	
PRIVATE PATIENT	0.64	UNDERPAID OF INVOICE	
OVERPAYMENT OF SALARY	2.11	UNDERPAID OF INVOICE	
WAGESTREAM	4.48	UNDERPAID OF INVOICE	
OVERSEAS PATIENT	10.00	FEE ON OVERSEA PAYMENT	
WAGESTREAM	43.07	COLLECTION EFFORTS EXHAUSTED - NOT VIABLE FOR CCI	
OVERPAYMENT OF SALARY	59.20	COLLECTION EFFORTS EXHAUSTED - NOT VIABLE FOR CCI	
WAGESTREAM	62.35	COLLECTION EFFORTS EXHAUSTED - NOT VIABLE FOR CCI	
SALARY SACRIFICE	115.75	CCI COLLECTION EFFORTS EXHAUSTED - RECOMMEND WRITE OFF	
OVERPAYMENT OF SALARY	124.90	CCI COLLECTION EFFORTS EXHAUSTED - RECOMMEND WRITE OFF	
OVERPAYMENT OF SALARY	146.13	CCI COLLECTION EFFORTS EXHAUSTED - RECOMMEND WRITE OFF	
PRIVATE PATIENT	172.93	CCI COLLECTION EFFORTS EXHAUSTED - RECOMMEND WRITE OFF	
OVERPAYMENT OF SALARY	271.26	DEBTOR HAS DECEASED	
OVERSEAS PATIENT	325.00	CCI COLLECTION EFFORTS EXHAUSTED - RECOMMEND WRITE OFF	
SALARY SACRIFICE	349.99	CCI COLLECTION EFFORTS EXHAUSTED - RECOMMEND WRITE OFF	
OVERPAYMENT OF SALARY	388.03	DEBTOR HAS DECEASED	
OVERSEAS PATIENT	420.79	CCI COLLECTION EFFORTS EXHAUSTED - RECOMMEND WRITE OFF	
OVERPAYMENT OF SALARY	860.58	CCI COLLECTION EFFORTS EXHAUSTED - RECOMMEND WRITE OFF	
Total Write Off	3,357.36		
4b Other	-	98.35 P11-26 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other		0.01 P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other		0.02 P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other		0.03 P11-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH	
4b Other		0.04 P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other		0.04 P11-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH	
4b Other		0.04 P11-26 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other		0.05 P11-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH	
4b Other		0.05 P11-26 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other		0.06 P10-26 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other		0.06 P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other		0.06 P11-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH	
4b Other		0.06 P11-26 Prince Philip Hospital~~P EXPIRED STOCK PPH	
4b Other		0.06 P11-26 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other		0.07 P11-26 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other		0.08 P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other		0.09 P10-26 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other		0.10 P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH	
4b Other		0.10 P11-26 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other		0.11 P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other		0.12 P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other		0.13 P10-26 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other		0.14 P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other		0.14 P11-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH	
4b Other		0.14 P11-26 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other		0.15 P11-26 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other		0.18 P11-26 Prince Philip Hospital~~P EXPIRED STOCK PPH	
4b Other		0.19 P10-26 Prince Philip Hospital~~P EXPIRED STOCK PPH	
4b Other		0.21 P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other		0.21 P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH	
4b Other		0.22 P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH	
4b Other		0.23 P10-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH	
4b Other		0.24 P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other		0.24 P11-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH	
4b Other		0.27 P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other		0.30 P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other		0.32 P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other		0.33 P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH	
4b Other		0.35 P10-26 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other		0.35 P10-26 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other		0.35 P11-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH	
4b Other		0.36 P10-26 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other		0.36 P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other		0.39 P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH	

	4b Other	4.90	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	5.21	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	5.23	P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	5.29	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	5.57	P10-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	5.59	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	5.75	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	5.79	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	11 EX-GRATIA	6.00	Travel costs for cancelled appointment - RE
	4b Other	6.25	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	6.47	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	6.48	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	6.71	P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	6.79	P10-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	6.82	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	6.94	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	7.09	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	7.49	P11-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	7.50	P10-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	7.52	P11-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	7.54	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	7.55	P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	7.56	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	7.71	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	8.03	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	8.26	P11-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	8.28	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	8.36	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	8.40	P11-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	8.40	P11-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	8.52	P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	8.63	P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	8.68	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	9.09	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	9.16	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	9.18	P11-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	9.38	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	9.44	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	9.60	P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	10.25	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	10.26	P11-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	10.28	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	10.83	P11-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	11.09	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	11.20	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	11.23	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	11.40	P10-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	11.40	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	11.48	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	11.60	P11-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	12.47	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	12.48	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	12.63	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	12.70	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	13.02	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	13.39	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	13.92	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	14.40	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	14.40	P11-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	14.62	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	14.78	P11-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	14.78	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	14.89	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	15.53	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	16.63	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	17.18	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	17.20	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	17.70	P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	17.82	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	18.26	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	18.90	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	19.20	P10-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	19.25	P11-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	19.63	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	11 EX-GRATIA	20.50	Travel costs for cancelled appointment - CS
	4b Other	20.65	P11-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	20.65	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	20.83	P11-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	21.00	P10-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	21.00	P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	21.11	P11-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	21.60	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	21.72	P11-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	21.83	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	22.07	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	22.31	P10-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	22.31	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	22.37	P10-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	22.80	P10-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	22.91	P10-26 Bronglais Hospital~~B EXPIRED STOCK BGH

	4b Other	23.52	P10-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	24.00	P11-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	24.18	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	24.51	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	24.94	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	25.50	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	25.71	P10-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	26.07	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	11 EX-GRATIA	26.50	Travel costs for cancelled appointment - MF
	4b Other	26.55	P10-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	26.82	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	11 EX-GRATIA	27.50	Travel costs for cancelled appointment - JG
	4b Other	27.60	P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	28.26	P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	28.68	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	28.97	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	29.32	P10-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	29.48	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	30.56	P10-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	30.76	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	30.83	P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	31.86	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	31.93	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	32.04	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	32.40	P11-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	33.00	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	33.00	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	11 EX-GRATIA	33.50	Travel costs for cancelled appointment - ZM
	4b Other	33.84	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	33.98	P11-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	34.28	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	35.66	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	35.72	P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	36.00	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	38.18	P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	38.57	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	38.72	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	38.81	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	39.74	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	42.00	P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	42.24	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	43.02	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	43.37	P11-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	45.60	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	45.76	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	46.98	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	47.17	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	11 EX-GRATIA	50.00	Float for H.Serv Shop Trolley
	4b Other	50.40	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	54.00	P10-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	55.20	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	57.60	P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	57.60	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	58.62	P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	60.18	P10-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	61.20	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	62.02	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	69.09	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	69.22	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	69.70	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	72.00	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	74.64	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	76.43	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	76.76	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	11 EX-GRATIA	80.00	Ex-Gratia - lost property
	4b Other	80.25	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	81.31	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	81.62	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	82.32	P11-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	90.00	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	92.69	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	93.60	P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	95.48	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	96.00	P11-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	96.34	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	99.05	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	100.80	P11-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	101.95	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	104.21	P11-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	113.02	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	114.00	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	122.26	P10-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	130.20	P11-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	137.40	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	141.40	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	143.71	P10-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	147.04	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	152.85	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	162.61	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	162.61	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH

4b Other	169.20	P10-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
4b Other	179.18	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	179.18	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	186.00	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	188.35	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	192.00	P11-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	210.69	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	220.80	P10-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
4b Other	241.90	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	259.50	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	297.00	P11-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	316.22	P11-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	325.22	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	346.18	P11-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
4b Other	384.00	P10-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	438.16	P11-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
4b Other	477.60	P10-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
4b Other	503.58	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	527.40	P10-26 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	839.10	P11-26 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	866.88	P11-26 Bronglais Hospital~~B EXPIRED STOCK BGH
Sub total	14,128.65	
Total	17,486.01	



Appendix 4a

Losses and Special Payments

Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for NHS Wales or passed legislation. By their nature they are items that ideally should not arise. They are, therefore, subject to special control procedures compared with the generality of payments, and special notation in the accounts to draw them to the attention of the Welsh Government.

Special payments are those which fall outside the normal day-to-day business of the health body, or exceptionally, those for which no statutory authority exists. They fall into one of four main categories:

- compensation payments made under legal obligation;
- extra contractual payments to contractors;
- ex-gratia payments; and
- extra statutory or extra regulatory payments.

The Health Board assessment is that the recognition payment made to eligible Health Care Support Workers falls within the Manual for Accounts definition of an ex-gratia payment.

Recognition and Corrective Payments made to eligible Health Care Support Workers

In July 2021 minor changes were made by the NHS Staff Council to provide clarification on the important differences between the Band 2 and Band 3 national job profiles. Hywel Dda in common with several other organisations, including in England and Scotland, received requests for review of banding since these profiles were issued.

This culminated in summer 2024 with NHS Wales Employers being asked to seek a national agreement in terms of Job Description and process for review of banding and to seek a without prejudice settlement/collective agreement on a “backstop” for backdating.

An Employers Reference group was established comprising workforce, finance and nursing colleagues. The national approach has been closely aligned to that taken in England, with learning noted in relation to expected workforce design going forward and the importance of individual role profiling being undertaken.

In July 2025 NHS Wales Job Descriptions for the relevant roles affected were agreed through Welsh Partnership Forum. An Implementation Framework, developed to support the consistent application of the national Job Descriptions, was finalised in November 2025. The framework agreement includes both a Recognition payment and Corrective payment, to be paid to all eligible staff.

Assessment of Recognition Payment in Hywel Dda

Work had already been undertaken to commence the process within Hywel Dda, (to the extent that a provision was made in the 2024/25 accounts) communications with

staff were well established and the review of roles had already been undertaken to enable the detailed, person by person assessment to be worked through and validated. The necessary information for the majority of affected staff was finalised in time for submission to Payroll in December to enable payment of staff in February's payroll. There are further payments to be made.

The latest figure for the recognition payment is £3.4m payable to 1,058 staff.

There is an ongoing review process in train as staff raise queries in respect of payments therefore the final position has yet to be established. An updated figure will be provided to Welsh Government once a reasonable provision for the outstanding queries is made to include in the 2025/26 accounts.

The Losses proforma required for submission to Welsh Government providing further details is attached as **Appendix 4b**.

SUBMISSION TO WG

Category –

Type of case - 7E Other

Reference number –

Health Body (name and code) – Hywel Dda University Health Board

1. Record the amount involved and the reasons why the loss arose.

- This payment relates to a national review of Healthcare Support Workers and their original band 2 status.
- Latest figures for Recognition payments are £3.4m, payable to 1058 staff. The payment process is currently live, calculations and payments are being processed by the NWSSP Payroll Team. The majority of staff affected were paid in February, with further payments in March and April. There is an ongoing review process in train as staff raise queries in respect of payments therefore the final position has yet to be finalised.
- As per Board Paper provided in Appendix 1 the Health Board approved for the Health Board to engage in All Wales discussions in respect of a framework agreement, and recognised there would be resulting liability to resolve the grievances raised, informed by latest national discussions and an initial local assessment of the workforce affected and principles to be applied.
- The national discussions in respect of a framework agreement were subsequently developed to include both a Recognition payment and Corrective payment, to be paid to all eligible staff.
- The payments reflects the clinical work that may have been completed previously in line with the Band 3 duties as per the Agenda for Change national profile for Band 3.
- The Health Board assessment is that the recognition payment is as per the Manual of Accounts an Ex Gratia payment. This means that it is a payment which a health body is not obliged to make or for which there is no statutory cover or legal liability.
- The Health Board recommendation is that the Recognition Payment element of the Local agreement is classified as a:
 - Special payment
 - Ex gratia payment
 - Category Other = 7e
- The standard Agenda for Change pay upgrade and associated arrears, which would go back to 1st January 2025, would feed through the staff cost lines in Note 3.3 within the annual accounts and do not meet the definition of a special payment.

2. Detail the background of case giving full reason why payment is necessary. Have other alternatives to the payment been investigated? If not, why not? If so, provide details.

In July 2021 minor changes in wording were agreed by the NHS Staff Council to provide clarification on the important differences between the band 2 and band 3 national job profiles, not to change the essence of the profiles themselves. The band 2 profile is concerned with personal care whereas the band 3 profile is concerned with a limited range of clinical tasks carried out under supervision.

These profiles, together with guidance for employers and matching panels, were issued in August 2021. All employers were asked to ensure that they had reviewed the roles in their organisations against these profiles and to ensure that the duties being undertaken were in line with the relevant Job Descriptions.

A number of organisations reported having received requests for review of banding either from individuals or from groups since these profiles were issued. HDUHB also received such requests.

Unison have run a “Pay fair for patient care” campaign since 2021. In England it has taken an employer-by-employer approach and reports having secured more than 40 deals and around £80m in back pay following extensive strike action. In England organisations defend and/or settle claims on an individual organisation basis while Scotland took the decision to negotiate on a national basis and have had no disputes or industrial action.

England has seen significant claims and associated settlements with some reaching 4 years of backdating to 2018 (Greater Manchester settled in 2022 backdating to 2018). Strike Action continues in several organisations e.g. September 2024 48-hour strike in Lewisham and Greenwich NHS Foundation Trust (Unison fighting for backpay to 2018), strikes in several Foundation Trusts and Trusts in 2024.

Scotland reached collective agreement in 2022 with a backstop of backpay to 2021 and a timebound framework for implementation of the review process.

The collective Trade Union position was, in summary:

- Review of banding for all Band 2 workers in scope
- Re banding to Band 3 to be offered to Band 2 workers undertaking Band 3 duties
- Either all placed on the top of Band 3 or protection of earnings to ensure no detriment
- Backdating of the difference for up to 6 years if the worker can demonstrate they have been undertaking these tasks
- If a Band 2 worker does not want to move to Band 3, they must not be moved.

In summer 2024, following an indication from the Trade Unions that significant resource was being invested in developing campaigns in Wales and notification of the first significant claims being submitted to one of the Health Boards, NHS Wales Employers was asked to seek a national agreement in terms of Job Description and process for review of banding and to seek a without prejudice settlement/collective agreement on a

“backstop” for backdating.

An Employers Reference group was established comprising workforce, finance and nursing colleagues. The national approach has been closely aligned to that taken in England, with learning noted in relation to expected workforce design going forward and the importance of individual role profiling being undertaken.

As of July 2025 NHS Wales Job Descriptions for the relevant roles affected have been agreed, through Welsh Partnership Forum (WPF), in accordance with the Job Evaluation Scheme/ NHS Job Evaluation Policy. The Job Descriptions are consistent with those developed and agreed in Scotland and in those organisations in England where disputes have been settled.

In addition, a draft Implementation Framework was developed to support the consistent application of the national Job Descriptions. This Framework includes the requirement for national oversight of implementation and an assessment process development in partnership with Executive Directors of Nursing and Midwifery.

The Implementation Framework was finalised in November (Appendix 2). In readiness for this, work had already been undertaken to commence the process, communications with staff were well established and the review of roles had already been undertaken to enable the detailed, person by person assessment to be worked through and validated. The necessary information was finalised for 1074 people in time for submission to Payroll in December to enable payment of staff in February’s payroll.

Further discussions regarding the interpretation of the Implementation Framework at a national level, have resulted in additional staff being within scope. As such there was an additional cohort of staff identified as needing to be included in the review, these were progressed during February and details have been sent to Payroll for calculation, a further 46 people. The intention is for these staff to be paid in April.

3. **Was fraud involved?** If so, complete a fraud report and ensure that the LCFS, the relevant NHS CFS Wales team, Internal and External Auditors, and where relevant the police, are informed of the fraud in accordance with Welsh Government Directions to NHS Wales health bodies on Counter Fraud Measures and using the reporting system as specified by the NHS CFS Wales. Enter dates of completion of fraud report.

No

4. **Was theft or criminal damage involved?** If so, have the police been informed? If not, give the reasons why not? All security related incidents must be reported to the Local Security Management Specialist once trained, accredited and in place in accordance with forthcoming guidance issued by NHS Security Management Service.

No

5. **For abandoned works**, were detailed specifications identified before the scheme went ahead? How did the projected work compare to these detailed specifications? At what level, by whom, and why was the scheme approved? Why was the scheme abandoned and by whom? Could the scheme have been aborted earlier? Was the scheme joint financed? If so, was any agreement signed? Was legal advice taken in the drawing up of an agreement? Is the other party prepared to pay half of the costs of the scheme?

No

6. **For Bad Debts and Claims Abandoned.** Were invoices raised on a regular basis? Was the debt monitored and chased regularly? Were services withdrawn upon continued non-payment? Enclose report showing when invoices were raised and where relevant paid.

For cases involving businesses – has the business gone into liquidation/receivership? If so, are you listed as a creditor and do you have confirmation of this from the liquidator /receiver? If not, why not? Are any dividends being paid out? Was the financial integrity of the business looked into before goods or services were supplied? If not, why not and have procedures been revised to ensure this is carried out in the future?

No

7. **For rental cases only** – did the tenant enter into lease agreements prior to occupation? If not, why not? If the lease was faulty investigate whether action can be taken against legal advisors who drew up the agreement? Provide an analysis of rent and services charges.

N/A

8. **For private patients** cases was an undertaking to pay signed? If not, why not? Was a full estimate of potential costs given and full deposit taken to cover these costs? If not, why not?

For overseas private patient's cases – have the relevant embassies been contacted for payment (if applicable)? For overseas visitors, are robust procedures in place in the NHS Body to identify and charge liable overseas visitors? If not, why not? Was the overseas visitor informed that he/she would be liable to pay for the full cost of treatment? Was treatment, in a clinical opinion, immediately necessary or urgent? If treatment was not urgent, why was it given before obtaining a sizeable deposit?

N/A

9. **Stores (only)** – Are any linen losses calculated at 50% of the replacement value? Is this in accordance with the guidance? Is the total loss more than 5% of the total stock value? Confirm that the loss has been valued at book value less net disposal proceeds.

N/A

10. For extra contractual payments to contractors. Have other alternatives to the payment been investigated? If not, why not? If so, provide details. Provide detailed calculations on which the payment is based.

N/A

11. For ex gratia payments. Have other options been considered? If not, why not? Explain why an ex-gratia payment offers the best value for money. Confirm that the proposed payment does not place the claimant in a better position than if the error had not occurred? If it does, why? In cases of hardship record what evidence exists on this? Provide detailed calculations to support the proposed payment and demonstrate why the proposed sum is in accordance with the relevant paragraphs of this guidance. For settlements on termination of employment has relevant central guidance on such payments been followed in all respects? If not, why not? For clinical negligence and personal injury cases has the relevant central guidance for such cases been followed in all respects? If not, why not?

This ex gratia payment is directly linked to a national agreement of the Implementation Framework. The Recognition and Corrective payment elements were considered through the negotiations between Unions, NHS Employers and the Health Board.

12. Is the value of the loss reduced by insurance? If so, record the value of the gross loss and the value of the amount recovered by insurance.

N/A

13. Have all reasonable steps been taken to recover the loss? Provide details of the attempts that have been made to recover the loss or explain why no action has been taken. Has appropriate legal advice been sought? If not, why not? If advice has been sought, what recommendations were made and have these been followed? If not, why not?

N/A

14. Identify any failings in the actions of employees, including supervisors. Having considered this, is there a need for disciplinary action? Record what action has been taken or is proposed, or if no action is to be taken, explain why. Include dates, names of individuals and positions.

N/A

15. Was there any apparent breakdown of procedures? Detail weakness or fault in system of control or supervision.

Lessons learned exercise to be carried out nationally.

16. What proposed improvements have been put forward to correct defects in the existing systems or procedures? Include the timetable for implementation of the improvements. What monitoring measures have been introduced to ensure the improvements are working effectively?

Lessons learned exercise will determine any corrective action.

17. Is it necessary to inform the board/chief executive? If not, why not?

Board/ Executives briefed over the last 12 months and fully cognisant of issues.

18. Do your SFIs require a Board report for this case? If so, please enclose the report. If not, consider whether in the light of this case your SFIs should be amended to require a Board report in such cases.

19. Having completed the above steps, detail the general lessons that can be drawn from this case. If a system weakness has been identified which has possible implications across the NHS the LCFS or the NHS CFS Wales should report the problem to NHS Protect using either the intranet fraud prevention referral system for fraud or the Area Security Management Specialist for security matters so that measures can be taken nationally to amend policy or systems.

- No fraud evident
- Lessons learned exercise being undertaken which will reflect on local and national processes involved.

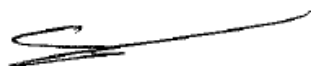
20. Please give details of name and position of person forwarding this case for Welsh Government approval (if applicable). Give the date when this case was first brought to the attention of the Welsh Government H&SSG FD (if applicable).

Name – Hywel Jones

Position – Director of Finance, Health, Social Care and Early Years Group

Date Welsh Government H&SSG FD notified – The MMR return for M09 2024/25 (Appendix 3) submitted January 2025 referenced the issue in the latest assessment of 2024/25 outturn and was acknowledged in the subsequent MMR Response Letter received from Hywel Jones

21. I have considered fully each point on this checklist and my findings are recorded in the attached case summary and/or in the spaces above. I confirm that the details recorded above and on the attached case summary are complete and accurate, and that all aspects of the checklist have been properly considered and actioned.



Signed by – Siân Jenkins, Deputy Director of Finance

22. I confirm that the above details are complete and accurate, and all aspects of the checklist have been properly considered and actioned. I agree that write off of this loss offers the best value for money for this case.

This case is novel, contentious or repercussive and I therefore request formal approval from the Welsh Government H&SSG FD

Signed by -

Date –

Countersigned by -

Date -

Please note this section must be signed by two senior officers in accordance with the delegated limits set by the board. Please print names and position held in the organisation.



Name - Phil Kloer

Position held – Chief Executive

Countersigned by - Huw Thomas

Position held – Director of Finance

23. Appendices

➤ Appendix 1 – Board Paper March 2025



9. HCSW Band 2-3
IC Board March 2025

➤ Appendix 2 – Implementation Framework



2025_11_14
Without Prejudice -

➤ Appendix 3 – MMR M09 2024/25



Private &
Confidential_ Hywel



Appendix 5

Scheme specific limits for Withybush Fire Scheme Phase 2 and Bronglais Fire

Limit	Original scope of fireworks	Increase in-year cashflow compared with budget	Any items which increase Scheme financial outturn	Assigned Officer	Additional Reporting requirements
Up to £10,000	✓	✗	✗	Consultant NEC Project Manager	
Up to £50,000	✓	✗	✗	Capital Development Manager	
Up to £100,000	✓	✓	✗	Assistant Project Director	Reporting to Capital Scheme Project Board
Up to £250,000	✓	✓	✗	Project Director Major Infrastructure Projects (Project Director)	Reporting to Capital Scheme Project Board and Capital Sub-Committee
Greater than £250,000 and all items which affect financial outturn	✓	✓	✓	Director of Strategy and Planning (Senior Responsible Officer)	Approval by Capital Sub Committee and reporting to Strategy and Planning Committee

6.2

12:05, 0 Mins

6.2 - Financial Grip and Control

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

DEFERRED to 7 May 2026 meeting

| For assurance

6.3

12:05, 5 Mins

6.3 - Counter Fraud Annual Report 2025/26

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

| For information

Attachments

[6.3 SBAR CF Annual Report.pdf](#)

[6.3 Counter Fraud Annual Report 2025-26.pdf](#)



PWYLLGOR ARCHWILIO A SICRWYDD RISG AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	14 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Counter Fraud Annual Report 2025/26
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
<u>Sefyllfa / Situation</u> 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) throughout 2025/26. 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 NHS Counter Fraud Authority standard areas.
<u>Cefndir / Background</u> To evidence the provision of services within a sound governance framework.
<u>Asesiad / Assessment</u> The Health Board is compliant with the Welsh Government Directives.
<u>Argymhelliad / Recommendation</u> The Audit and Risk Assurance Committee is invited to receive for information the Counter Fraud Annual Report 2025/26.

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

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

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



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

**HYWEL DDA UNIVERSITY
HEALTH BOARD**

**COUNTER FRAUD ANNUAL REPORT
2025/26**



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1 Introduction

Hywel Dda University Health Board maintains a professionally accredited Local Counter Fraud Service delivered by two full-time Local Counter Fraud Specialists (LCFS), who in 2025/26 provided 420 operational working days. This is some 20 days less than planned in the annual work plan, however, this is accounted for by way of annual leave purchased by the team and absence days through ill health. The 420 days worked in 2025/26 mirrors what was planned for and worked in 2024/25.

This service ensures that the organisation meets its statutory obligations in relation to fraud, bribery, and corruption. Historically, counter fraud activity was structured around four key principles under Welsh Government Directions:

Key Principle 1: Strategic Governance – ensuring robust governance arrangements that embed anti-crime measures at all levels of the organisation. This includes maintaining effective communication with senior leaders and ensuring ongoing oversight through the Audit and Risk Assurance Committee.

Key Principle 2: Inform and involve – promoting awareness of fraud risks across the Health Board to foster a workforce that is informed, vigilant, and intolerant of fraud, bribery, and corruption. Effective and varied communication channels will remain central to this principle.

Key Principle 3: Prevent and deter – identifying and mitigating anomalies indicative of fraud and developing a fraud-resistant environment that minimises opportunities for wrongdoing.

Key Principle 4: Hold to Account – ensuring that all suspicions of fraud are investigated promptly and professionally, with appropriate sanctions and redress applied to reinforce a zero-tolerance approach.

These principles continue to underpin the Health Board's counter fraud culture and remain essential to maintaining organisational resilience. However, as the national framework for NHS-funded services has evolved, the Health Board is now required to operate in full accordance with the Government Functional Standard GovS 013: Counter Fraud (GovS 013).

GovS 013 sets out mandatory expectations for managing fraud, bribery, and corruption across government and the wider public sector. The NHS Counter Fraud Authority (NHSCFA) provides oversight and requires organisations to complete an annual RAG-rated self-assessment (SRT), which is externally validated.

The report will seek to provide detail of the work carried out by the Health Board that relates to anti-fraud, bribery, and corruption over the preceding financial year. The Welsh Government directions and standards have been developed to support NHS organisations in implementing appropriate measures to counter fraud, bribery and corruption and are presented under the four key areas of work referenced above.

The report will demonstrate and highlight the work completed in line with the Government Functional Standards 013 – Counter Fraud and NHS Requirements to meet those standards is available at:

[Government Functional Standard 013 Counter Fraud | NHS Counter Fraud Authority | NHSCFA](#)

The report will also reference the SRT as part of the Quality Assurance process, which presents an overall RAG rating for each of the key areas of activity. The report style follows a prescribed format as recommended within the NHS Counter Fraud Authority's annual report template. The report gives details of work carried out by the LCFS. The information referred to in this report contributes to the Counter Fraud strategy for the Health Board.

The Counter Fraud Work Plan provides a more detailed account of the specific tasks undertaken by the Counter Fraud Officers. This Work Plan is used to inform the Audit and Risk Assurance Committee (ARAC), on a regular basis, of progress made against the planned activity throughout the year.

Table to illustrate Resource position 2025/26

AREA OF ACTIVITY	Resource Used (days)	Resource Used (%)
STRATEGIC GOVERNANCE	38 days	75%
INFORM AND INVOLVE	85 days	80%
PREVENT AND DETER	127 days	80%
HOLD TO ACCOUNT	170 days	75%
TOTAL	420	95%



Area	Days Used
Proactive work (Inform and Involve & Prevent and Deter)	250
Reactive work (Hold to account)	170

2 Management Summary

The main achievements highlighted in this report are as follows:

All key requirements of the Welsh Government Directions to NHS Bodies on Counter Fraud Measures have been achieved.

During 2025/26, the Counter Fraud Team carried over 11 active cases from the previous year and received and recorded 60 new referrals; of which, 60 investigations were undertaken and closed. 11 cases will remain open and under review at the end of this financial year and will be carried over into the next. Of the 11, 3 are at the stage where a Voluntary Interview Under Caution (VIUC) has either been completed or awaiting completion.

Of the investigations that were closed, 7 civil sanctions were instigated, including the recovery of funds totaling £99,627 and 2 internal disciplinary referrals. Of the 2 internal disciplinary referrals, 1 member of staff resigned prior to the completion of proceedings and 1 member of staff received a final written warning. This is in addition to the proactive activities undertaken and reported throughout the year.

It is noted that the number of referrals has increased from 55 during 2024/25 to 60 this year and this can be attributed to the introduction of mandatory training, an increase in pro-active work and the development of the Health Board's NHS Fraud Awareness programme.

It is important to note that not all referrals received were crimes, some of these would have been concerns or system weaknesses, which would have been reviewed and actioned accordingly.

In conjunction with the Health Board's Workforce and Organisational Development Directorate, all cases developed that were linked to a current employee were referred to the relevant workforce contact, and subsequent workforce reviews / disciplinary cases were completed following the sharing of intelligence around the Counter Fraud findings.



Additionally, as a matter of professional routine practice, where investigations involved members of professional bodies, referrals were made to each respective body, allowing them the opportunity to consider undertaking their own investigations with regards to the conduct of the specific individual involved. Such relationships and professional working practices will continue through the current working period, and continued liaison will remain for cases carried forward.

Communication and awareness development have been utilised on a targeted basis throughout the year. Training was provided to high-risk staff groups such as Procurement, Medical and Nursing teams, which includes Overseas Nurses and Doctors, and the Estates and Finance directorates. This sits alongside the mass awareness programme which utilised mass communications to deliver the counter fraud message via face-to-face awareness events, e-newsletters, social media, global email system, staff alerts and bulletin board.

There has been a notable increase in the number of staff contacting the Counter Fraud Team to request advice and assistance in relation to concerns around risk or system weaknesses. This meets the intended strategy of evolving the Team from being a contact to report 'when things go wrong', to a contact point to reach out to for mitigation advice and support.

The LCFS has continued to support the Corporate Governance Team in raising awareness around the requirements of the Standards of Behaviour Policy. Specifically, the requirement around Declaration of Interests and Gifts, Hospitality and Sponsorship.

The LCFS continue to work closely with NHS CFS Wales Regional Team to provide appropriate information and to liaise on all referrals with particular use made of the financial investigation capabilities of the Regional Team including use of Proceeds of Crime Act powers. Casework was reported on a quarterly basis for the NHS Counter Fraud Authority to monitor activity nationally.

Liaison between both internal and external auditors has been maintained, in conjunction with regular review of Audit Papers submitted by internal audit via ARAC. In addition, the Local Counter Fraud Champion and Board Secretary provide a governance link to the Counter Fraud Department, raising any concerns when appropriate.

Updates are presented and reviewed where audit reveals a potential fraud risk or system vulnerability for the Counter Fraud Team to assess. The key focus has been retained with fraud awareness and the improvement of early involvement of the Counter Fraud officers through partnership working as main priorities.



The application of recommendations identified at the conclusion of each Counter Fraud investigation is also considered essential in reducing the opportunities for loss through fraud. The Counter Fraud team, responding to a committee request, has strengthened how fraud risks and recommendations are monitored. A shared Counter Fraud / Assurance and Risk channel has been established, supported by a live Fraud Risk and Recommendations Report in Excel, which will be continually updated with new risks, actions taken, and responsible officers. This enables improved tracking of progress, outcomes, and review frequency, with regular summaries reported to the Audit and Risk Assurance Committee. All previously identified risks have now been migrated into this new system, meaning all future monitoring will follow the updated process as part of the 2026/27 workplan. To underpin these improvements, the team has also developed a Fraud Risk Strategy, setting out the organisation's approach to identifying, assessing, mitigating, and reporting fraud risks.

Greater communication between the LCFS and external organisations has continued to result in improved levels of intelligence, in accordance with Data Protection and legal sharing provisions, including greater collaboration between the Police and NHS Wales Shared Services Partnership (NWSSP) functions, such as Post Payment Verification (PPV).

The LCFS has strengthened collaborative working across the Health Board, ensuring consistent reporting of fraud cases and trends and reinforcing a zero-tolerance approach to fraud. They have identified and reported policy weaknesses in established fraud cases and worked with Corporate Governance to update the Standards of Behaviour policy and review the effectiveness of the Declaration of Interest process.

Targeted staff alerts and communications have significantly increased engagement, with more staff proactively seeking advice to mitigate fraud risks—demonstrating a positive cultural shift from reactive reporting to preventative support. The LCFS has also fraud-proofed internal policies and procedures in response to identified risks.

Through the recommenced Post Payment Verification (PPV) workplan and joint working with Primary Care leads, the team has identified a fraud case and secured civil recovery. A series of proactive exercises were undertaken relating to IR35 compliance, declarations of interest, medication dispensing, rostering, ID badge controls, right-to-work concerns, GOS claiming, and procurement breaches.



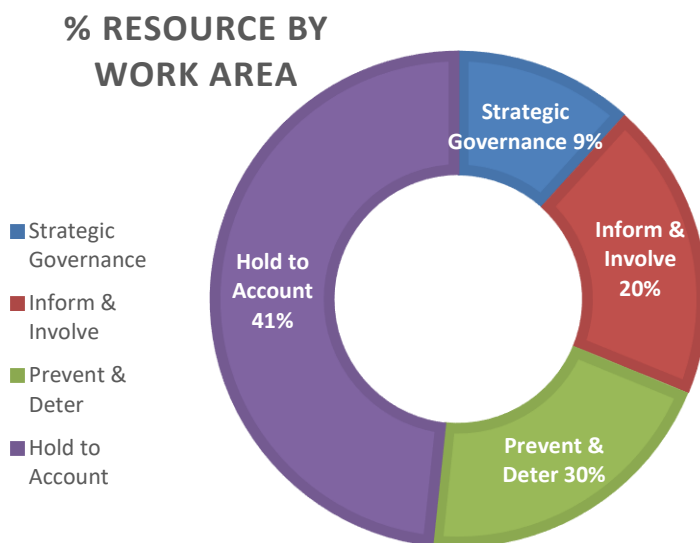
The team continued full participation in the National Fraud Initiative (NFI), contributing to national data-matching exercises led by Audit Wales and the Public Sector Fraud Authority. The latest NFI cycle supported the recovery of approximately £33,000.

The LCFS continue to develop and embed an anti-fraud culture across the Health Board through an ongoing programme of awareness, training, and engagement. A comprehensive suite of fraud awareness materials was delivered in multiple formats, including induction resources, mandatory ESR e-learning, and targeted sessions for higher-risk groups such as Estates, Medical Staffing, Primary Care teams, and student cohorts. Tailored virtual and face-to-face training was provided in partnership with relevant departments, with positive evaluation feedback used to further refine learning content.

Communication channels were enhanced, with increased use of Viva Engage, global messages, updated intranet pages, and digital newsletters, improving reach and staff engagement. Fraud Awareness Week was delivered both in person and online, supported by daily communications to staff and the public.

Over the year, the Counter Fraud Team delivered 39 awareness events, 44 deterrence exercises, and 19 fraud prevention activities, alongside an ESR mandatory training compliance rate of 83.14%. Additional presentations were delivered to Medicines Management teams and first-year Nursing Students at Aberystwyth University, embedding counter-fraud principles early in the professional education journey.

Area of Activity Overview



As per previous years, the 2025/26 work overview illustrates how a significant amount of work activity fell around the area of Hold to Account; however, there has been a slight decrease in time spent investigating crimes, with a shift towards more time being spent on proactive activities. It is hoped that this trend will continue, to a point where we are able to prevent more than we investigate.

3 Welsh Government Direction

The following grid identifies the key requirements under Welsh Government (WG) Directions July 2006 and outlines current activity within each section. The table illustrates that, in line with WG directions, supported through compliance with the standards for Wales, Hywel Dda University Health Board Counter Fraud provision is illustrating positive performance in delivery of its Counter Fraud Strategy.

Para.	Instruction	Action taken by health body
2 (1)	Each NHS body must take all necessary steps to counter fraud in the NHS in accordance with these Directions and in accordance with. (a) the NHS Counter Fraud and Corruption Manual; and (b) the policy statement “Applying appropriate sanctions consistently” published by the CFS, (c) and having regard to guidance or advice issued by the CFS.	Achieved
2 (2)	Each NHS body must require its Chief Executive and Director of Finance to monitor and ensure compliance with these Directions.	Achieved



Para.	Instruction	Action taken by health body
3 (1)	Each NHS body must co-operate with the CFS to enable the CFS efficiently and effectively to carry out its counter fraud functions and in particular each NHS body must, subject to the following paragraphs of this direction. (a) enable the CFS to have access to its premises. (b) put in place arrangements which will enable the CFS to have access, as appropriate, to the NHS body's staff; and (c) supply such information including files and other data (whether in electronic or manual form) as the CFS may require for the purposes of the CFS counter fraud functions.	Achieved
3 (2)	In the case of information required under paragraph (1)(c) in connection with the CFS responsibility for quality inspection, fraud measurement, National Proactive Exercises (NPEs) and fraud prevention reviews, inspections and instructions, an NHS body must respond to any request from the CFS as soon as reasonably practicable.	Achieved
3 (3)	In the case of information required under paragraph (1)(c) for the purposes of investigations relating to the CFS' counter fraud functions, an NHS body must respond to a request as soon as reasonably practicable and in any event within seven days from the date the request was made.	Achieved



Para.	Instruction	Action taken by health body
3 (4)	Nothing in paragraph 1(b) contravenes any right a member of staff may otherwise have to refuse to be interviewed.	N/A
3 (5)	Nothing in paragraph 1(c) or direction 7(f) obliges or permits an NHS body to supply information which is prohibited from disclosure by or under any enactment, rule of law or ruling of a court of competent jurisdiction or is protected by the common law.	N/A
3 (6)	Without prejudice to the generality of direction 2(1)(a), each NHS body must comply with the requirements specified in the NHS Counter Fraud and Corruption Manual concerning. (a) the arrangements for reporting fraud cases to the LCFS and to the NHS body's audit committee and auditors. (b) the arrangements for agreeing to undertake a criminal prosecution and to refer a matter to the police. (c) the confidentiality of information relevant to the investigation of suspected fraud. (d) the arrangements for the LCFS to report weaknesses in fraud related systems to the CFS and the NHS body's audit committee and auditors; and (e) the arrangements for gathering information to enable the Director of Finance to seek recovery of money lost through fraud.	Achieved
5 (1)	Each NHS body must nominate at least one person that it proposes to appoint as the body's LCFS within six weeks of the date on which these Directions come into force.	Achieved



Para.	Instruction	Action taken by health body
5 (2)	A person nominated under paragraph 5(1) may be either employed by the NHS body or a person whose services are supplied to it by an outside organisation.	Achieved
5 (3)	The name of the nominee must be notified to the CFSMS together with the information specified in the NHS Counter Fraud and Corruption Manual within 7 days of the nomination.	Achieved
5 (4)	Without prejudice to the generality of direction 2(1), before making a nomination each NHS body must consider any guidance issued by the CFSMS on the suitability criteria for an LCFS.	Achieved
5 (5)	After a nominee has. (a) been approved by the CFS as a person suitable for appointment. (b) successfully completed any training required by the CFS; and (c) been accredited by the Counter Fraud Professionals Accreditation Board, the NHS body may appoint the person as its LCFS.	Achieved



Para.	Instruction	Action taken by health body
5 (6)	Where an NHS body nominates a person, whose services are provided to it by an outside organisation, it must: (a) comply with the requirements of the CFS as to the suitability of the organisation in question. (b) satisfy itself and the CFS that the terms on which those services are provided are such as to enable the LCFS to carry out his functions effectively and efficiently and in particular that he will be able to devote sufficient time to that NHS body; and (c) give to the CFS a copy of the contract under which the services of the LCFS are supplied to it.	N/A
5 (7)	A further nomination must be made within 3 months of the date on which an NHS body learns that there is to be a vacancy for an LCFS.	N/A
5 (8)	The procedures in paragraphs (3) to (6) also apply to a person nominated under paragraph (7).	Achieved
6 (1)	Each NHS body must specify a job description for its LCFS which includes the operational and liaison responsibilities specified by the CFS.	Achieved
6 (2)	The job description under paragraph (1) must include a requirement that the LCFS must adhere to the CFPAB Principles of Professional Conduct as set out in the NHS Counter Fraud and Corruption Manual.	N/A



Para.	Instruction	Action taken by health body
6 (3)	An LCFS must report directly to the NHS body's Director of Finance.	Achieved
6 (4)	An LCFS must not undertake responsibility for or be in any way engaged in the management of security for any NHS body.	Achieved
7	Each NHS body must. (a) require that in addition to the job description mentioned in direction 6(1), the LCFS and the Director of Finance agree, at the beginning of the financial year, a written work plan which outlines the LCFS's projected work for that financial year by reference to the seven generic areas of counter fraud activity set out in the NHS Counter Fraud and Corruption Manual.	Achieved
	(b) enable its LCFS to attend the NHS body's audit committee meetings.	Achieved
	(c) require its LCFS to keep full and accurate records of any instances of fraud or suspected fraud.	Achieved
	(d) require its LCFS to report to the CFS any weaknesses in fraud related systems of the NHS body and any other matters which may have fraud related implications for the NHS.	Achieved



Para.	Instruction	Action taken by health body
	(e) ensure that its LCFS has all necessary support including access to the CFS secure intranet site to enable him efficiently and effectively to carry out his responsibilities.	Achieved
	(f) subject to any contractual or legal constraint, require all of its staff to co-operate with the LCFS and in particular that those responsible for human resources disclose information which arises in connection with any matters (including disciplinary matters) which may have implications in relation to the investigation, prevention, or detection of fraud.	Achieved
	(g) enable its LCFS to receive training recommended by the CFS.	Achieved
	(h) require its LCFS, its other employees and any persons whose services are provided to the NHS body in connection with counter fraud work to have regard to guidance and advice on media handling of counter fraud matters which may be issued by the CFS.	Achieved
	(i) enable its LCFS to participate in activities in which the CFS is engaged, including national anti-fraud measures, where he is requested to do so by the CFS.	Achieved
	(j) enable its LCFS to work in conditions of sufficient security and privacy to protect the confidentiality of his work.	Achieved



Para.	Instruction	Action taken by health body
	(k) enable its LCFS generally to perform his functions effectively, efficiently, and promptly.	Achieved

4 NHS Counter Fraud Authority Quality Assurance Standards

NHS Counter Fraud Authority (NHSCFA) undertake an annual review of the counter fraud activity completed within the Health Board. The LCFS is required to complete a Self-Review Tool (SRT).

All NHS funded services are required to provide assurance against the Government Functional Standards 013 – Counter Fraud and NHS Requirements. This should be overseen by the organisation's finance director and audit committee, and in line with the organisation's existing approach to assurance against counter fraud requirements.

The previous NHS specific Standards have been aligned to the new NHSCFA Requirements, and the four areas of activity are:

Strategic Governance - (Organisational governance / Staff Resource / Training)

Inform and involve – (Fraud Awareness / development of Anti- Fraud Culture)

Prevent and deter – (Reducing opportunity / Policy review and improvement)

Hold to Account – (Detection and investigation of Fraud / Sanctions / Criminal Process)

Area of activity	RED / AMBER / GREEN
Strategic Governance	GREEN
Inform and involve	GREEN
Prevent and deter	GREEN
Hold to Account	GREEN



Overall level	GREEN

Declaration

I declare that the counter fraud, bribery, and corruption work carried out during 2025/26 has been self-reviewed against the Government Functional Standards 013 – Counter Fraud and NHS Requirements, and that the above rating has been achieved.

Organisation	Hywel Dda University Health Board
Director of Finance / Chief Financial Officer / Executive Board Member Signature	Huw Thomas Director of Finance
Date	31 March 2026
Date of last Local Counter Fraud Assessment	31 March 2026

4.1 Inform and Involve

The LCFS have an on-going work programme with the NHS Counter Fraud Service Wales (NHS CFS Wales) to develop an Anti-Fraud Culture within the NHS. There is an anti-fraud, bribery and corruption policy in place that outlines the responsibilities of staff in countering Fraud and corruption within HDdUHB.

Fraud awareness materials and presentations have been provided in a variety of different formats, to include an Induction leaflet and Mandatory ESR E-Learning package to new starters, Student placements, Medicine Safety Days, Finance, Primary Care teams, including GP providers, Opticians and Pharmacists in addition to Medical Staffing Groups, including Overseas Doctors.

Bespoke virtual and face to face Counter Fraud learning has been provided to targeted staff groups, identified as higher risk of contact with fraud, such as the Estates Directorate, where a greater emphasis was placed on the importance of recording and maintaining accurate data linked to rostering systems. This training was delivered in partnership with the Rostering Department.



Evaluations of sessions have been conducted, with positive comments received regarding the value of receiving these awareness sessions. Evaluations and feedback have informed the tailoring of learning, to ensure that bespoke guidance can be offered.

Communications links have been enhanced and developed over this work period. The Counter Fraud Team now engages with employees via Viva Engage and Global messages. The Team has also maintained and updated its intranet pages and has published digital newsletters via this platform, which in turn notifies all staff of new additions to the platform via digital alerts issued by email and or Viva engage. This allows for a more interactive approach to delivering awareness, including utilising and embedding digital material into the documents.

This year's Fraud Awareness Week was delivered both face to face and online, with daily communications issued to both staff and the public, highlighting Fraud Risks, reporting mechanisms, and making awareness materials available.

Examples of key work areas and successful outcomes include:

- Several virtual and in person presentations conducted to staff and key contacts.
- Current ESR Counter Fraud Mandatory Training compliance stands at 83.14%.
- During 2025/26, the Counter Fraud Department has undertaken 39 awareness events, 44 deterrence exercises (including newsletters, global messages, or counter fraud activities) and 19 Fraud Prevention activities, which have been reported to CFS Wales throughout the year.
- The Fraud Awareness Week campaign was undertaken both in person and online, resulting in the circulation of promotional literature, placement of Fraud Reporting line details within key areas and presentations to various staff groups.
- The medicines management presentation has continued both online and in person, successfully delivering Counter Fraud presentations to both Health Board employees and Student Placement Nurses.
- Following a request from Aberystwyth University, the Counter Fraud Team has commenced a programme of Fraud Awareness to first year Nursing Students, embedding a counter fraud mindset from the commencement of their journey into the profession.

4.2 Prevent and Deter

The LCFS have effectively liaised with Health Board employees and relevant departments when reporting cases or fraud trends, to ensure that a consistent approach is taken, and the message is sent out that fraud will not be tolerated within the Health Board.

The LCFS provide reports on policy weaknesses in each case where fraud is established to both CFS Wales and relevant department within the Health Board, most recently working with Corporate Governance to review and update the Health Board's Standards of Behaviour policy, as well as undertaking a local proactive exercise into the effectiveness of the Health Board's Declaration of Interest process.

Staff alerts displayed on the Health Board website and circulated through mass communications have also encouraged engagement and demonstrated real advantages to maintaining an anti-fraud culture. There has been a significant increase throughout the year in staff seeking advice and guidance to reduce the risk of fraud in their respective areas of work. This represents a shift from the Counter Fraud Team being viewed as a contact point for referral of information for investigation, to an asset to be utilised to prevent fraud from occurring.

The LCFS has also undertaken fraud-proofing of internal policies and procedures, both during the Global Consultation of such policies but also in response to fraud risks.

Following the recommencement of the Post Payment Verification (PPV) workplan, the LCFS has continued to monitor reports with the relevant Primary Care Lead officers. Further collaborative work is being undertaken with bi-monthly meetings at an all Wales and local level. This has resulted in the identification of Fraud Case and subsequent Civil Recovery. The LCFS has undertaken several Pro-Active exercises, some of which were linked to identified risks, these included:

- IR35 compliance.
- Declaration of Interest.
- Dispensing processes linked to Semaglutide type medication.
- Time off in lieu (TOIL) accrual managed through allocate rostering systems.
- Allocation of HB endorsed ID badges.
- Right to work / Impersonating registered Nurses / Healthcare Support Workers.
- General Ophthalmic Services (GOS) Claiming.
- Procurement – Breach of SFI.

The Counter Fraud team has continued to participate in the National Fraud Initiative (NFI), which is overseen by the Public Sector Fraud Authority (PSFA) – part of the UK Government’s Cabinet Office and HM Treasury. Audit Wales leads the exercise in Wales under the Auditor General’s powers in the Public Audit (Wales) Act 2004. The Auditor General’s Code of Data Matching Practice summarises the key legislation, and controls, governing the exercise in Wales. The Auditor General has mandated that unitary local authorities, NHS bodies, police forces, and fire and rescue authorities participate in the NFI. NFI helps prevent and detect fraud by sharing and matching sets of data electronically. Further information on the initiative can be found [here](#), National Fraud Initiative | Audit Wales.

Final data sets were released in January 2025, with work being completed at the end of October that same year. The exercise has assisted in the recovery of approximately £33,000. A breakdown of each exercise and a summary of activity undertaken has been provided below:

Match Type	Purpose of the match	Total Matches	Opened	Reviewed and closed	Remarks
Payroll to Payroll	To identify individuals who may be committing employment fraud by failing to work their contracted hours because they are employed elsewhere or are taking long-term sickness absence from one employer and working for another employer at the same time. The criteria for a match are a person having one full-time post plus at least one other post elsewhere.	86	86	85	1 enquiry remains open. This matter is linked to an ongoing investigation into an offence of Fraud by False Representation. NWSSP is leading on the case as the subject concerned is a substantive employee of theirs.
Payroll to Pension	To identify cases where employees who have gone back into employment after drawing a pension that could result in an abatement of pension.	110	110	110	Enquiries undertaken include working with NWSSP Pensions to ensure each entry is valid and compliant. No issues have been identified, and all matches are now closed.



Payroll to Creditors	The match identifies instances where an employee and creditor are linked by the same bank account or the same address to identify employees with interests in companies with which your organisation is trading. This may indicate potential undeclared interests and possible procurement corruption or where a member of staff has set up a creditor with their own bank details in order to receive payments they are not entitled to.	24	24	24	All matches are now complete, resulting in no concerns being identified.
Payroll to companies' house	To identify potential undeclared interests that have given a pecuniary advantage. To do this NFI have matched payroll data to companies' house information and then to your creditors data. The reports are split between those highlighting employees who appear to be registered directors of companies that the employing body has traded with and those where the employees address appears to have links to the company directors or the company.	49	49	49	All matches are now complete, resulting in no concerns being identified.

Throughout the year, risk assessments have been undertaken and reported to Audit and Risk Assurance Committee. In response to a committee request into the reporting and monitoring of Fraud risks and recommendations, the Counter Fraud team have met with the Assurance and Risk team and the following actions agreed:

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



This new process will allow for better monitoring of progress against each risk, outcomes and where applicable, the frequency of risk reviews. A summary of this document will be presented to the Audit and Risk Assurance In-Committee session throughout the year.

- To migrate all previously identified and reported risks into this new process, Counter Fraud have reviewed all previously recorded matters and migrated each one into the 'Fraud Risk and Recommendations report.' All risks will now go through the new review process as part of the 2026/27 workplan.

To further support this approach, Counter Fraud have developed a Fraud Risk Strategy, which outlines our mission and approach to identifying, assessing, mitigating, and reporting of fraud risks.

4.3 Hold to Account

The LCFS has continued to work with internal and external audit services, including Assurance and Risk and workforce leads, to ensure that counter fraud work was carried out in accordance with the Counter Fraud Strategy.

The LCFS receives information from several sources and processes are in place to ensure referrals are prioritised and investigated. As part of the required reporting processes, all notified concerns are reported utilising the Counter Fraud Authorities crime reporting system, Clue3.

Clue3 ensures the effective and secure recording of sensitive information relation to ongoing investigation. The system will allow for users to accurately document the types of investigations being undertaken, outcomes and systems weaknesses at an all-Wales level. This will enable the Counter Fraud Authority to release more accurate benchmarking and trend analysis data throughout 2026/27.

In addition, the system allows users to record data associated with pro-active exercises undertaken at a local level, including any fraud risks identified and potential savings produced. This information will allow the Counter Fraud Authority to demonstrate a financial value associated with Pro-active / risk-based activity.

Update reports on current case positions have been supplied to ARAC on a bimonthly basis. The reports are discussed during the In-Committee section of the meeting, to ensure confidentiality of investigation and fairness to investigation subjects. An end of year report has been supplied alongside this report for discussion during the In-Committee meeting.

During 2025/26, the Counter Fraud Team carried over 11 active cases from the previous year and received and recorded 60 new referrals; of which, 60 investigations were undertaken and closed. 11 cases will remain open and under review at the end of this financial year and will be carried over into the next. Of the 11, 3 are at the stage where a Voluntary Interview Under Caution (VIUC) has either been completed or awaiting completion.

Of the investigations that were closed, 7 civil sanctions were instigated, including the recovery of funds totaling £99,627 and 2 internal disciplinary referrals. Of the 2 internal disciplinary referrals, 1 member of staff resigned prior to the completion of proceedings and 1 member of staff received a final written warning. This is in addition to the proactive activities undertaken and reported throughout the year.

It is noted that the number of referrals has increased from 55 during 2024/25 to 60 this year and this can be attributed to the introduction of mandatory training, an increase in pro-active work and the development of the Health Board's NHS Fraud Awareness program.

It is important to note that not all referrals received were crimes, some of these would have been concerns or system weaknesses, which would have been reviewed and actioned accordingly. In addition, there have been referrals where an investigation has demonstrated that a crime had not occurred. In such scenarios, the LCFS will assess why the referrals were made and address any system weaknesses. An example of this involved a referral in connection with an employee not fulfilling their contractual hours. Upon review, the LCFS identified that the rostering system available to view by all staff had not been updated with a recently approved flexible working pattern, resulting in the assumption that the employee concerned was arriving to work late and leaving early. In this case, the LCFS was able to demonstrate that a crime had not occurred, although poor management of rostering system caused others to raise a concern. This has prompted the identification of fraud risks associated with the management of rostering systems, which was undertaken as part of a Local Proactive Exercise.

4.4 Strategic Governance

The Counter Fraud Work Plan agreed with the Director of Finance was presented to ARAC and quarterly monitoring reports submitted for information.

Meetings with Health Board Senior Managers have continued and the identification of further areas of risk from a local perspective, with the application of their professional experience



within the Health Board, has been achieved. One identified area being Procurement related fraud risk, which will be further explored as part of the 2026/27 work plan.

Throughout the year, both LCFS have attended conferences and training sessions provided by Counter Fraud Services Wales and the NHS Counter Fraud Authority in accordance with CFA requirements.

Submission of the return for NHS Counter Fraud Authority Quality Assurance Assessment was made within the due deadline. Throughout the year, quarterly returns for WG and NHS Counter Fraud Authority in relation to investigation statistics were provided.

The necessary support has been received from the Health Board, allowing LCFS to perform their functions effectively. Continued training for specialist delivery has been maintained for all staff.

Regular contact has been maintained between the Lead LCFS and Fraud Champion throughout the year, ensuring a top-down approach to developing an effective Counter Fraud Culture within the organisation.

5 Conclusion

The Health Board's Counter Fraud provision has demonstrated compliance with the requirements of the Welsh Government Directions to NHS Bodies on Counter Fraud Measures.

The overall green rating from the Quality Assurance assessment (SRT), demonstrates the continued efforts from the LCFS in working in an innovative way to achieve a balance of both reactive and proactive work to meet the NHS Counter Authority's Standards.

A key strategy from previous years has been to change the view amongst the wider Health Board of the Counter Fraud Team, from being a reactive unit for referral and investigation, to a proactive unit purposed to prevent fraud and reduce fraud risk. This is showing signs of taking effect, with increased contact seeking advice and assessment. This strategy will continue, whilst being mindful that the message around the importance of investigation should not be lost.

The Counter Fraud Team can demonstrate a continued trajectory of improvement across the service, with continued success shown across key measurables. Key areas of work for next year will be to maintain focus on inform and involve, continuing to raise awareness of Fraud, Bribery and Corruption and further embedding a counter fraud culture fostered over preceding years as well as further developing work associated with Prevent and Deter,



including building on Fraud Risk Analysis, identifying specific Fraud Risk based proactive exercises and recording outcomes on Clue3 against the Government Functional Standards 013 – Counter Fraud and NHS Requirements.

The Health Board's counter fraud provision has demonstrated compliance with the requirements of the Welsh Government Directions to NHS Bodies on Counter Fraud Measures.

Benjamin Rees

Head of Local Counter Fraud Services.

For presentation to Audit and Risk Assurance Committee: 14 April 2026.



Appendix - Case and Sanction Information Overview

Case Information	Number
Cases carried forward from previous year	11
Cases opened during period	60
Cases closed in period	60
Cases ongoing	11

Sanction Imposed	Number
Disciplinary referrals	2
Civil	7
Criminal	0

6.4

12:10, 5 Mins

6.4 - Counter Fraud Work Plan 2026/27

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

| For approval

Attachments

[6.4 SBAR CF Work Plan.pdf](#)

[6.4 Counter Fraud Work Plan 2026-27.pdf](#)



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	14 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Counter Fraud Annual Work Plan 2026/27
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Ben Rees, Head of Local Counter Fraud Services

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

NHS bodies in Wales must implement anti-fraud, bribery and corruption measures in accordance with Government Directions on Counter Fraud Measures and the service agreement under section 83 of the Government of Wales Act 2006. As well as the Welsh Government directions, NHS bodies are also obliged to demonstrate compliance with NHS Counter Fraud Authority Requirements of the Government Functional Standard GovS 013: Counter Fraud.

This document provides to Audit and Risk Assurance Committee the Counter Fraud Work Plan which sets out the intended actions for 2026/27. The Work Plan is devised to address identified fraud risks and to ensure compliance with both the Government Functional Standards 013 - Counter Fraud (GovS 013) and Welsh Government Directions to NHS Bodies on Counter Fraud Measures.

The workplan refers to a draft Self-Review Assessment, which has been undertaken and which has been submitted to the Committee as a separate item.

Cefndir / Background

To evidence the provision of services within a sound governance framework and provide a basis and strategic direction for counter fraud work in 2026/27.

Asesiad / Assessment

The Work Plan presented covers all aspects of applicable standards and directions as well as encompassing work around identified fraud risks. Contingency is built into the Plan to ensure response to emerging fraud risks.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is requested to **APPROVE** the Counter Fraud Work Plan 2026/27.

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

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

Parties / Committees consulted prior to Audit and Risk Assurance Committee:	

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

Counter Fraud Work Plan 2026/27

Benjamin Rees
Head of Local Counter Fraud Services

14 April 2026

COUNTER FRAUD WORK PLAN 2026/27

Introduction

Hywel Dda University Health Board maintains a professionally accredited Local Counter Fraud Service delivered by two full-time Local Counter Fraud Specialists (LCFS), who collectively provide 435 operational working days per year. This service ensures that the organisation meets its statutory obligations in relation to fraud, bribery, and corruption. Historically, counter fraud activity was structured around four key principles under Welsh Government Directions:

Key Principle 1: Strategic Governance – ensuring robust governance arrangements that embed anti-crime measures at all levels of the organisation. This includes maintaining effective communication with senior leaders and ensuring ongoing oversight through the Audit and Risk Assurance Committee.

Key Principle 2: Inform and involve – promoting awareness of fraud risks across the Health Board to foster a workforce that is informed, vigilant, and intolerant of fraud, bribery, and corruption. Effective and varied communication channels will remain central to this principle.

Key Principle 3: Prevent and deter – identifying and mitigating anomalies indicative of fraud and developing a fraud-resistant environment that minimises opportunities for wrongdoing.

Key Principle 4: Hold to Account – ensuring that all suspicions of fraud are investigated promptly and professionally, with appropriate sanctions and redress applied to reinforce a zero-tolerance approach.

These principles continue to underpin the Health Board's counter fraud culture and remain essential to maintaining organisational resilience. However, as the national framework for NHS-funded services has evolved, the Health Board is now required to operate in full accordance with the Government Functional Standard GovS 013: Counter Fraud (GovS 013).

COUNTER FRAUD WORK PLAN 2026/27

GovS 013 sets out mandatory expectations for managing fraud, bribery, and corruption across government and the wider public sector. The NHS Counter Fraud Authority (NHSCFA) provides oversight and requires organisations to complete an annual RAG-rated self-assessment, which is externally validated. This assessment forms a key element of assurance to both the Cabinet Office and Welsh Government. Under GovS 013, counter fraud work is now organised into two principal streams:

Proactive Work – activities designed to prevent and reduce fraud risk, including awareness programmes, training, communication initiatives, proactive exercises, risk identification, and the development of fraud-resistant systems. NHSCFA guidance emphasises that this work must be protected and not displaced by reactive demand.

Reactive Work – activities undertaken in response to referrals and intelligence, including investigations, analysis of system weaknesses, and engagement with internal and external audit partners. This also includes applying appropriate sanctions and taking recovery action where necessary.

This Annual Work Plan aligns with the requirements of GovS 013 and ensures that the Health Board maintains strong governance, addresses areas requiring improvement, and continues to strengthen its resilience against fraud, bribery, and corruption. It is a dynamic, risk-based document and will be reviewed throughout the year to reflect emerging risks, operational pressures, and organisational priorities. Progress will be reported quarterly to the Director of Finance and the Audit and Risk Assurance Committee, with outcomes captured in the annual report and the NHSCFA Functional Standard Return.

A self-assessment against each component of GovS 013 is completed annually using a RAG-rating methodology. One area requiring continued development is:

GovS 013 Component 3, Requirement 3 – Fraud, bribery, and corruption risk assessment.

COUNTER FRAUD WORK PLAN 2026/27

Work to strengthen this area continued throughout 2025/26, including a review of the reporting and recording mechanism for fraud risks, undertaken in partnership with the Risk Management team, which will now be adopted into the 2026/27 work plan.

Full details of the Government Functional Standards and corresponding NHS requirements are available at:

<https://cfa.nhs.uk/government-functional-standard/NHS-requirements>

This Work Plan has been designed to maintain areas of existing strength; address identified weaknesses and ensure full alignment with GovS 013. Where individual Work Plan actions relate directly to components of the Standard, the relevant reference is provided (e.g., GovS 013 Component X).

To safeguard the Health Board's resilience against fraud, bribery, and corruption, an Annual Work Plan is compiled by the Head of Local Counter Fraud Services, agreed with the Executive Director of Finance, and submitted to the Audit and Risk Assurance Committee (ARAC) for approval at the start of each financial year.

Engagement with key personnel and insight from staff surveys play a key role in shaping this plan. Survey feedback may also highlight emerging risks requiring proactive preventative or detection work. Any risks identified by Counter Fraud are recorded in accordance with the newly adopted Fraud Risk Strategy and nationally via the CLUE case management system. These risks will be shared with ARAC to ensure ownership and assurance that risks are being appropriately managed.

In addition to internal intelligence, external information, such as NHSCFA fraud alerts, fraud prevention notices, and identified inherent risks will be considered.

COUNTER FRAUD WORK PLAN 2026/27

PROACTIVE ACTIVITY (Inform & Involve, Prevent & Deter and Strategic Governance)			
Task / Objective		GovS 013 Component	Delivery Timescale
1	Design and deliver a programme of counter fraud awareness presentations to staff at all levels within the Health Board, with the aim of ensuring that the organisation is proactive in raising fraud awareness and building an anti-fraud culture. Review and maintain materials and media used. Evaluate presentations, collate results, and amend presentations in line with feedback received.	GovS 013 component 11	Throughout the year.
2	Undertake a suitable exercise to identify the level of fraud awareness within the organisation utilising compliance data associated with ESR Mandatory Training and further develop communications / learning in areas of low compliance.	GovS 013 component 11	Q1.
3	To develop and maintain the counter fraud information contained on the Health Board intranet site and Newsletter, to include details of successfully prosecuted Counter Fraud cases – both local and national. Producing and publicising relevant media via Viva engage where appropriate.	GovS 013 component 11	Q2 and Q4.
4	Enhance awareness of the Health Board's "Counter Fraud" Policies, and promote the correct lines for reporting fraud, bribery, or corruption (including the freephone Fraud, Bribery and Corruption Reporting Line, online reporting tool, and local reporting mechanisms).	GovS 013 component 11	Throughout the year.

COUNTER FRAUD WORK PLAN 2026/27

PROACTIVE ACTIVITY (Inform & Involve, Prevent & Deter and Strategic Governance)			
Task / Objective		GovS 013 Component	Delivery Timescale
5	Engage with the Health Board's Learning and Development department to monitor compliance and promote the Counter Fraud mandatory E-Learning package.	GovS 013 component 11	Throughout the year.
6	Issue messages to all staff groups advising them of current data sharing arrangement in place between HDdUHB and the National Fraud Initiative.	Service Requirement and GovS 013 component 11	As required.
7	Publish a Counter Fraud Newsletters via the Counter Fraud Intranet site and Viva engage to raise awareness of key issues and Fraud risks.	GovS 013 component 11	Throughout the year.
8	Use findings from fraud risk assessments to inform delivery of bespoke counter fraud training to business areas of higher risk of exposure to fraud.	GovS 013 component 7 and 12	Throughout the year.
9	Undertake targeted surveys of staff to measure awareness of: Counter Fraud, Bribery and Corruption Policy and Response Plan. Fraud, Bribery and Corruption incident reporting routes; and Policy and procedures relating to Conflicts of Interests, Gifts and Hospitality.	GovS 013 component 4, 7 and 12	Q1.
10	Engage with the NHS Counter Fraud Services Wales / The Counter Fraud Authority to develop awareness materials focusing on identified trends, with a view of disseminating the information to staff via global messaging systems.	GovS 013 component 11	Q1 and 2.

COUNTER FRAUD WORK PLAN 2026/27

PROACTIVE ACTIVITY (Inform & Involve, Prevent & Deter and Strategic Governance)			
Task / Objective		GovS 013 Component	Delivery Timescale
11	Review key organisational policies, procedures, and documents, to ensure that they are adequately robust in terms of reducing the risk of fraud to a minimum. The communication of revised policies, procedures, and documents as appropriate, emphasising the organisational commitment to countering fraud.	GovS 013 component 3 and 10	As required.
12	Conduct risk analysis in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology. Record and manage assessed risk in line with the Health Board's Risk Management policy and Fraud Risk Strategy, reporting on threats where appropriate.	GovS 013 component 3	Throughout the year.
13	Develop a fraud risk profile from risk assessment work to effectively evaluate, evidence, and measure the effectiveness of counter fraud work in mitigating and reducing fraud risk or expenditure and influencing of policy and procedure aimed at reducing fraud.	GovS 013 component 2 and 5	Throughout the year.
14	Review existing fraud risk assessments with Risk Owners.	GovS 013 component 2, 3 and 5	Throughout the year.
15	Use National Fraud Initiative data, which matches payroll records to creditors and suppliers, to undertake a proactive exercise to measure compliance with the conflicts of interest policy.	GovS 013 component 10 and 12	Q1.

COUNTER FRAUD WORK PLAN 2026/27

PROACTIVE ACTIVITY (Inform & Involve, Prevent & Deter and Strategic Governance)			
Task / Objective		GovS 013 Component	Delivery Timescale
16	Maintain regular contact with the Head of Internal Audit (NWSSP Audit and Assurance)	Service level requirement	Throughout the year.
17	Record and respond to ad-hoc requests for assistance received.	Service level requirement	Throughout the year.
18	Action Fraud Prevention Notices (FPN) and or Risk Alerts, issued by NHS Counter Fraud Authority and/or Counter Fraud Services Wales as and where appropriate.	GovS 013 component 3	As required.
19	Issue fraud alerts to all appropriate staff, raising awareness of existing or emerging threats.	GovS 013 component 11	As required.
20	Maintain regular liaison with the Post Payment Verification Location Manager (NWSSP Primary Care) and Primary Care leads to ensure that any contractor visits which result in the identification of anomalies are reported to the LCFS.	Service level requirement	Throughout the year.
21	Participate in mandatory national proactive exercises, as instructed by NHS Counter Fraud Authority, Counter Fraud Services Wales, Auditor General for Wales, and/or the Cabinet Office (e.g., NFI).	GovS 013 component 10	Throughout the year.
22	Participate in thematic fraud risk evaluation exercises as instructed by the NHS Counter Fraud Authority.	GovS 013 component 10	As required.

COUNTER FRAUD WORK PLAN 2026/27

PROACTIVE ACTIVITY (Inform & Involve, Prevent & Deter and Strategic Governance)			
Task / Objective		GovS 013 Component	Delivery Timescale
23	Conduct proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery, and corruption. Results of this work will be recorded on Clue3, evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery, and corruption. Any losses, recoveries or savings are to be identified and reported (data metrics). Areas of work will be linked to both locally and nationally identified risks which will be evidenced within Clue3 by way of referencing a Risk Assessment, FPN or Investigation.	GovS 013 component 10	Throughout the year.
24	Maintain membership of Local Intelligence Network and regular attendance at meetings.	Service level requirement	As required.
25	Provide outturn reports for managers to recommend appropriate action following any weaknesses identified through investigative work. Monitor and report findings to the Director of Finance / Audit and Risk Assurance Committee.	Service level requirement	As required.
26	Periodically review the Health Board's Risk Register for entries which may have a fraud or corruption bearing.	GovS 013 component 3 and 10	As required.
27	Attendance at Fraud Forum meetings held by CFS Wales for the purpose of CPD and development of strategic objectives.	Service level requirement	As required.

COUNTER FRAUD WORK PLAN 2026/27

PROACTIVE ACTIVITY (Inform & Involve, Prevent & Deter and Strategic Governance)			
Task / Objective		GovS 013 Component	Delivery Timescale
28	Maintain regular contact with the Health Board's Fraud Champion, ensuring any concerns are raised, discussed, and actioned appropriately.	GovS 013 component 1	Throughout the year.
29	Completion and agreement of the annual work plan and annual report with the Director of Finance or nominated deputy.	GovS 013 component 2	Q4.
30	Regular meetings/liaison with Director and/or Assistant Director of Finance	GovS 013 component 1	Throughout the year.
31	Preparation for and attendance at Audit Committee meetings.	GovS 013 component 1	As required.
32	Full participation in the quality assurance process as directed by NHS Counter Fraud Authority	Service level requirement	Q4 and as required.
33	Undertake additional training as required by the Health Board or NHS Counter Fraud Authority.	Service level requirement	As required.
34	Ensure that all Fraud, Bribery, and Corruption investigative and proactive activity, including all outcomes, recoveries and system weaknesses identified during investigations and/or proactive prevention and detection exercise are recorded on Clue3 and presented to ARAC where required.	GovS 013 component 8	Q1 and throughout the year.

COUNTER FRAUD WORK PLAN 2026/27

PROACTIVE ACTIVITY (Inform & Involve, Prevent & Deter and Strategic Governance)			
Task / Objective		GovS 013 Component	Delivery Timescale
35	Review the Health Board's Counter Fraud Policy and Response Plan to ensure up to date and relevant contents as well as alignment to Government Functional Standards.	GovS 013 component 4 and 7	Q1.
36	Provide relevant data to CFS Wales on a quarterly basis to allow for the reporting and analysis of reported incidents of fraud, bribery and corruption, the value of identified fraud losses, the value of fraud recoveries, the value of fraud prevented, criminal sanctions and disciplinary sanctions.	GovS 013 component 6	Quarterly.
37	Record and report on recommendations to both Department leads and ARAC, tracking relevant actions.	GovS 013 component 1, 5, 8 and 10	Throughout the year.
38	Develop, complete and report on Local Proactive Exercises that are designed to assess system weaknesses and the effectiveness of existing controls used to mitigate the risk of fraud.	GovS 013 component 2, 3, 10 and 11	Throughout the year.
39	Undertake a review of all existing, previously reported risks in line with guidance / methodology issued by the NHS Counter Fraud Authority.	GovS 013 component 2, 3, 10 and 11	Throughout the year.
40	Undertake a review of Procurement related fraud risks, including those associated with existing due diligence processes.	GovS 013 component 2, 3, 10 and 11	Throughout the year.
TOTAL DAYS ALLOCATED			245

COUNTER FRAUD WORK PLAN 2026/27

REACTIVE (Hold to Account)			
Task / Objective		GovS 013 Component	Delivery Timescale
41	Conduct investigations into all allegations of economic crime as required, in line with the requirements of the NHS Counter Fraud Authority Counter Fraud Manual, and all relevant guidance and legislation.	GovS 013 component 9	As required.
42	Record and maintain accurate data on the designated Crime Management system, Clue3, in line with NHS Counter Fraud Authority and NHS CFS Wales requirements.	GovS 013 component 6 and 8	As required.
43	Assist NHS Counter Fraud Services Wales with information as required for any regional or national fraud cases. Ensure comprehensive information to enable risk exercises to be conducted effectively is submitted in a timely manner.	GovS 013 component 9	As required.
44	Ensure the application of sanctions in line with legislation and the policy document 'Applying Appropriate Sanctions Consistently'.	GovS 013 component 6 and 9	As required.
45	Where appropriate, apprise the Health Board's Workforce and OD department on investigations that involve HDdUHB employees and where applicable, share information that will assist in the assessment and mitigation of any risks associated with said person's employment and or ability to perform their duties.	GovS 013 component 1, 5, 8, 9 and 10	As required.

COUNTER FRAUD WORK PLAN 2026/27

REACTIVE (Hold to Account)			
Task / Objective		GovS 013 Component	Delivery Timescale
	This will include the submission of a case report at the conclusion of an investigation.		
46	Identify and maintain appropriate records and, wherever possible, seek financial redress/recovery in respect of any proven loss to the Health Board, having due regard to the circumstances of each case.	GovS 013 component 6 and 8	As required.
47	Review professional competencies and capabilities of accredited staff nominated to undertake the full range of counter fraud work to assess requirements for professional development opportunities.	GovS 013 component 9	Q1.
48	Undertake review of information held, stored, and processed in relation to case files and evidence store.	Service level requirement	As required.
49	Provision of information via Clue3 and secure information exchange channels to enhance national intelligence sharing.	GovS 013 component 6 and 9	As required.
50	Maintain an appropriate and correct interaction with NHS CFS Wales regarding the conduct and progression of an investigation.	GovS 013 component 9	As required.
TOTAL DAYS ALLOCATED			175

COUNTER FRAUD WORK PLAN 2026/27

STRATEGIC AREA OF ACTIVITY	RESOURCE ALLOCATED (in days)
PROACTIVE ACTIVITY	245
REACTIVE ACTIVITY	175
TOTAL	420

Conclusion

Key areas of work for this year will be a focus on 'Proactive' activity to further embed the culture fostered over preceding years, as well as further developing areas of work associated with prevention and deterrence of fraud by way of a robust and effect fraud risk management strategy, which will build on Fraud Risk Analysis, identifying specific fraud risk-based proactive exercises and recording outcomes on Clue3.

Overall, this work plan has been developed in response to identified fraud risks, offences under the Fraud Act 2006, the new offence of Failure to Prevent Fraud under the Economic Crime and Corporate Transparency Act 2023 Offence and in line with the Health Board's obligations derived from the Welsh Government Directions on Counter Fraud Measures and the Welsh Government Directions on Counter Fraud Measures.

The actions contained therein are aimed at reducing fraud, bribery, and corruption within the Health Board to an absolute minimum and embedding an anti-fraud culture. It is recommended that the Committee **approve** the work plan as presented.

Huw Thomas
Director of Finance

Ben Rees
Head of Local Counter Fraud Services

6.5

12:15, 0 Mins

6.5 - NHS Counter Fraud Authority Draft SRT Return

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

| For information

Attachments

[6.5 SBAR CF Draft SRT.pdf](#)

[6.5 SRT of NHS Requirements Government Functional Standards.pdf](#)



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	14 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Counter Fraud Draft review of NHS Requirements Government Functional Standards
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

NHS bodies in Wales must implement anti-fraud, bribery, and corruption measures in accordance with Government Directions on Counter Fraud Measures and the service agreement under section 83 of the Government of Wales Act 2006.

As well as the Welsh Government directions, NHS bodies are also obliged to demonstrate compliance with NHS Counter Fraud Authority Requirements of the Government Functional Standard GovS 013: Counter Fraud. A self-review assessment against the standards is completed on an annual basis using a RAG rating system.

This report provides to the Audit & Risk Assurance Committee the Counter Fraud Draft review of NHS Requirements Government Functional Standards.

The report will present a breakdown as to how each requirement is met and the review rating applied. The Assessment provides an overall rating of Green, with one identified area of improvement linked to Fraud Risk Management.

Please note, the Counter Fraud Authority have imposed a word count limit, as such abbreviations have been used throughout.

Cefndir / Background

To evidence the provision of services within a sound governance framework in line with the Government Functional Standards 013 – Counter Fraud and NHS Requirements.

Asesiad / Assessment

The Health Board is compliant with Welsh Government Directives and Government Functional Standards 013 – Counter Fraud and NHS Requirements, with an overall RAG rating of Green.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is requested to receive for information this draft report, prior to it being submitted via the Counter Fraud Authority.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

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

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	2025/26 Counter Fraud Workplan and Annual Report.
Rhestr Termiau: Glossary of Terms:	LCFS – Local Counter Fraud Specialist/s CF – Counter Fraud CFS Wales – Counter Fraud Services Wales NHS CFA – NHS Counter Fraud Authority NWSSP – NHS Wales Shared Services Partnership LPE – Local Proactive Exercise FRA – Fraud Risk Assessment

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Not Applicable.

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



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University Health Board

COUNTER FRAUD, BRIBERY & CORRUPTION

HYWEL DDA UNIVERSITY HEALTH BOARD

Review of NHS Requirements Government Functional Standards - 013 Counter Fraud

Overall Rating – GREEN

To be submitted to the Counter Fraud Authority.

Counter Fraud Functional Standard Return – Organisational Information	Comments
Name of the organisation	HYWEL DDA UNIVERSITY LHB
Annual budget of the organisation	Over £1 billion.
Staff headcount at the organisation including contracted employees	10,000 to 15,000
Organisation code	7A2
Organisation / provider type	Health Board
Co-ordinating Commissioner for this provider	WALES
Region	WALES
NHS England Region	WALES
Name of the member of the executive board or equivalent body responsible for overseeing and providing strategic management	Mr Huw Thomas
Name and email of the Local Counter Fraud Specialist	Mr Benjamin Rees
Email of the Local Counter Fraud Specialist	Benjamin.Rees2@Wales.nhs.uk
Name of the counter fraud provider organisation (including in-house)	In House (Wales)
Counter Fraud provide type	WALES
Name of the Chair of the Audit Committee	Rhodri Evans
Email of the Chair of Audit Committee	Rhodri.Evans7@wales.nhs.uk
Name of the Counter Fraud Champion	Mrs Joanne Wilson
Email of the Counter Fraud Champion	joanne.l.wilson@wales.nhs.uk
Pro-active days used	250
Reactive days used for counter fraud work	170
Total days used for Counter Fraud work	420
Number of investigations open as at 31/03/2026	11
Number of investigations open as at 31/03/2026 as recorded on the case management system	11
Rationale for any discrepancy between case management system investigations open as of 31/03/2026 and expected	Not applicable
Have you had an engagement visit which provided recommendations by NHSCFA to improve counter fraud work in the last two financial years	No (Engagement visit undertaken, no recommendations received to date).
Have you actioned the recommendations	None to date.



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Review of NHS Requirements Government
Functional Standards - 013 Counter Fraud

Please provide a statement outlining your progress against
your recommendations

N/A

Functional Standard		Rating	Comments
NHS Requirement 1A	A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery, and corruption work within the organisation. The accountable board member is responsible for the provision of assurance to the executive board in relation to the quality and effectiveness of all counter fraud bribery and corruption work undertaken. The accountable board member is responsible for ensuring that nominations to the NHSCFA for the accountable board member, audit committee chair and counter fraud champion are accurate and that any changes are notified to the NHSCFA at the earliest opportunity and in accordance with the nominations process.	GREEN	The UHB's Chief Executive Officer (CEO) and Director of Finance (DoF) are responsible for ensuring there are appropriate arrangements to counter fraud, and that procedures for dealing with suspected cases are complied with. The DoF is the delegated person responsible for providing strategic management on all aspects of economic crime. This is evidenced by the preparation of the antifraud, bribery and corruption work plan, agreement of the annual Self Review Tool (SRT), along with counter fraud annual report and progress reports presented on a quarterly basis to Audit & Risk Assurance Committee (ARAC). Additional to this, the LCFS presents regular updates and briefings directly to the DoF and Assistant DoF when required with clear lines of communication between all parties, allowing the DOF to engage with Exec Directors on issues involving their portfolios, ensuring appropriate action is taken where necessary. All LCFS Nominations are reviewed and approved by the DOF.
NHS Requirement 1B	The organisation's non-executive directors, counter fraud champion or lay members and board/governing body level senior management are accountable for gaining	GREEN	There are clear communication lines with the Senior Health Board Management and Independent Members (IMs) by way of

Functional Standard		Rating	Comments
	assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation. The counter fraud champion understands the threat posed and promotes awareness of fraud, bribery, and corruption within the organisation. Board level evaluation of the effectiveness of counter fraud, bribery and corruption work undertaken is documented. Where recommendations have been made by NHSCFA following an engagement, it is the responsibility of the accountable board member to provide assurance to the board surrounding the progress of their implementation. The organisation reports annually on how it has met the requirements set by NHSCFA in relation to counter fraud, bribery and corruption work, and details corrective action where requirements have not been met.		regular attendance at Audit and Risk Assurance Committee meetings (ARAC) which provides an opportunity for members to be updated on matters and provide input on direction. At these meetings regular update reports are presented, including any identified risks. Learning arising from LCFS work around risk reduction and investigation outcomes are shared with relevant leads and updates provided via the ARAC. Any arising actions are reviewed and monitored by the ARAC in subsequent meetings. Standards are reviewed on a regular basis and cross referenced against work undertaken. The annual report is presented to the DOF for approval and is presented to the ARAC for approval and assurance of meeting the standards. Additionally, as part of the Quality Assurance process, the HB undertakes a self-review (SR) to assess continued compliance. A Fraud Champion has been nominated.
NHS Requirement 2	The organisation aligns counter fraud, bribery, and corruption work to the NHSCFA counter fraud, bribery, and corruption strategy. This is documented in the organisational over-arching strategy or counter fraud, bribery, and corruption policy, and is submitted upon request. The counter fraud work plan and resource	GREEN	The HB has a Counter Fraud Policy & Response Plan (CFPRP) in place which includes the overall strategic aims of counter fraud work and operational response aligned to the NHSCFA counter fraud, bribery, and corruption strategy.

Functional Standard		Rating	Comments
	allocation are aligned to the objectives of the strategy and locally identified risks.		In addition, the Health Board has in operation a Standards of Behaviour Policy which incorporates professional behaviour with reference to Fraud, Corruption, and the Bribery Act. Awareness work around requirements is carried out by both the Corporate Governance Team and LCFS. Proactive work is undertaken utilising databases such as the National Fraud Initiative (NFI) to assist in measuring compliance levels. Having proactively promoted the policies there has been a demonstrable increase in returns / compliance. An annual work plan is developed in line with key objectives of the strategy, alignment to national standards and includes response to nationally and locally identified risks. The CFPRP are reviewed (within the policy review cycle) and agreed by DoF and ARAC.
NHS Requirement 3	The organisation has carried out comprehensive local risk assessments to identify fraud, bribery, and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. Risk analysis is undertaken in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology and is recorded and managed in line with the organisation's risk management policy	AMBER	Risk assessments (RA) are carried out in line with the HB Risk Management Policy and a CF Risk Strategy. The HB DATIX system has a fraud specific module allowing managers to add fraud themed risks(FR). The LCFS receives updates to new or existing themes. The annual CF plan is informed by RA. The work plan is

Functional Standard		Rating	Comments
	and included on the appropriate risk registers, and the risk assessment is submitted upon request. Measures to mitigate identified risks are included in an organisational work plan, progress is monitored at a senior level within the organisation and results are fed back to the audit committee (or equivalent body). For NHS organisations the fraud risk assessments should also consider the fraud risks within any associated sub company of the NHS organisation.		reviewed and agreed by the DoF and ARAC, who monitor progress and receive updates on Fraud risks. The level of proactive resource is approved by the DoF & ARAC. Arrangements have been agreed and will be embedded in the next review cycle to improve both the recording and implementation of fraud risks, using NHSCFA risk writing methodology to ensure compliance with both GOV13 standards and local procedures. Actions and recommendations arising from a RA will be fed back to ARAC by way of an in-committee paper & outstanding actions recorded & monitored.
NHS Requirement 4	The organisation has a counter fraud, bribery and corruption policy and response plan (the policy and plan) that follows NHSCFA's strategic guidance and has been approved by the executive body or senior management team. The plan is reviewed, evaluated, and updated as required, and levels of staff awareness are measured.	GREEN	The HB has a CF Policy & Response Plan in place which includes the overall strategic aims of counter fraud work and operational response aligned to the NHSCFA counter fraud, bribery, and corruption strategy. In addition, the HB has a Standards of Behaviour Policy which incorporates professional behaviour with reference to fraud, corruption, bribery and offences linked to the failure to prevent Fraud and Bribery. Executive approval of policies is provided via the Policy Review Process. The CF policy is available to all staff and highlighted within the CF intranet page and

Functional Standard		Rating	Comments
			policy library. The Policy is actively promoted within the HB's programme of awareness. A mandatory online training package is in place, reinforcing key messages and local policies, measuring compliance, and identifying areas of improvement. Areas of work undertaken are communicated to ARAC by way of committee papers. Awareness is also raised by way of CF newsletters, social media posts and bespoke training, including to high-risk groups.
NHS Requirement 5	The organisation maintains an annual work plan that is informed by national and local fraud, bribery and corruption risk assessment identifying activities to improve capability and resilience. This includes (but is not limited to) defined objectives, milestones for the delivery of each activity and measurable areas for improvement in line with strategic aims and objectives. The plan is agreed, and progress monitored by the audit committee (or equivalent body).	GREEN	The HB has a CF Policy & Response Plan in place which includes the overall strategic aims of counter fraud work and operational response aligned to the NHSCFA counter fraud, bribery, and corruption strategy. An annual work plan is developed in line with key objectives of the strategy, alignment to national standards and includes response to identified risks. The resource within the annual work plan is proportionally allocated according to risk based need in the context of 4 strategic areas of counter fraud work. The plan is presented to ARAC, who review & agree in conjunction with the DoF. Progress against the plan is monitored and

Functional Standard		Rating	Comments
			evaluated throughout the year with regular meetings with DoF and regular reporting to ARAC. Objectives and activity are planned around milestones in year to allow progress to be monitored. Policy reviews are undertaken and reviewed for fraud risk. Recommendations are made, recorded, and implemented. National CF guidance is reviewed & utilised for improvement.
NHS Requirement 6	The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance. This should be informed by national and local risk assessment, national benchmarking, and other comparable data. Proactive and reactive outcomes and progress are recorded on the approved NHS fraud case management system. Metrics should include all reported incidents of fraud, bribery and corruption, the value of identified fraud losses, the value of fraud recoveries, the value of fraud prevented, criminal sanctions and disciplinary sanctions.	GREEN	Clue3 has allowed the LCFS to record all investigations, documenting the types of offences, subjects, outcomes, system weaknesses. Details of local proactive exercises are being recorded, including financial values, which allow the LCFS / CFA to identify cost savings associated with pro-active work. This is currently in operation and data is being reported to CFS Wales on a quarterly basis.
NHS Requirement 7	The organisation has well established and documented reporting routes for staff, contractors, and members of the public to report incidents of fraud, bribery, and corruption. Reporting routes should include NHSCFA's Fraud and Corruption Reporting Line and online reporting tool. All incidents of fraud, bribery and corruption are recorded on the approved NHS fraud case management system.	GREEN	The HB has well documented reporting routes for any party to report incidents. Reporting routes are formalised in the CF and Bribery Policy & Response Plan. This includes NHSCFA Reporting Line and Online Reporting Tool. The reporting routes are publicised on the Health Board's intranet and internet sites and are included

Functional Standard		Rating	Comments
	The incident reporting routes are publicised, reviewed, evaluated, and updated as required, and levels of staff awareness are measured.		within the CF awareness programme. The effectiveness is evaluated by use of statistical referral data and this is reported to DoF and ARAC. Staff awareness is measured via surveys. Mandatory CF training is in operation for all staff groups. The HB has in place an 'All Wales NHS staff to Raise Concerns Procedure', which provides reassurance to staff that concerns will be recorded, reviewed, and actioned. The LCFS has received referrals for investigation as a result, allowing the identification, recording and management of Fraud Risks. All cases are recorded appropriately via the NHSCFA, and case updates provided to both the DOF & ARAC.
NHS Requirement 8	The organisation uses the approved NHS fraud case management system to record all incidents of reported suspect fraud, bribery, and corruption, to inform national intelligence and NHS counter fraud functional standard return submission by the NHSCFA. The case management system is used to record all fraud, bribery, and corruption investigative activity, including all outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercise.	GREEN	The HB currently utilises Clue3 to record all investigations and LPEs, which allows for the reporting of crimes & case management. It also allows the reporting of system weaknesses alongside documented intelligence surrounding the subject of concern. The HB supports all investigations of fraud, bribery, and corruption with adherence to legislative requirements and the guidance outlined in the CF manual & case file toolkit. This being evidenced in the investigation plans

Functional Standard		Rating	Comments
			and recorded actions undertaken. As well as recording cases, Clue3 provides an opportunity to record outcomes of both proactive/reactive work. Outcomes will be recorded, & data utilised. Clue3 now includes an approved formula to standardise the calculation and reporting of identified fraud loss and ongoing savings/preventions values.
NHS Requirement 9	The organisation employs or contracts in an accredited, person (or persons) nominated to the NHSCFA to undertake the full range of counter fraud, bribery, and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work to hold those who commit fraud, bribery, or corruption to account. The organisation will ensure that any changes to nominations are notified to the NHSCFA at the earliest opportunity and in accordance with the nominations process. The accredited nominated person (or persons) must demonstrate continuous professional competencies and capabilities on an annual basis by examples of practical application of skills and associated training to include (but is not limited to), obtaining witness statements, conducting interviews under caution, and maintaining up to date knowledge of legal and procedural requirements.	GREEN	The HB employs 2 full time LCFS. Both LCFS are qualified, nominated & accredited. Both conduct the full range of anti-fraud, bribery & corruption work on behalf of the HB. All work is undertaken in line with the CF work plan devised around the 4 strategic areas and organisational risks. The LCFSs continue to receive relevant training to enhance their abilities to deliver the role effectively. The LCFS undertakes all interviews under caution in accordance with Code C of the Police and Criminal Evidence Act 1984 and retains documented details surrounding interviews completed and witness statements obtained in accordance with Achieving Best Evidence. Witness statements are reviewed in line with issued guidance to ensure best practice.

Functional Standard		Rating	Comments
			Relevant training will be undertaken in line with emerging risks.
NHS Requirement 10	The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery, and corruption. Relevant information and intelligence may include (but is not limited to) internal and external audit reports, information on outliers, recommendations in investigation reports and NHSCFA led loss measurement exercises. The findings are acted upon promptly.	GREEN	The HB undertakes proactive work to detect fraud using relevant info, RA's & intel to identify anomalies indicative of fraud, bribery & corruption(FBC), undertaking proactive work, investigations & participation in national exercises where necessary. This work & its result are recorded, evaluated & where appropriate fed into improvements to prevent & deter FBC. Relevant info & intel are utilised to identify & investigate instances of fraud. Information is obtained by way of communication & sharing of information with both internal/external partners, including. Internal/external audit, Payroll, Finance, Procurement, Post Payment Verification (PPV), Primary care & NHSCFA/CFS Wales. Utilising Audit reports, RAs, NHSCFA alerts / bulletins / circulars and guidance allowing CF to undertake measurement exercises and acting on findings. Where anomalies are identified the HB carries out proactive exercises/investigations/RAs to address. Recommendations are reported

Functional Standard		Rating	Comments
			to ARAC & fed into improvements in the detecting of anomalies.
NHS Requirement 11	The organisation has an ongoing programme of work to raise awareness of fraud, bribery, and corruption and to create a counter fraud, bribery, and corruption culture among all staff, across all sites, using all available media. This should cover the role of the NHSCFA, LCFS and the requirements and national implications of Government Counter Fraud Functional Standard providing a standardised approach to counter fraud work. Content may be delivered through presentations, newsletters, leaflets, posters, intranet pages, induction materials for new staff, emails, and other media, making use of the NHSCFA's fraud awareness toolkit as appropriate. The effectiveness of the awareness programme is measured.	GREEN	The HB has a programme of work (in line with work plan) to raise awareness of CF. Key methods of delivering this are by way of presentations and a mandatory CF e-learning package, supported by newsletters & intranet pages, all of which promote, • The NHSCFA reporting line & online reporting tool, • The Health Board's CF strategy & the role of the LCFS. Awareness materials, including animations & posters are utilised to raise awareness amongst HB employees, primary care, contractors and public. The CF Dept provides an input into the HB's induction programme, Medicines Management & Managers Passport. Attendance at sites have also added to enhancement of an anti-fraud culture. Internal & External Web pages have also been updated, alongside frequent use of global messages & social media. Bespoke training is offered to departments & tailored training has been delivered to high-risk areas. Sessions are evaluated through feedback. Statistics are

Functional Standard		Rating	Comments
			maintained & analysed to assess awareness levels.
NHS Requirement 12	The organisation has a managing conflicts of interest policy and registers that include gifts and hospitality that is proactively communicated to all staff. The managing conflicts of interest policy and registers that include gifts and hospitality is fully implemented and is demonstrably effective. The organisation measures levels of awareness of the managing conflicts of interest policy and registers that include gifts and hospitality among staff. The results are used to determine where further awareness raising needs to be undertaken.	GREEN	The HB has a Standards of Behaviour Policy which incorporates professional behaviour (including, declarations of interest, gifts, hospitality, and sponsorship) with reference to fraud, corruption, and the Bribery Act 2010. This is reinforced by the CF Bribery & Corruption Policy and Standard Operating Procedures. Relevant records / lists are maintained for review. Awareness work around requirements is carried out by both the Governance Team and LCFS. Proactive work is undertaken utilising NFI to assist in measuring compliance levels. Having proactively promoted the policies there has been a demonstrable increase in returns / compliance. Awareness in this area is also delivered by way of presentations, communications & mandatory online training. An increase in FRA will assist in developing actions / proactive exercises to mitigate risks, such as actively promoting declarations of interest and Fraud awareness to high-risk groups of staff.

Counter Fraud Functional Standard Return - ACC Declaration

I declare that the anti-fraud, bribery, and corruption work carried out during the year to date has been self-reviewed against the NHS CFA requirements for anti-fraud, bribery, and corruption.

As the Audit and Risk Assurance Committee Chair, and in line with the Committee's responsibility for the strategic assurance and oversight of counter fraud work as described in section 5.6 of the NHS Audit Committee Handbook, I confirm that the information contained in this self-review for HYWEL DDA UNIVERSITY LHB reflects the work reported and considered by the Audit and Risk Assurance Committee.

Submitted by:

Counter Fraud Functional Standard Return – DOF Declaration

I declare that the anti-fraud, bribery, and corruption work carried out during the year to date has been self-reviewed against the NHS CFA requirements for WALES anti-fraud, bribery, and corruption.

As the responsible member of the executive board or equivalent body I confirm that by ticking this authorisation box the information contained in this self-review for HYWEL DDA UNIVERSITY LHB is correct and complete.

Submitted by:

Counter Fraud Functional Standard Return Declaration



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University Health Board

Review of NHS Requirements Government Functional Standards - 013 Counter Fraud

Please ensure that this Functional Standard Return has been fully completed. If your director of Finance and/ or audit committee chair have not authorised or reviewed the functional standard return you will not be able to submit it. Once you have submitted the functional standard return, no further changes are possible.

Submitted by: lcfs12510

7 - Assurance and Risk

7.1

12:15, 5 Mins

7.1 - Risk Assurance Report

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

| For assurance

Attachments

[7.1 Risk Assurance Report ARAC April 2026.pdf](#)

[7.1 Appendix 1 - Risk Maturity Assessment 2026 FINAL.pdf](#)



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Audit and Risk Assurance Committee

Risk Assurance Report

14 April 2026

Situation and Background



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Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

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.

The Risk Management Framework sets out the components that provide the foundation and organisational arrangements for supporting risk management processes in Hywel Dda UHB (the Health Board).

The Risk Management Strategy provides a supportive framework that ensures the integration of risk management into policy making, planning and decision-making processes.

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

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 December 2025:

Next Steps	Progress Made
To identify a suitable risk management system and commence work on its implementation and roll-out ahead of 30 November 2027	In progress - The identification of a suitable risk management system is one of the three key objectives set out within the refreshed Risk Management Strategy, approved by the Board at its meeting in September 2025. The Assistant Director of Assurance & Risk and the Head of Assurance & Risk have engaged in All-Wales discussions to explore the feasibility of a joint procurement approach with other NHS Wales organisations, and work through requirements to develop a system specification. As it currently unclear whether this will be allowed, as the current contract under OnceForWales is also being tendered for, the Directors of Corporate Governance in February 2026, have allowed Health Boards to explore local procurement options to avoid not having a system in place by November 2027. Concerns regarding the timeframe required to implement a new risk management system, as well as the availability of the necessary resources, have been recorded on the Governance function’s operational risk register.
To finalise the review of existing risk themes, to ensure these are a manageable and meaningful set.	In progress - The review of existing risk themes is nearing completion with revised themes for Workforce & Organisational Development now established and a meeting scheduled in March 2026 to further review the ‘Patient Safety and Quality’ theme to ensure it is as effective and meaningful as possible and appropriately aligned to revised governance structures.

The Health Board has undertaken its annual risk maturity self-assessment in February 2026 in accordance with the Orange Book (a recognised risk management standard for the public sector). The outcomes of this assessment will inform the objectives for the Risk Management Strategy, due for review in September 2026.

The assessment framework aligns to the five principles in the Orange book, namely:

- **Governance and Leadership** - Risk management shall be an essential part of governance and leadership, and fundamental to how the organisation is directed, managed and controlled at all levels
- **Integration** - Risk management shall be an integral part of all organisational activities to support decision-making in achieving objectives
- **Collaboration and Best Information** - Risk management shall be collaborative and informed by the best available information and expertise.
- **Risk Management Processes** - Risk management processes shall be structured to include risk identification, risk treatment, risk monitoring and risk reporting
- **Continual Improvement** - Risk management shall be continually improved through learning and experience

How have we undertaken the assessment

For each of the five principles above, a series of questions have been answered to determine an overall risk maturity assessment for each with full outcomes included in **Appendix 1**. Feedback has been obtained from the Executive Team at its formal meeting held on 4 March 2026, and from staff across the organisation via the completion of a targeted questionnaire throughout February 2026 to strengthen responses to the self assessment.

Categorisation	Definition
Naïve	No formal approach developed. Risk is unmanaged and reactive. Lack of understanding of benefits arising from risk management.
Aware	Fragmented / silo-based approach. Risk is recognised and discussed, but processes are inconsistent and not embedded.
Defined	Framework, strategies and policies in place, with roles and processes defined. While processes followed, lack of credible and deliverable plans to fully manage and mitigate risks, and risks are not used to inform planning, decision-making and performance management.
Managed	Enterprise approach to risk management developed and communicated. Risk management is not consistently influencing planning, decision-making, and performance management.
Embedded	Risk management and internal controls fully embedded, and a risk-aware culture where risk insights drive strategy, planning, decision making innovation, and continuous improvement across the organisation.

Principle	Outcome	Observation
Governance and Leadership	Managed	The Health Board shows a consistently managed approach to risk governance, with clear accountability structures, defined roles for senior risk leaders. Strong commitment is evidenced through endorsed frameworks, regular executive-level oversight, and embedded operational processes, though opportunities remain to strengthen local ownership and consistency across the Health Board.
Integration	Aware	The Health Board demonstrates a defined approach to integrating risk into strategic and operational decision-making, using the Board Assurance Framework, defined risk appetite statements and a range of impact assessments to inform strategy, policy and decision making. While governance forums routinely consider emerging risks, the timeliness and consistency of risk articulation and entry onto risk registers remain areas for improvement.
Collaboration and Best Information	Aware	The Health Board has a developing but maturing approach to aggregating and sharing risk information, with themed risk registers and operational governance forums in place, though sharing risks with regional partners and local authorities remains inconsistent and requires clarity. While technical expertise is provided to support risk leads across the Health Board via a business-partnering model and structured training, broader organisational uptake of risk training would enhance consistency and strengthen overall risk management maturity.
Risk Management Processes	Defined	The Health Board has a defined and maturing approach to assessing risks, supported by clear risk categories, an annually approved risk appetite, standardised scoring criteria, and challenge and scrutiny through governance forums. Timely and consistent articulation of risks at operational levels requires strengthening. Variable quality in action plans, delays in updating risk registers and limited collaboration between different functions limit the organisation's ability to fully reflect its risk profile, exacerbated by resource and capacity constraints. Assurance arrangements are well-coordinated and embedded, with regular reporting, internal and external reviews and transparent annual disclosures, positioning the Health Board to strengthen and improve the quality and consistency of risk information used for decision-making.
Continual Improvement	Managed	The organisation has a managed and structured approach to assessing its risk maturity, undertaking an annual maturity assessment that gathers feedback from across the organisation and highlights areas for improvement to inform updates to the Risk Management Strategy. Progress against these improvement objectives is monitored and reported to the Audit and Risk Assurance Committee three times a year, ensuring visibility and accountability at senior levels.

Risk Maturity Assessment 2026: Key Themes and Observations Noted in Feedback



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Setting strategy and priorities

Senior leadership felt that risks are considered when setting and changing strategy and priorities. Responses from operational leads expressed concerns on items that are operational **issues** rather than true **risks being identified**, leading to overcrowded registers, reduced clarity, and difficulties in prioritising risks. Further observations included the **need to identify dependencies** across risks and other areas within the Health Board to support and enhance planning processes.

Training and capability building

Training was frequently mentioned as an area for improvement area from feedback obtained from operational leads. Staff describe wanting **more training overall**, especially earlier in career pathways, and **follow-up or refresher training**, not just one-off sessions. Several note that training is often accessed only at senior levels, leaving junior staff less equipped, with further training specifically noted in responses received from operational colleagues relating to **risk appetite** and **risk tolerance**.

Partnership Working

Respondents generally felt that improvements could be made in the **gathering and consideration of external stakeholder views** when risk owners identify and update risks.

Improvements to Datix and digital tools

Several respondents highlight the need for **better software**, particularly improvements or alternatives to Datix. Key matters raised include **lack of reminders for overdue actions**, and that Datix is clunky and time consuming to use. Further suggestions include the **increased use of AI** to support risk management.

Culture, communication, and organisational alignment

Whilst responses noted the clear accountability of risk ownership, responses were mixed regarding the dynamism of the risk register. Some respondents noted the need for more **discussion of risks across management teams, better communication about expectations, and clearer guidance on when risks can be tolerated**. Others felt **more hands-on support is required**, including having a dedicated person within each department to support and co-ordinate risk management.

The Assurance and Risk Team will review and update the Risk Maturity Feedback form as sent staff across the Health Board to assess against those areas where responses to the assessment have been scored poorly.



Risk Management Framework



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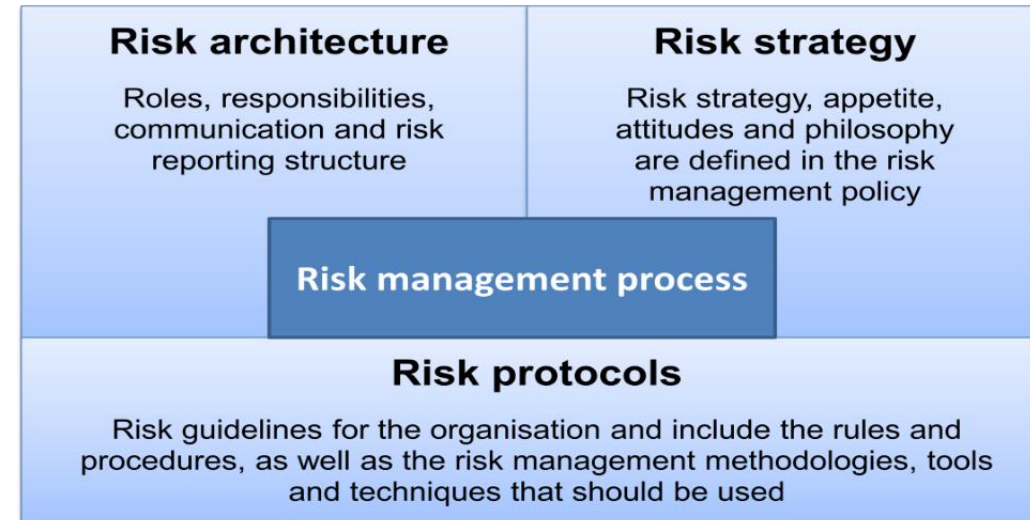
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Risk Management Framework (the Framework)

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 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



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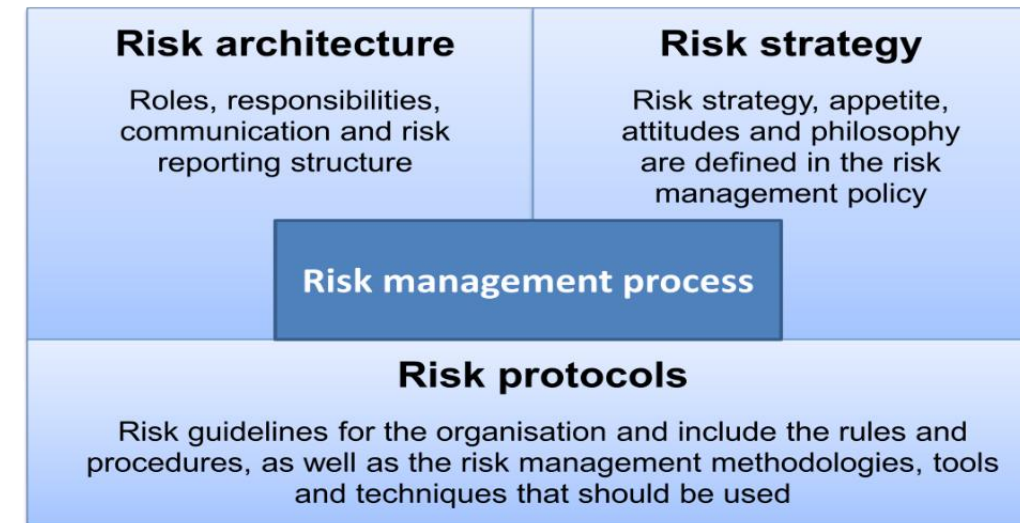
The [Health Board's Risk Management Strategy](#) provides a supportive framework that ensures the integration of risk management into policy-making, planning and decision-making processes, and specifically: -

- To improve the quality of service and protect patients, carers, staff and others who come in to contact with the Health Board;
- To create awareness through the Health Board about the importance of recognising and managing risk in a timely manner and providing staff with the appropriate knowledge, skills and support;
- To promote positive risk taking in the context of clinical care and in controlled circumstances;
- To provide a robust basis for strategic and operational planning through structured consideration of key risk elements;
- To enhance partnership working with stakeholders in the delivery of services;
- To improve compliance with relevant legislation and national best practice standards; and
- To enhance openness and transparency in decision-making and management.

The [Risk Management Strategy](#) (the Strategy), approved by Board in September 2025, sets 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 aims to support a dynamic and systematic approach to risk management, and to ensure prompt and comprehensive identification, assessment and management of risks that threaten the delivery of its strategic objectives and day-to-day operations.

The following slides detail the progress made against the objectives per the current Risk Management Strategy.



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



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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	In Progress – 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	In Progress - 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 Q1 and Q2 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	In Progress - Training Needs Analysis 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 will meet with colleagues in Learning and Development during Q1 of 2026/27 to determine how its utilisation can be improved at a local level, with a supporting checklist to be developed. The Assurance and Risk Team commenced delivering Risk Management New Managers Training Package in February 2026 as part of the Health Board-wide managers training programme. This will highlight importance of identifying the risk 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	Not started - The Board Assurance Framework is due to be presented to Board in July 2026 for approval, following which training materials will be revised to reflect any developments by August 2026 .

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



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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	In Progress - The Assurance and Risk Sharepoint site will be further developed when required to promote awareness of risk management arrangements, with improved utilisation of Viva Engage to communicate key messages as part of the development of a communications plan. The Head of Assurance and Risk will develop a documented communications plan for 2026/27 in Q1, which will: • link with key business processes such as Annual Planning; • consultation on the Risk Management Strategy ahead of its presentation to ARAC in August 2026; • Advertising risk management training; • Obtaining feedback to inform the outcomes of the next risk maturity assessment; and • Obtain input from Datix risk register users across the Health Board to further develop requirements for the new risk management system.
Developing a detailed scope and procure a new risk register system	In progress - A high-level project specification document for a risk management system has been developed, with a collaborative specification nationally expected to be completed by 31 March 2026. The Assistant Director of Assurance and Risk and Head of Assurance and Risk are working alongside colleagues in Procurement to finalise a detailed system specification document and agree delivery and implementation timescales.

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



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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. It is recognised that the approach to risk appetite is new to the organisation, implemented during 2025/26. 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 over Q1 and 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	Not started - The risk appetite statements will be reviewed by the Executive Team and will be discussed at Board Seminar in June 2026 .
Reviewing and updating strategic risks and Board Assurance Framework as part of Strategy Refresh	In progress - 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 will be 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



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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	In Progress - 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). Risk Maturity Assessment responses have been collated for 2026, with outcomes presented within this paper. The Head of Assurance and Risk will review and update the feedback form for completion by the wider organisation in Q1 2026/27, taking in to account the outcomes of this years' Risk Maturity Assessment so that progress and further areas of improvement can be identified.
Further development of risk management training material, with more focus on the identification of opportunities	In Progress - The Assurance and Risk Team continue to deliver and develop risk training including communication, as outlined in Objective 1. Material will be developed during Q1 2026/27 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	In Progress – 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 Head of Assurance and Risk will review and update the feedback form for completion by the wider organisation in Q1 2026/27, 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. The Assurance and Risk Team will develop written guidance on partnership risk management and include in relevant training and Sharepoint material once arrangements have been agreed, with the Risk Management Framework to be revised reflecting these arrangements

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 objectives and to deliver healthcare services in the ‘here and now’
- **Operational** – Risks that affect the objectives of a Function.

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

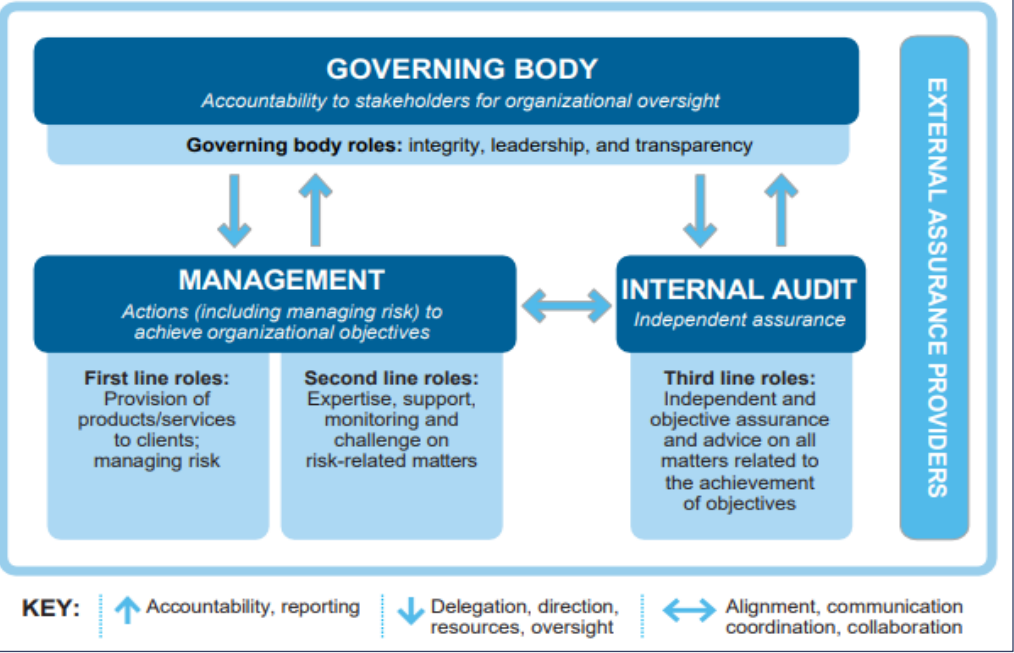
Risk architecture is the organisational arrangements for risk management which details the roles, responsibilities and the lines of communication for reporting on risk. These are detailed in the Risk Management Framework which was approved by Board in September 2025.



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.

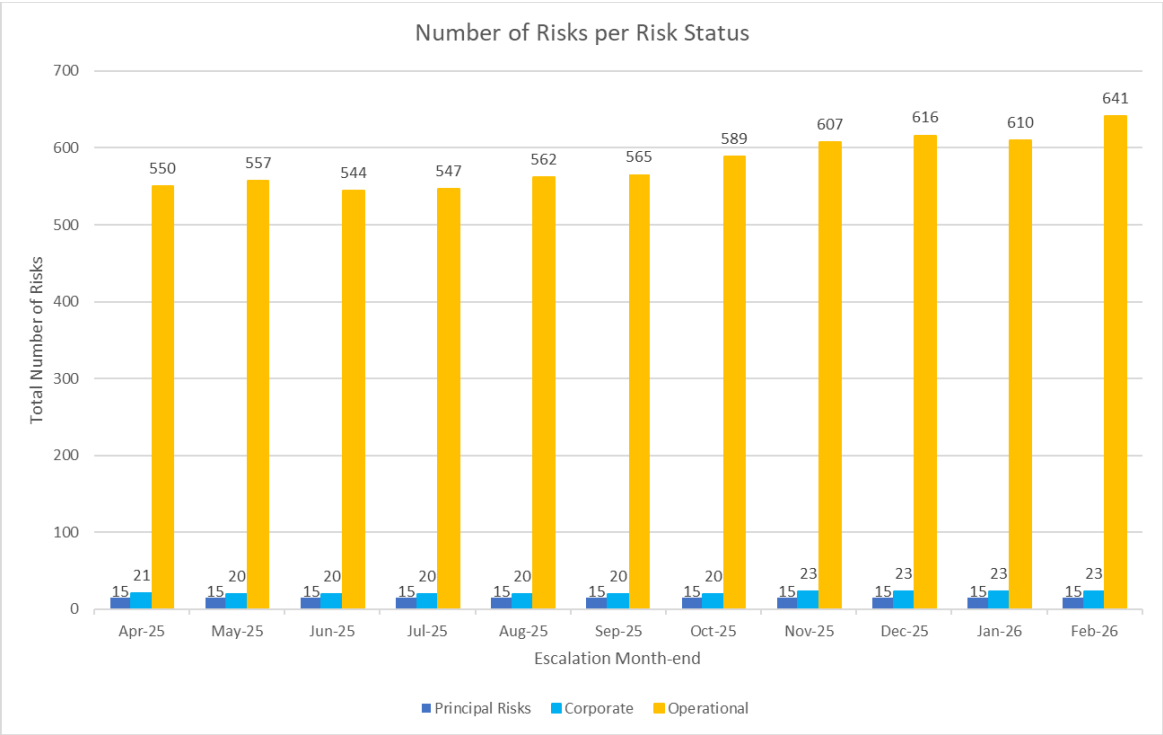
The IIA’s Three Lines Model



Context

The Health Board has 679 open risks on the Datix Risk Module as of 28 February 2026 (October 2025: 624) split across principal*, corporate and operational risk levels.

The chart shows a significant increase in the identification of operational risks in during Q4 of 2025/26, driven by the risk-based approach adopted as part of the Annual Planning process, with the highest numbers attributed to Planned & Specialist Care and Community & Integrated Medicine, with analysis provided on the next slides.



*The focus of this report and the Improving Together metrics are on Corporate and Operational Risks as the principal risks are reviewed by the Executive Team as part of the Board Assurance Framework

1st Line of Defence

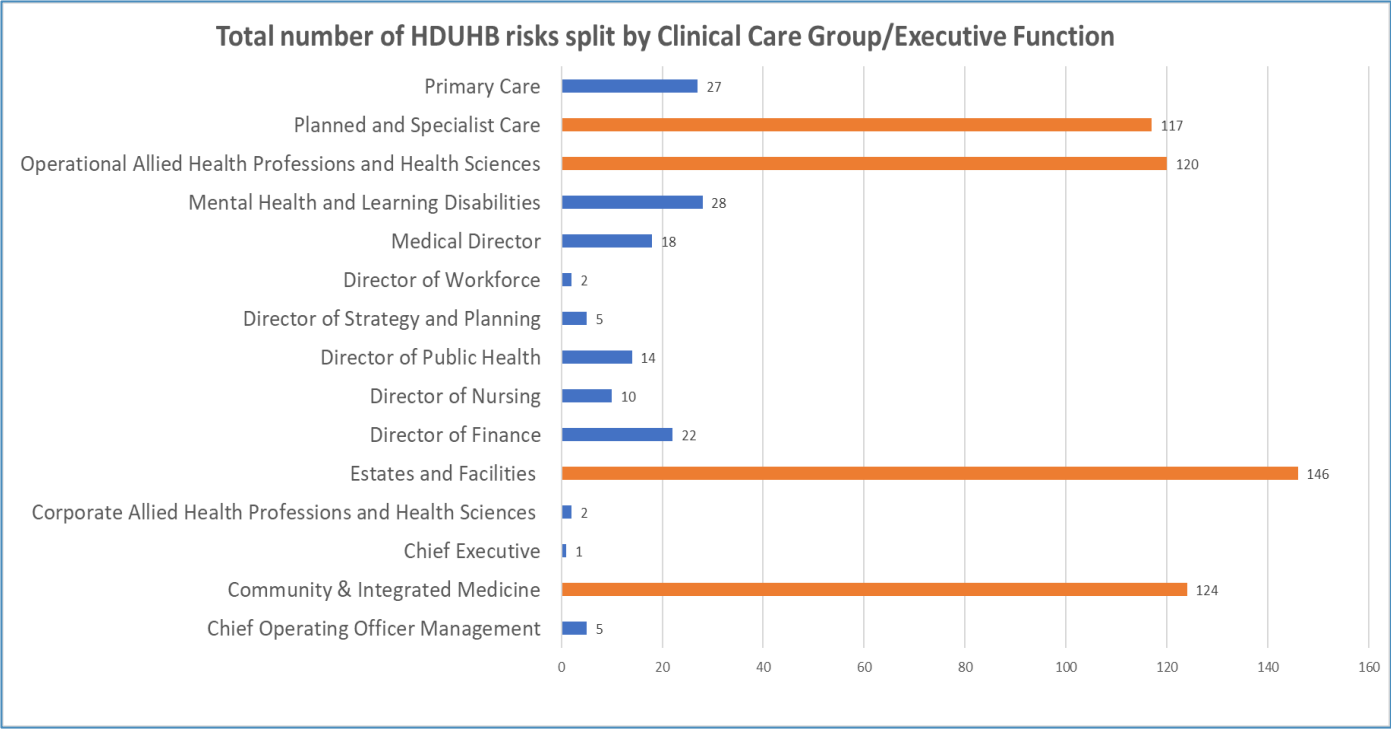
Risks by Function– February 2026

Estates and Facilities hold the largest number of risks at 146 (Oct 2025: 146), primarily relating to the condition of the Health Board’s ageing estate and infrastructure (including fire safety devices and equipment); with at least 76% 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* (February 2026: Current Risk Score - 15).

Community and Integrated Medicine hold 124 risks, a 27% increase since the previous report (October 2025: 98) reflecting an improvement in the timely addition of new risks onto Datix, as well as a reflection of the risks associated with winter pressures and operational challenges within unscheduled care.

Planned & Specialist Care hold 117 risks, a 12% increase since the previous report (October 2025: 105), reflecting the continued challenges with workforce shortages, service fragility, demand exceeding capacity, reliance on ageing or insufficient equipment, and the ongoing disruption to theatre activity due to three theatres currently out of commission within the Health Board.

Operational Allied Health Professions & Health Sciences hold 120 risks, a 4% increase since the previous report (October 2025: 116), with financial risks and service fragility cited as main drivers.



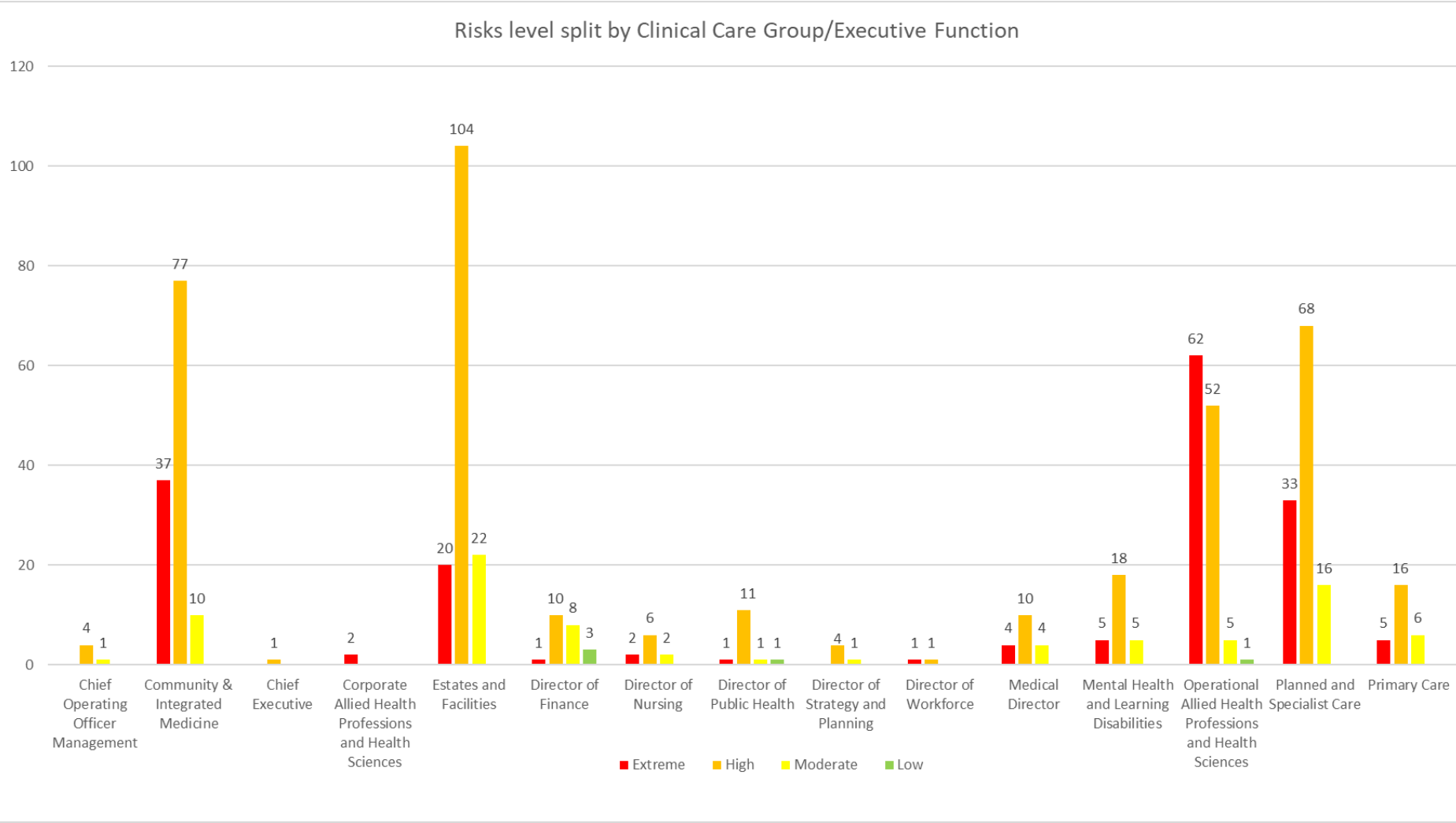
1st Line of Defence

Risk Management: Level of Risk held by Clinical Care Group/ Executive Function

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 28 February 2026, **Operational Allied Health Professions & Health Sciences** continues to hold the highest number of extreme-level risks across the organisation: **62 risks** (October 2025: 59) accounting for over 50% of their risk register.

32 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

The number of overdue risks have remained broadly consistent (remaining around 11% of the total number of risks) with **73 risks overdue for review as at 28 February 2026** (October 2025: 75).

Of those risks noted as overdue at February 2026, **36 have recently lapsed and are not overdue by more than one month** (October 2025: 64) and considered to be within an acceptable timeframe for review.

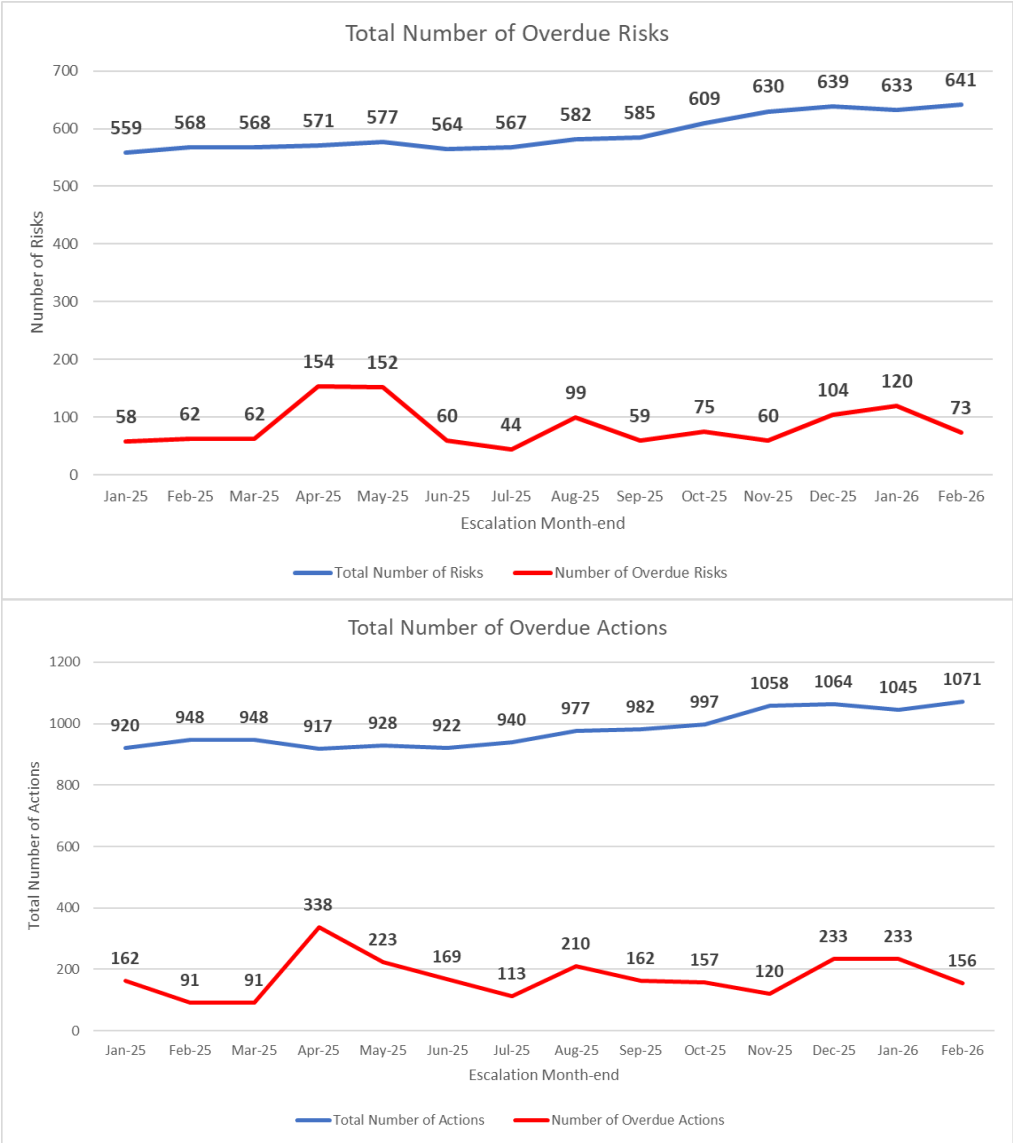
37 risks were overdue by more than one month (October 2025: 11), with **16 of these overdue by more than 2 months** indicative of the operational pressures faced Clinical Care Groups.

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.

A sustained number of risk actions are overdue; **15% at February 2026**, compared to 16% at October 2025, 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.

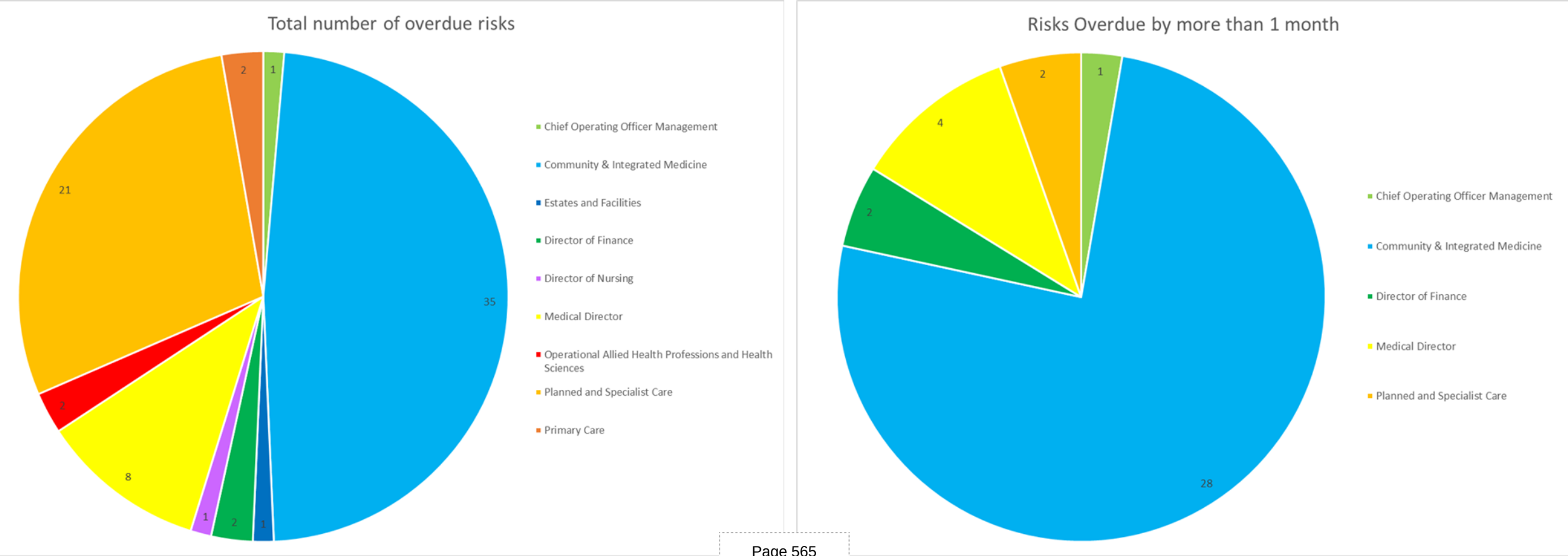


1st Line of Defence

Risk Management - Overdue Risks

The **73 overdue risks** at 28 February 2026 are shown below split by function. **Community & Integrated Medicine has the largest number of overdue risks** (35 out of 124 risks on their risk register, 28%) (Oct 2025: 19%) and overdue risk actions (57 of 238 actions (24%), Oct 2025: 29%). They also have the highest number of risks overdue by more than one month. This is reflected in their current escalation level of level 3, under the Governance domain. The CCG has shown improvement at February 2026 month end however it was not sufficient to de-escalate. **Planned & Specialist Care also hold a high number of overdue risks** with 21 out of 117 (18%) in February 2026 (Oct 2025: 13%), with 17% of their risk actions also being overdue, which is reflected in their current escalation level of level 2.

Overdue risk actions indicate that either the risks themselves have not been reviewed, or that the associated actions were not updated during the review process. Assurance and Risk Officers continue to provide support to risk leads to ensure that risks are updated appropriately and in a timely manner.



1st Line of Defence

Risk Management - Risk Treatment

9 risks do not currently have an ‘Expected Date to Achieve Target Risk Score (TRS)’.

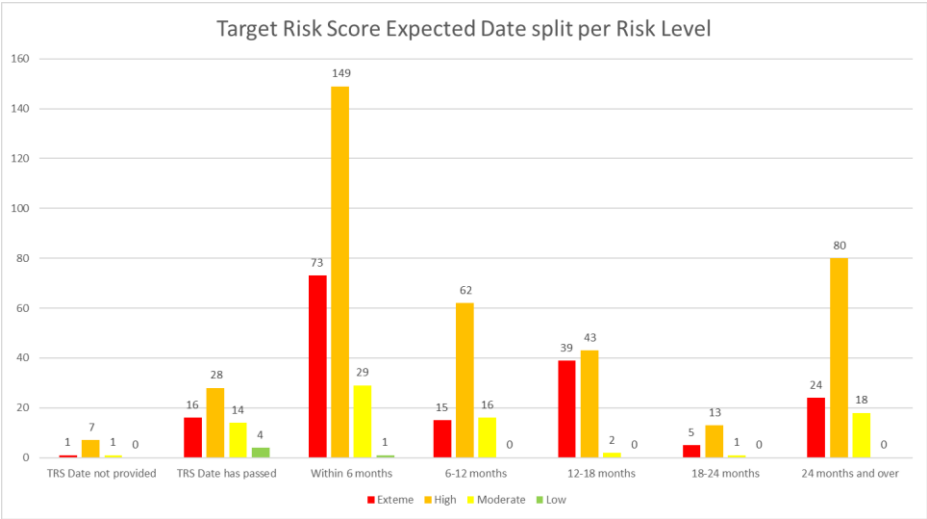
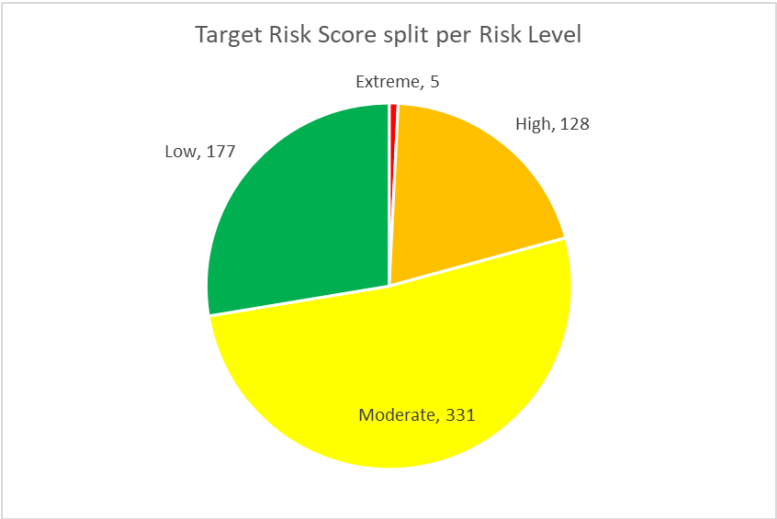
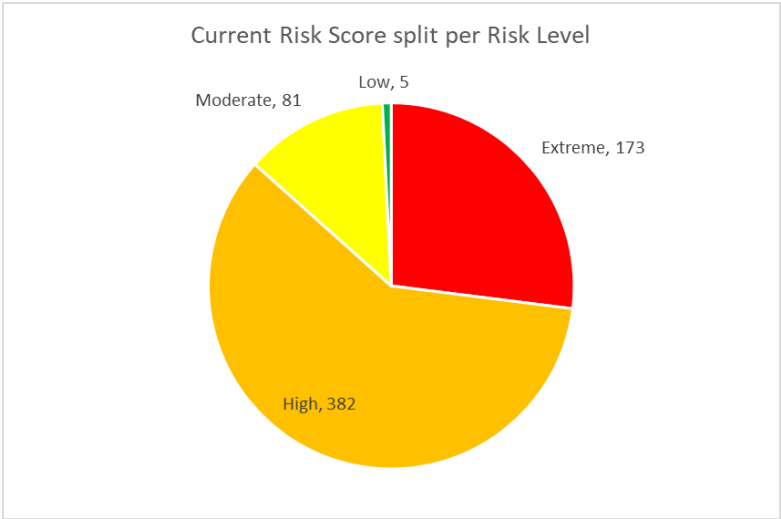
Risks have been reviewed, however the ‘Expected Date to Achieve TRS’ section has not been updated.

62 risks have an ‘Expected Date to achieve TRS’ that has passed, of which 18 have a current risk score that meets the TRS score:

- 23 risks have not been reviewed within timeframe
- 39 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 the 5 risks with an Extreme TRS, these are held by Operational Allied Health Professions and Health Sciences (3), Community and Integrated Medicine (1) and Mental Health and Learning Disabilities (1).

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.



2nd Line of Defence

Oversight of Risk - Internal Escalation



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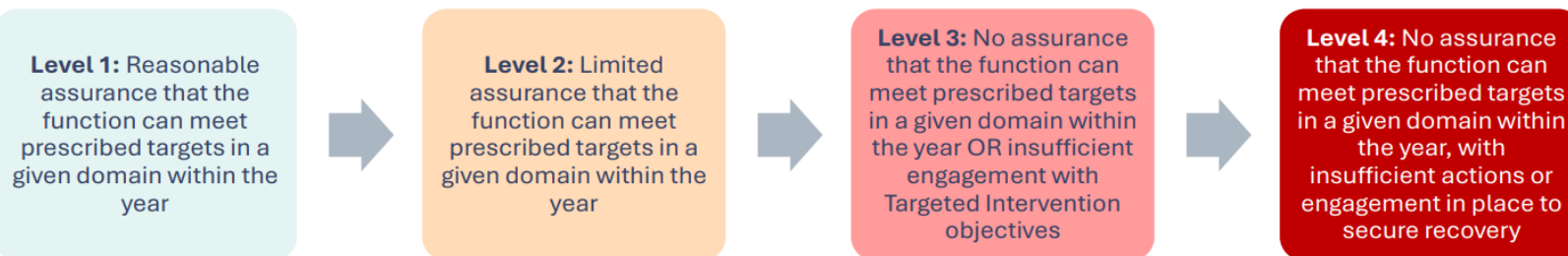
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Internal Escalation

The Health Board has an internal escalation process, as part of the Executive Improving Together (EIT) Framework, whereby CCG / Executive Functions are assessed monthly against seven domains. 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 due to be implemented from April 2026.



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 leadership to make informed decisions on prioritisation of resources

2nd Line of Defence

Internal Escalation Framework – Governance Domain



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Service	October 2025	November 2025	December 2025	January 2026	February 2026
Chief Operating Management	2	2	2	2	2
Community & Integrated Medicine	3	3	3	3	3
Estates & Facilities	1	1	1	1	1
Executive Director of Allied Health Professions and Health Sciences	1	1	1	1	1
Executive Director of Finance	1	1	2	2	2*
Executive Director of Nursing, Quality and Patient Experience	2*	2	2	1	1
Executive Director of Public Health	1	1	1	1	1
Executive Director of Strategy and Planning	1	1	1	1	1
Executive Director of Workforce and Organisational Development	1	1	1	1	1
Medical Director	1	1	1	1	1
Medicines Management	n/a	n/a	1	1	1
Governance and Communication	1	1	1	1	1
Mental Health and Learning Disabilities	2	1	1	1	1
Operational Allied Health Professions and Health Sciences	1	1	1	1	1
Planned and Specialist Care	2	2	2	3	2
Primary Care	2*	2	2		2*

As at 28 February 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:

- Chief Operating Management;
- Planned & Specialist Care.

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 (Primary Care and Director of Finance) 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

Community & Integrated Medicine

As at 28 February 2026, the Clinical Care Group (CCG) had **35 of 124 risks overdue (28%)**, an improvement on the January 2026 position (38%) but still met the Level 3 criteria for Governance escalation (less than 80% compliance).

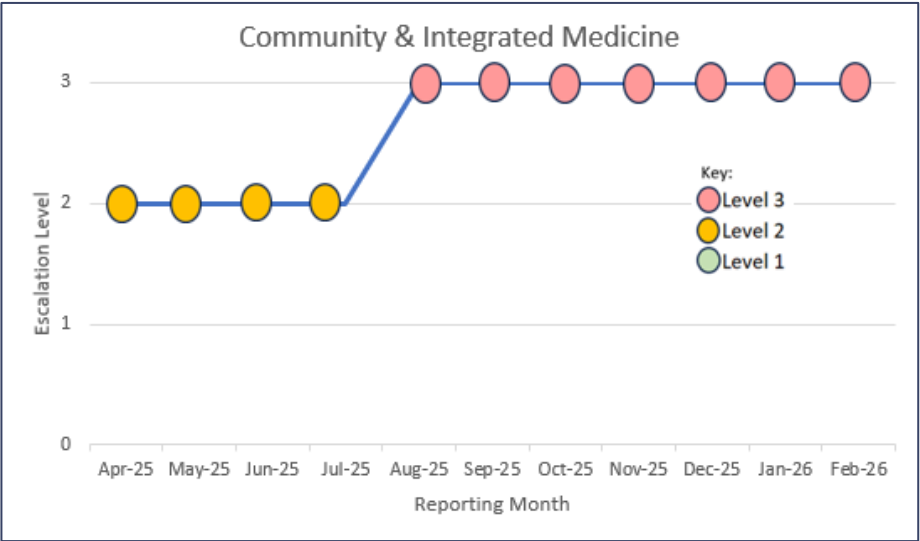
The CCG had 238 open risk actions, of which 57 **were overdue (24%)**. Whilst an improvement on the January 2026 position (33%), the CCG again met Level 3 criteria (less than 80% compliance of risk actions being updated within required timescales).

Additionally, **6 risks (2 extreme and 4 high scoring risks) did not have any open actions**.

5 of the 124 risks (4%) did not have an ‘Expected Date to achieve TRS’, and a further **11 risks do not have a ‘Rationale for Target Risk Score (TRS)’** noted on Datix. 8 risks had been reviewed which had an ‘Expected Date to achieve TRS’ which had passed and the date not been revised accordingly, suggesting that risks are not fully updated during review.

Recent improvements include the increased pace of adding new/emerging risks to Datix, which had previously been an area of concern. 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. The Assurance and Risk Officer is also supporting the Carmarthenshire Integrated System to review the whole system risk register with risk deep dive meetings scheduled in March and April 2026.

The Assurance and Risk Officer continues to offer support to the CCG by meeting when required with risk leads and highlighting this information at the relevant governance meetings.



2nd Line of Defence

Internal Escalation Framework – Governance Domain Level 2 – Limited Assurance



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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 21](#) based on data available at 28 February 2026:

Clinical Care Group / Executive Function	Reason for award of L2	De-escalation Criteria
Chief Operating Officer	Sustained position with 1 (20%) risk overdue and 1 (25%) risk action overdue (less than 80% compliance). This is not a significant concern due to the small total numbers (5 risks and 4 actions).	To achieve Level 1, 90% of risks and risk actions are reviewed within timeframes and compliance achieving TRS dates
Planned and Specialist Care	An improved position with 21 out of 117 (18%) risks overdue and 29 out of 186 (16%) risk actions overdue (over 80% compliance) . This was primarily due to services not updating their risks 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

2nd Line of Defence

Thematic Analysis



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Risk owners can assign multiple 'themes' to their risks on Datix, which allows the Health Board to share risk information on specific areas, with the relevant subject matter experts within the Health Board. They in turn can offer specific support and guidance to risk owners in the management of risk and identify trends and areas of concern.

Each 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.

Further work is being undertaken by the team to review certain risk themes, such as 'Patient Safety and Quality', to ensure these are as effective and meaningful as possible and appropriately aligned to the relevant group within the revised governance arrangements underpinning QSEC.

The following slide details the progress made and planned work relating to risk themes since the previous report presented to ARAC.



2nd Line of Defence

Thematic Analysis



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Risk theme	Committee theme reported to	Review undertaken
Climate Change and Adaptation	Strategy and Planning Committee	This theme was added to the risk register system and identified risks have recently been aligned, with the following definition noted for the theme: <i>Risks arising from the impacts of climate change on healthcare services, infrastructure, supply chains, and workforce, including the adequacy of adaptation measures to maintain resilience and continuity of care</i>
Fragile Services	Quality, Safety and Experience Committee	A review meeting is being held in March 2026 with the Interim Assistant Director of Nursing to review these themes due to the new reporting structures under QSEC to ensure their oversight at the appropriate sub-group of QSIG.
Infection Control	Quality, Safety and Experience Committee	
Medication	Quality, Safety and Experience Committee	
NICE/National Guidance	Quality, Safety and Experience Committee	
Patient Safety	Quality, Safety and Experience Committee	
Quality	Quality, Safety and Experience Committee	
Safeguarding	Quality, Safety and Experience Committee	The Workforce theme has now been reviewed to better align to the Workforce & OD Directorate Pillars with all risks having been re-aligned to the revised themes, enabling more meaningful information to be captured from the data, to provide better insight.
Workforce - Recruitment	People, Organisational Development and Culture Committee	
Workforce - Leadership	People, Organisational Development and Culture Committee	
Workforce - Culture	People, Organisational Development and Culture Committee	

2nd Line of Defence: Committee and Reporting Structures



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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 [November 2025](#) as part of the BAF Dashboard. The Health Board is updating the planning objectives, principal risks and outcome measures which support the four strategic objectives as part of the Strategy Refresh which will be presented to Board in July 2026. There has been a pause in the reporting of principal risks to Committees while this work is being completed.

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 [January 2026](#), with a total of 23 risks on the Corporate Risk Register as at February 2026.

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 is able 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. However, due to operational pressures, these sessions have been rescheduled to recommence in May 2026, with a minimum of two risks to be reviewed each month.



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2nd Line of Defence: Committee and Reporting Structures

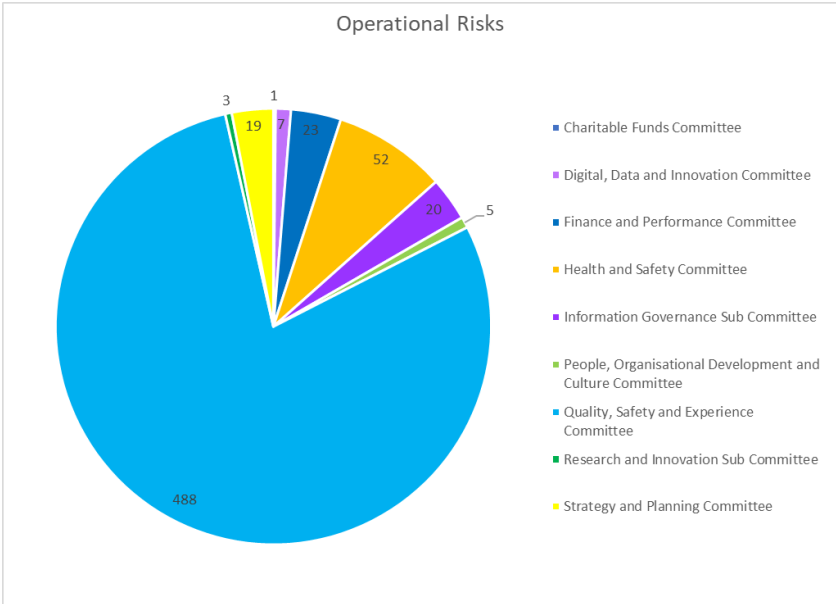
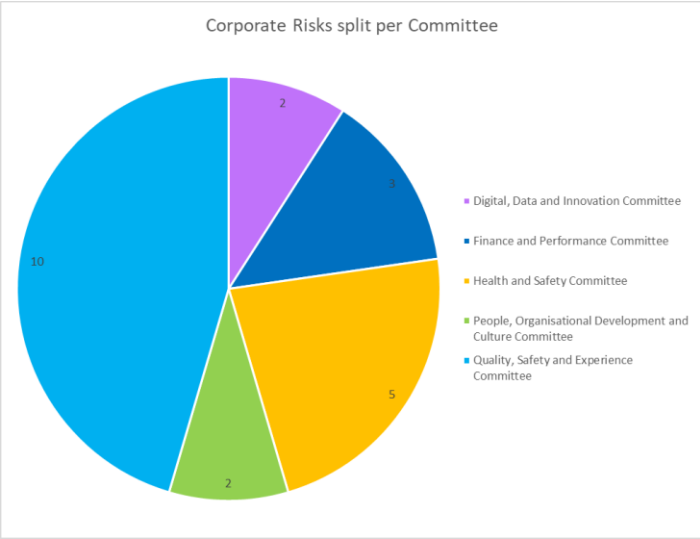
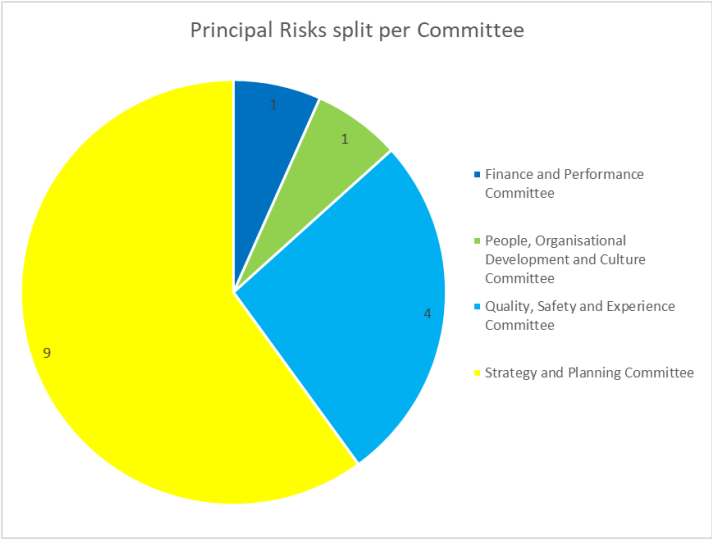
2. Board Committees and Sub-Committees

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. Following the change in reporting arrangements, all risks (principal, corporate and operational) are now 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.

Operational risks are also reported to sub-committees, each of whom have delegate authorities 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.

Tables of Actions are generated from meetings reflecting any queries or actions from committee discussions in relation to risk management which require to be clarified or further actions undertaken.



2nd Line of Defence: Committee and Reporting Structures Corporate Risk Register



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The tables below summarise the changes to the Corporate Risk Register (CRR) since the previous report presented to ARAC in December 2025. All changes are included in risk reports presented to Board and Committees.

Additions to the Corporate Risk Register

Risk Ref and Title	Clinical Care Group/Executive Function	Lead Committee	Current Risk Score Feb-26	New or escalated Risk	Date of change on CRR
2204 - Risk of Health Board being unable to meet statutory CRL due to uncertainties around funding provision and capital commitments	Strategy & Planning	Strategy and Planning Committee	12	New Risk	09/03/2026
2305 - Risk to staff wellness due to pace and breadth of organisational change	Workforce & Organisational Development	People, Organisational Development and Culture Committee	20	New Risk (see below)	12/03/2026
1988 - Risk of prolonged outage following cyber-attack caused by insufficient measures to recover.	Finance	Digital, Data and Innovation Committee	12	Escalated and replaced risk 1352 (see below)	03/12/2025

Removals from the Corporate Risk Register

Risk Ref and Title	Clinical Care Group/Executive Function	Lead Committee	Reason for Removal	Date of change on CRR
1352 - Risk of business disruption and delays in patient care due to a cyber attack	Finance	Digital, Data and Innovation Committee	Closed and superseded by risk 1988 (see above)	03/12/2025
1821 - Risk to the welfare of Health Board staff due to current demands	Workforce & Organisational Development	People, Organisational Development and Culture Committee	Closed and superseded by risk 2305 (see above)	12/03/2026

2nd Line of Defence: Committee and Reporting Structures Corporate Risk Register



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The table below summarises the changes to the Corporate Risk Register (CRR) since the previous report presented to ARAC in December 2025. All changes are included in risk reports presented to Board and Committees.

Changes in Current Risk Score:

Risk Ref and Title	Clinical Care Group/Executive Function	Lead Committee	Current Risk Score Oct-25	Nature of Change	Date of change on CRR
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	16	Increase in Current Risk Score from 12 to 16	19/02/2026
2086 - Risk that the cash consequences of the Health Board deficit cannot be covered by WG should it exceed our Target Control Total	Finance	Finance and Performance Committee	12	Decrease in Current Risk Score from 15 to 12	26/02/2026
1531 - Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Planned & Specialist Care	Quality, Safety and Experience Committee	15	Increase in Current Risk Score from 10 to 15	05/03/2026

Changes in Target Risk Score:

Risk Ref and Title	Clinical Care Group/Executive Function	Lead Committee	Current Risk Score Oct-25	Nature of Change	Date of change on CRR
1032 - Risk of timely ASD diagnostic assessment for CYP due to increasing demand	Mental Health & Learning Disabilities	Quality, Safety and Experience Committee	20	Decrease in Target Risk Score from 16 to 12	20/02/2026
797 - Risk of adverse patient and workforce outcomes if health board wide ultrasound services are unsustainable	Operational Allied Health Professions & Health Sciences	Quality, Safety and Experience Committee	25	Decrease in Target Risk Score from 15 to 10	14/01/2026

3rd Line of Defence

Independent Assurance



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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.

Audit Wales also recommended that the Health Board update the Board Assurance Framework Dashboard to include committee oversight arrangements. In response, the Board agreed in November 2025 to incorporate these oversight arrangements into the supporting information on the BAF Dashboard. In addition, Principal Risks are now included in the Assurance and Risk reports presented to each Committee.



3. 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, alternating the agendas of Quality, Health & Safety, and Business, Planning, Performance & People.

The CCG's remit is to evidence to the Integrated Quality, Finance and Performance Delivery Group (IQFPDG) that these risks are being managed and monitored effectively in line with the Health Board's Risk Management Framework, or escalated as required. The requirements of the CCG are stipulated within the Operational Scheme of Delegation as has been 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.



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Next Steps and Recommendations



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Next Steps

This report highlights the progress made against the objectives as set out in the Risk Management Strategy, and identified the following actions for which updates will be provided to ARAC in the next Risk Assurance report in August 2026:

- 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; and
- 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 for endorsement.

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.



Risk Maturity Definitions

Categorisation	Definition
Naïve	No formal approach developed. Risk is unmanaged and reactive. Lack of understanding of benefits arising from risk management.
Aware	Fragmented / silo-based approach. Risk is recognised and discussed, but processes are inconsistent and not embedded.
Defined	Framework, strategies and policies in place, with roles and processes defined. While processes followed, lack of credible and deliverable plans to fully manage and mitigate risks, and risks are not used to inform planning, decision-making and performance management.
Managed	Enterprise approach to risk management developed and communicated. Risk management is not consistently influencing planning, decision-making, and performance management.
Embedded	Risk management and internal controls fully embedded, and a risk-aware culture where risk insights drive strategy, planning, decision making innovation, and continuous improvement across the organisation.

Governance and Leadership - *Risk management shall be an essential part of governance and leadership, and fundamental to how the organisation is directed, managed and controlled at all levels.*

Overall Assessment: Managed

Assessment Criteria	Risk maturity level	Comments
How is the desired risk culture defined, communicated, and promoted? How is this periodically assessed?	Managed	• Risk Management Framework, Strategy and Policy in place, and available to staff across the organisation via Sharepoint. • Defined risk appetite statements in place and reviewed annually, aligned to the organisations' risk domains. Available to staff across the organisation via Sharepoint. • Annual Risk Maturity Assessment undertaken. • Business partnering approach from a dedicated Assurance and Risk Team, who provide risk training and promote the requirements of the Framework, Strategy and Policy.
How do human resource policies and performance systems encourage and support desired risk behaviours and discourage inappropriate risk behaviours?	Defined	• Job descriptions for roles developed with reference to risk management requirements included as applicable and relevant to the position. • Standardised job templates in place which reference the requirement of all staff to undertake Health and Safety / Display Screen Equipment assessment as appropriate to their role.

		• Risk Management Training Needs Analysis is contained within Risk Management Framework. Risk not a mandatory learning area for training, however suite of training materials available via "New Managers Training", and staff are able to access technical risk training and risk system training via the Assurance and Risk Team. • Feedback from operational staff continue to highlight that risk training / risk awareness is not being identified by managers as part of local induction/PADRs.
How has the nature and extent of the principal risks that the organisation is willing to take in achieving its objectives been determined and used to inform decision making? Is this risk appetite tailored and proportionate to the organisation?	Defined	• Review of the Board Assurance Framework three times a year by the Executive Team, which the principal risks underpin. Strategy Refresh undertaken in 2025/26, with work currently underway to review and refresh the organisation's principal risks to align with the four strategic objectives. • Executive Team annually review the Health Board's risk appetite prior to Board approval. Risk leads are required to deliver a credible plan to achieve the target risk scores by an expected date which is in line with the Health Board risk appetite, and to escalate where needed any risk which cannot be reduced to this acceptable level.
How are the board and other governance forums supported to consider the management of risks, and how is this integrated with discussion on other matters?	Managed	• Regular reporting of principal and corporate risks to the Board via the Chief Executive's report. • The Formal Executive Team review and oversee the principal and corporate risks. • Regular reporting of principal, corporate and operational risks to the Board committees via the Assurance and Risk Report to provide assurance that risks are being managed effectively. • Regular reporting of corporate and operational risks to Clinical Care Group and Executive Function governance and management groups for discussion and focus on operational management of identified risks, with risks escalated as appropriate to the Executive Team either at IQFPD or FET. • Reports submitted to Board and its committees are requested to highlight any associated risks within the reporting templates, Committees able to request deep dive on risks where deemed necessary and appropriate.
How effective are risk information and insights in supporting decision-making, in terms of the	Aware	• Risk registers are utilised widely to inform decision making, however it is recognised that further work is needed to ensure risk registers fully reflect the

focus and quality of information, its source, its format and its frequency?		organisational risk profile. Risks do not always accurately reflect the current context or risk.
How are authority, responsibility and accountability for risk management and internal control defined, co-ordinated and documented throughout the organisation?	Managed	• Authority, responsibility and accountability outlined in the Risk Management Framework. • Risks and risk registers have identified risk leads and risk owners. • Each risk required to detail internal controls in place to manage and mitigate them • Quality of risks are assessed via the Health Board's internal escalation processes within the Governance domain, recognising that as at February 2026, 3 Clinical Care Groups have been awarded either Level 2 or Level 3 within the Governance domain reflecting improvements required in risk management. • Risks are shared regularly with subject matter experts within Health Board via themed risk registers, however capacity can limit the amount of support that can be provided to risk leads. • Annual Risk Maturity Assessment.
How is the designated individual responsible for leading the overall approach to risk management positioned and supported to allow them to exercise their objectivity and influence effective decision-making?	Embedded	• Director of Corporate Governance / Board Secretary attends the Board, ARAC, FET and other Health Board Committees. • Director of Corporate Governance / Board Secretary has managerial responsibility and is supported by the Assistant Director of Assurance and Risk (ADOAR), Head of Assurance and Risk (HAR) and the Assurance and Risk Team. • Responsibilities are clearly set out in the Risk Management Framework.
How are the necessary skills, knowledge and experience of the organisation's risk practitioners assessed and supported?	Embedded	• Dedicated Assurance and Risk Team who support leads across the organisation with risk management, with ADoAR, HAR and Officers all IRM qualified. • Internal training framework in place to support individuals in obtaining IRM certification via Annex 21. • Job descriptions in place detailing required experience and qualifications for ADoAR, HAR and Assurance and Risk Officers. • Job descriptions across the wider organisation in place detail requirements for risk management where appropriate. • All-Wales Governance forums in place which are attended by the Assurance and Risk Team where best practice is shared amongst Health Boards and facilitates discussions on topics including risk management.

		- Internal audits undertaken with relevant risks reviewed as appropriate. - Audit Wales undertake an annual Structured Assessment where risk management arrangements are examined.
How has the necessary commitment to risk management been demonstrated?	Managed	- Endorsement of Risk Management Framework, Strategy and Procedure by the Board, its Committees and the Executive Team, and underpinning risk appetite statements. - Regular reporting of principal, corporate and operational risks to committees with active oversight of risks. - Monthly risk meetings with Executive Team who oversee the principal and corporate risks, consider the risk appetite, RM Framework and organisational risk maturity. - Each Clinical Care Group and Executive Function has its own operational risk register and risk management is included as part of its local integrated governance group. - Risk management considered as part of the Health Board's internal escalation framework within the Governance domain. - Dedicated risk support function via the Assurance and Risk Team. - It is recognised that effective and full delivery of the Risk Management Framework is dependent on leadership capacity.

Integration - Risk management shall be an integral part of all organisational activities to support decision-making in achieving objectives.

Overall Assessment: Aware

Assessment Criteria	Risk maturity level	Comments
How are risks considered when setting and changing strategy and priorities?	Defined	- Board Assurance Framework in place which identifies risks to the achievement of the Health Board's strategic objectives. Focussed discussions on these risks as a result of the organisation's strategic refresh throughout 2025/26 via workshops with the Executive Team and individual meetings with executive risk leads. - Organisational risk appetite in place, with all risks required to be assessed as to whether they are within it, with the ability to escalate those outside acceptable levels to support the prioritisation of matters which require addressing.

		• Risk based approach adopted with the Annual Planning process in 2025/26, however it is recognised that further work is needed to ensure risk registers fully reflect the organisational risk profile. • QIAs, EQIAs, DPIAs, HIAs are undertaken to inform strategic decision-making.
How are risks transparently assessed within the appraisal of options for policies, programmes and projects or other significant commitments?	Defined	• Reports submitted to Board and its committees which require decision are requested to highlight any associated risks. Whilst Board and committee reports evidence up to date and accurate risks associated with decisions, these are not always as accurate or up to date on the risk management system. Documentation is publicly available. • QIA, EQIA, DPIA, HIAs etc undertaken on the development of policies and procedures, programmes, etc.
How are emerging risks identified and considered?	Aware	• Emerging risks are regularly requested for consideration at all levels through the organisation via operational meetings such as Formal Executive Team, Clinical Care Group governance meetings, Executive Function management meetings. • Escalation of risks where appropriate through management and governance structures. • Assessment of the timeliness of the addition of identified new / emerging risks via the internal escalation framework (Governance domain). • While processes are in place, it is recognised that risks are not always articulated and included on risk registers in a timely manner, and reviews of risk assessments do not always reflect the current risks/mitigations (current and planned) which can impact business planning and prioritisation. • Feedback obtained has also highlighted that there are instances where issues are being framed as risks.
How are risks to the public assessed and reflected within policy development and implementation?	Aware	• Completion of QIAs, EQIAs, HIAs to inform Committee scrutiny and Board decision-making. • Consultations on decisions with significant impact to the public, with feedback taken onboard. • Risk domains on the risk management system include those linked to patient safety, quality and reputation, however it is recognised that risks are not always articulated and updated on risk registers in a timely manner.
How are National Risk Register risks, that are particularly pertinent to the organisation,	Naïve	• The National Risk Register has been utilised in relation to emergency planning risks, however work is required to link NRR risks with Health Board risk themes to

recognised in risk assessments and discussions?		ensure a holistic review and consideration, with key findings to be presented to the Executive Team.

Collaboration and Best Information - *Risk management shall be collaborative and informed by the best available information and expertise.*

Overall Assessment: Aware

Assessment Criteria	Risk maturity level	Comments
How is an aggregated view of the risk profile informed across the organisation, joint committees, partnership boards, hosted functions, national organisations (such as DCHW, Velindre NHS Trust) and the extended enterprise supporting the delivery of services?	Aware	Organisationally • Risk reporting with heatmaps as noted above via Board and Committee reporting, reporting to FET and operational governance meetings, and escalated as appropriate. • Utilisation of themed risk registers, aligned to relevant Committees for assurance purposes, and sent to themed risk experts (SMEs in their relevant fields) to support risk leads where appropriate. • Included in Accountability Report annually. Externally • Governance arrangements in place regionally with Swansea Bay UHB as part of RJC, with risks being reported to Board, however this is in its infancy. While arrangements are in place between the Health Board and Local Authorities, risks are not regularly shared. • Poor articulation of risks on the Health Board risk register which reflect the impact of external organisations that we work with affect our ability to deliver against our own objectives.
How are the views of external stakeholders gathered and included within risk considerations?	Aware	• By risk owners and their interactions with relevant stakeholders. Feedback obtained from leads across the organisation highlighted that services continue to work in silo, and not necessarily on a system-wide basis. • External audits, inspections and regulatory reviews which highlights gaps in control that should subsequently be risk assessed, however not always appropriately reflected on risk assessments. • Consultation and engagement processes with the public on significant changes to services.

		RJC / RPB structures in place, and meetings with Welsh Government (eg JET and IQPD).
How does communication and consultation assist stakeholders to understand the risks faced and the organisation's response?	Defined	- Board and Committee papers publicly available, demonstrating a commitment to transparency on decision being made and areas of concern. - Health Board governance arrangements available on the website, including structures and terms of references detailing the role of risk for each group. - Outcomes of consultation processes regularly communicated to stakeholders via organisational social media platforms and press releases.
How is function and professional expertise used to inform strategies, plans, programmes, projects and policies?	Aware	- Utilisation of themed risk registers, aligned to relevant Committees for assurance purposes, and sent to themed risk experts (SMEs in their relevant fields) to support risk leads where appropriate, and identify gaps in organisational controls. However, this is dependent on the capacity of risk theme experts support risk management activities. - Utilisation of risk registers as part of the Fragile Services Framework, Annual Planning Processes, however recognising that this is dependent on risks being appropriately articulated and updated on risk management system.
How do expert functions and professions inform the identification, assessment and management of risks and the design and implementation of controls?	Aware	- Business partnering model adopted within a dedicated risk team, providing technical risk advice and guidance to risk leads with the aim to ensure appropriate and good-quality risks are articulated and noted on risk registers. - Regular review of risks between risk leads and the Assurance and Risk Team for principal, corporate and operational risks. - in-house Risk training in place, delivered by IRM qualified individuals to leads across the organisation highlighting the significance of the identification, assessment and management of risks, including highlighting gaps in control and supporting the development of deliverable and credible risk action plans. Feedback obtained from operational leads has highlighted that risk training is not embedded throughout all levels of the organisation (eg on local induction) and can be seen as a management objective. - Utilisation of themed risk registers, aligned to relevant Committees for assurance purposes, and sent to themed risk experts (SMEs in their relevant fields) to support risk leads where appropriate, and identify gaps in organisational controls. However this is dependent on the capacity of risk theme experts support risk leads and to support the timely identification of risks and their articulation.

How are functional standards communicated and their adherence monitored across the organisation?	Defined	- Risk Management Framework, Strategy and Policy in place and shared with staff across the organisation. - Internal Escalation Framework in place with areas of concern identified via the Governance domain – risk management being a key component of this assessment. As at February 2026, 1 Clinical Care Group has been assessed as Level 3 due to risk management, with a further 2 Clinical Care Groups assessed as Level 2 (out of 16 Clinical Care Groups / Executive Functions). These 3 functions hold 36.8% of the Health Board's risk register.

Risk Management Processes - *Risk management processes shall be structured to include:*

- risk Identification and assessment to determine and prioritise how the risks should be managed;*
- the selection, design and implementation of risk treatment options that support achievement of intended outcomes and manage risks to an acceptable level;*
- the design and operation of integrated, insightful and informative risk monitoring; and*
- timely, accurate and useful risk reporting to enhance the quality of decision-making and to support management and oversight bodies in meeting their responsibilities.*

Overall Assessment: Defined

Assessment Criteria	Risk maturity level	Comments
How are risk taxonomies or categories used to facilitate the identification of risks within the overall risk profile?	Aware	- Risks assigned to one domain per the organisation's risk matrix, based on the biggest impact of the risk. - Risk appetite statements linked to risk domains, and a risk matrix in place to support a consistent approach to scoring, and facilitate clarity in the prioritisation of risks which exceed the Health Board's risk appetite and support their escalation as appropriate for further discussion and decision. Capacity limits the ability to review all risks to ensure their consistent application, and the embedding of the approach to risk appetite is further required for operational leads. - Ability to categorise risks by risk themes, with thematic risk registers sent to SMEs bi-monthly to support the comparing of risks across the organisation, identify common themes, trends and actions to manage and mitigate risks.

		Definitions for each theme in place and communicated to the organisation via Sharepoint site.
How are risk criteria set to support consistent interpretation and application in assessing the level of risk? How effective are these in supporting the understanding and consideration of the likelihood and consequences of risks?	Defined	• Defined risk appetite statements reviewed annually and approved by the Board. • Risk matrix in place to promote the consistent scoring of risks based on risk domains. Capacity limits the ability to review all risks to ensure their consistent application. • Risk criteria, processes and protocols are outlined within the Risk Management Framework, Strategy and Procedure documents. • Dedicated risk training in place to embed risk criteria with staff across the organisation, however recognising feedback from survey that this could be embedded better at lower levels in the organisation. • Standardised approach to the wording of risk narrative to support consistency across the organisation (There is a risk of / This is caused by / This will have an impact/effect on), recognising that risk still remains subjective and the quality of the narrative and risk articulation can vary.
How are limitations and influences associated with the information and evidence used with risk assessments highlighted?	Defined	• Reporting of risks to Board Committees allows challenge on the scoring and management of risks, with Committees able to request deep dive on risks if further discussion required. • Risk profiles of Clinical Care Groups and Executive Functions are reported via the Risk Assurance report, based on the levels awarded as part of the internal escalation framework which is presented to the Audit and Risk Assurance Committee three times a year. • Support is offered to operational leads across the organisation from dedicated qualified risk professionals within the Assurance and Risk Team to check and challenge risks. • Discussion on operational risks at Clinical Care Group governance meetings / Executive Function management meetings which provides the opportunity to moderate and appropriate challenge from colleagues in the wider function, based on reports provided by the Assurance and Risk Team.
How are interdependencies between risks or possible combinations of events ('domino' risks) identified and assessed?	Aware	• Fragile services framework and the annual planning process allow the consideration of risks which are interdependent, and to inform business and strategic decision making, however recognising that communication between different Clinical Care Groups and Executive Functions can improve to ensure risks are assessed appropriately and collaboratively where required.

		- Current risk management system allows risk owners to link relevant risks, recognising that this is a manual and time-consuming process. - Regular meetings between Assurance and Risk business partners which identify risks that may cross-cut various Clinical Care Groups and Executive Functions - Utilisation of themed risk registers, however dependent on the capacity of risk theme experts support risk leads, undertake appropriate analysis and to support the timely identification of risks and their articulation.
How dynamic is the assessment of risks and the consideration of mitigating actions to reflect new or changing risks or operational efficiencies?	Aware	- Whilst risks may be identified, they are not always articulated and added to the risk registers in a timely manner. - Risk leads on each review are required update their risk controls, gaps in controls and risk action plans as necessary. The regularity of risk review depends on the level of the Current Risk Score, and defined in the Risk Management Procedure. - Regular discussion of risks by operational leads at Clinical Care Group / Executive Function Senior Leadership Team meetings, recognising that quality of the discussions vary across the organisation. - Analysis of risk scores suggest that risks remain static which may reflect the current challenging environment that the Health Board is operating within, with limited resources available to either fully manage and mitigate, or to reduce risks to an acceptable / tolerable level as defined per the risk appetite.
How are exposures to each principal risk assessed against the nature and extent of risks that the organisation is willing to take in achieving its objectives – its risk appetite – to inform options for the selection and development of internal controls?	Aware	- Risk appetite in place linked to risk domains, and reviewed annually by the Executive Team and approved by the Board. - Principal risks reviewed throughout the year by executive leads and their nominated deputies, supported by the Assistant Director of Assurance and Risk and Head of Assurance and Risk, and directly linked to the strategic objectives of the Health Board. - Revised approach to risk acceptance/risk tolerance has been adopted during 2025/26, and for each risk (principal, corporate and operational), risk leads are expected to provide a rationale for their target risk score, outlining how this aligns to the organisation's risk appetite, and a date at which they expected to achieve it. Where the target risk score is considered to be above the organisation's risk appetite, these should be escalated as appropriate for further action and discussion to determine whether the organisation is able to prioritise and support actions to further manage and mitigate the risk, or whether it requires to be tolerated. This process has been embedded in relation to

		corporate and principal risks via discussions at Formal Executive Team, however recognise that processes require strengthening for operational risks. • Risk management system allows all risks to be aligned to the relevant strategic objectives.
How are decisions made in balancing the potential benefits of the design and implementation of new or additional controls with the costs, efforts and any disadvantages of different control options?	Aware	• Whilst risk leads across the organisation identify controls and any gaps as part of the risk identification process, the quality of action plans to address these gaps are not consistent, with many risks not having risk action plans therefore underlying detail not able to fully support decision making. Examples where risk actions are not credible and deliverable due to funding / resource constraints. • A number of extreme and high scoring risks have not been escalated to inform decision-making on whether risks should be accepted or treated further through agreement of resources.
How are contingency arrangements for high impact risks designed and tested to support continuity, incident and crisis management and resilience?	Defined	• Risk management training highlights the requirement for risk leads to update controls, which can include detailing contingency arrangements in place. • Business continuity programme and exercises in place and regularly undertaken. • Regular reviews undertaken by Cyber Resilience Unit on cyber security arrangements.
How is the nature, source, format and frequency of the information required to support monitoring of risk management and internal control defined and communicated?	Embedded	• Requirements are defined within the Risk Management Framework, Strategy and Procedure documents which are available to all staff via internal communications (Sharepoint, Viva Engage when out to consultation etc). • Provision of Assurance and Risk reports to CCG and EF meetings on at least a monthly basis also highlight these requirements, and attended by risk leads, and a wide range of staff in the larger functions. • Expectations are also defined within risk management training materials, and via prompts and help text on Datix (our current risk management system).
How are new and changing principal risks highlighted and escalated clearly, easily and more rapidly when required?	Managed	• Review of the Board Assurance Framework three times a year by the Executive Team, which the principal risks underpin. • Strategy Refresh undertaken in 2025/26, with work currently underway to review and refresh the organisation's principal risks to align with the four strategic objectives.
How comprehensive, informative and coordinated are assurance activities in helping achieve	Managed	• Annual risk maturity assessment undertaken , the outcomes of which inform the Risk Management Strategy and operational risk management support such as training and system developments.

objectives and in supporting the effective management of risks?		- Regular reporting of corporate, principal and operational risks to the Board and its committees (3 times a year – alternate meetings). - Risk Assurance report presented to the Audit and Risk Assurance Committee three times a year. - Risk-based approach to internal audits, which provide assurance on risks from reviews with reports providing either substantial, reasonable, limited or no assurance. - External audits, along with inspectorate and regulatory reviews (eg HIW, Welsh Government) - Annual Structured Assessment undertaken by Audit Wales which reviews corporate governance arrangements.
How do disclosures on risk management and internal control contribute to the annual report being fair, balanced and understandable?	Embedded	- Accountability Report, as part of the annual report process, details the key principal and corporate risks which the organisation has faced during the financial year, along with a statement on the risk management arrangements in place and developments within the year. - Accountability report also provides detail on the findings of both internal and external auditors which provides a fair and balanced view of risk management arrangements.

Continual Improvement - *Risk management shall be continually improved through learning and experience.*

Overall Assessment: Managed

Assessment Criteria	Risk maturity level	Comments
How are policies, programmes and projects evaluated to inform learning from experience? How are lessons systematically learned from past events?	Managed	- Capital projects undertake post-project evaluations. - Listening and Learning Assurance Committee provide update reports to QSEC. - Quality Improvement Framework in place.
How is risk management maturity periodically assessed to identify areas for improvement? Is the view consistent across differing	Managed	- Annual risk maturity assessment undertaken, outcomes of which identify areas of improvement and focus for consideration when revising the Risk Management Strategy. - Feedback sought from across the organisation and from executive leads to further identify any areas of improvement as part of the annual assessment, and

parts or levels of the organisation?		to identify any common themes / trends / concerns from particular areas within the Health Board.
How are improvement opportunities identified, prioritised, implemented and monitored?	Managed	• Feedback sought from across the organisation and from executive leads to further identify any areas of improvement as part of the annual assessment, and to identify any common themes / trends / concerns from particular areas within the Health Board. • Progress against the objectives as included within the Risk Management Strategy are reported to the Audit and Risk Assurance Committee three times a year.

8 - Post Payment Verification

8.1

12:20, 5 Mins

8.1 - Post Payment Verification (PPV) Report

Huw Thomas (Hywel Dda UHB - Director of Finance), Amanda Legge (NWSSP - PCS), Sue Tillman (NWSSP - PCS)

| For assurance

Attachments

[8.1 SBAR PPV Annual Report April 25 - March 26.pdf](#)

[8.1 HDUHB End of year PPV Report 2025-2026.pdf](#)



PWYLLGOR ARCHWILIO A SICRWYDD RISG AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	14 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Post Payment Verification (PPV) Annual Report April 2025 – March 2026
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Amanda Legge, All Wales Post Payment Verification Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

The Audit and Risk Assurance Committee is asked to take assurance from the contents of this report. It highlights Post Payment Verification (PPV) progress and how practices have been performing over the current cycle. It compares the overall performance of the Health Board (HB) against the national PPV visits. PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

There are no options included in this report. The report is for assurance and will only detail specific risks, if any, and provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving.

Cefndir / Background

At mid-year and end of financial year, the PPV Manager will prepare a report for Health Board audit committees to outline how practices have been performing and highlighting PPV progress. The report is being produced for the Committee to review and seek assurance that the Post Payment Verification cycle is being managed appropriately.

The purpose of the PPV process is to provide assurance to Health Boards that the claims for payment made by primary care contractors are appropriate and that the delivery of the service is as defined by NHS service specification and relevant legislation.

Asesiad / Assessment

The following key points should be noted:

General Medical Services (GMS): We progressed well this year with our GMS routine visits and all are either closed or in progress by the end of this financial year. Beginning 2026/27, we will be concentrating the first quarter on GMS visits only and incorporating both revisits and the practice routine visit. This is part of our ongoing recovery plan.

Some vaccination claims are now being claimed on the Welsh Immunisation System (WIS) and due to PPV highlighting the issues we found whilst conducting our verification checks, new internal process changes have been implemented to stop the duplicate vaccination payments prior to payment and not post payment, which is beneficial to everyone.

General Ophthalmic Services (GOS): The visit plans for GOS 2025/26 progressed better than the last few years, based on the team having the ability to carry out remote access on more contractors who have transferred to electronic patient records. We have had to still carry out elements of physical visits too, as not all contractors are using electronic systems. In 2025/26, we verified claims for an additional two services, which were the WGOS 4 (Glaucoma and Medical Retina) and Independent Prescribing Optometry Service 5 urgent claims (IPOS5). These checks have been going well, with learning shared with our contractors and our teams.

General Pharmacy Services (GPS): In 2025/26, the PPV team undertook checks on the Collaborative Working Scheme, along with the Quality and Safety Scheme, which we conduct remotely by verifying the data we hold against the evidence that we request from the contractors. This again has been positive for all HB, PPV team and contractor learning.

Additional Service: The team progressed well with its quarterly dispensing data checks and has introduced a robust service moving forward into the new financial year, which resulted in future financial recoveries. The results for the five dispensing practices in Hywel Dda University Health Board have been added to PPV reports.

The PPV team also manages the Waste Management Audit programme on behalf of the Health Boards, offering advice and support to General Practitioners and Community Pharmacies in respect of Waste Management alongside the clinical waste self-assessments required to be completed by our contractors every three years. We will incorporate our GOS contractors into our clinical waste process in the next financial year. Meetings are scheduled with all Health Boards and Counter Fraud teams to regularly review the progress report and to discuss themes, recommendations, and any risks. The team is also continuing to investigate other avenues for savings from the provision of Clinical Waste services. The team also arrange bi-monthly National GMS, GOS Working Group meetings with Primary Care Managers and PPV, to discuss and agree any issues regarding the national application of the programme. These are beneficial to all parties who attend.

PPV training requirements continue to be delivered to Health Boards and contractors, whenever needed and we also facilitate one-on-one training requirements when requested, particularly for new practice staff within the Primary Care setting.

We currently have our data analysts looking at producing some PPV dashboards with information for submission to future committee meetings.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to:

- **NOTE** the contents of the PPV Annual Report 2025/26
- **TAKE ASSURANCE** from the contents of the report

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.14 Receive an assurance on Post Payment Verification Audits through bi-annual reporting to the Committee.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable 8. Transform our communities through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Evidence in collated based on claims submitted by contractors of a specific sample period.
Rhestr Termiau: Glossary of Terms:	Included in the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	To promote value for money by deterring and preventing fraud and loss.
Ansawdd / Gofal Claf: Quality / Patient Care:	N/A

Gweithlu: Workforce:	N/A
Risg: Risk:	N/A
Cyfreithiol: Legal:	N/A
Enw Da: Reputational:	N/A
Gyfrinachedd: Privacy:	N/A
Cydraddoldeb: Equality:	N/A

Audit Report - 1st April 2025 to 31st March 2026 = Hywel Dda University Health Board

General Medical Services (GMS)	H DUHB							ALL WALES				
	Visit Type	HB Annual Visits Due	No. In progress	No. Recoveries	Value of recoveries	Value of Duplicate Recoveries	Total Recoveries	All Wales Visits Due	All Wales No. in progress	All Wales Value of Recoveries	All Wales Value of Duplicate Recoveries	All Wales Total Recoveries
GMS 2024 - 2025	Combined		32				£48,617.85		197			£251,104.95
GMS 2025-2026	Routine	10	10	111	£6,864.56	£2,364.30	£9,228.86	103	102	£80,912.90	£72,691.84	£153,604.74
	Revisit	18	5	427	£5,298.85	£0.00	£5,298.85	148	54	£37,048.01	£5,736.38	£42,784.39
	TOTAL	28	15	538	£12,163.41	£2,364.30	£14,527.71	251	156	£117,960.91	£78,428.22	£196,389.13

General Ophthalmic Services (GOS)	H DUHB					ALL WALES		
	Visit Type	Annual Visits Planned	No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	All Wales Value of Recoveries
GOS 2024-2025	Combined		20		£3,744.78		100	£16,316.67
GOS 2025-2026	Routine	19	18	82	£3,052.58	168	127	£12,939.39
	Revisit	2	1	0	£0.00	11	9	£583.84
	TOTAL	21	19	82	£3,052.58	179	136	£13,523.23

General Pharmacy Services (GPS)	H DUHB					ALL WALES			
	Visit Type	Annual Visits Planned	No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	No. Recoveries	All Wales Value of Recoveries
GPS 2024 - 2025	Combined		32		£6,147.87		238		£48,153.27
GPS 2025 - 2026	Routine	30	30	0	£0.00	232	200	0	£0.00
	TOTAL	30							

New Recovery process					
DISPENSING 2025-2026	Quarter Period	Amount of Dispensing GP Practices	Value of Recoveries	All Wales Dispensing GP Practices	All Wales Value of Recoveries
Dispensing GP practices should not dispense to patients who live within 1.6 kms / 1 mile from a Local Community Pharmacy	Quarter 4 2024/25 (Jan to Mar 2025)	5	£295.05	64	£24,444.29

GMS Summary											
PRACTICE	Routine or Revisit	Overall Sample size	Claim errors	Error % recovery	Value of recovery	Value of Duplicate recovery	Total recovery	Breakdown of Recoveries and individual services with 10% or more error rate			
Practice 1	Revisit	253	10	3.95%	£498.60	£0.00	£498.60	Imms, Minor Surgery and Warfarin.			
Practice 2	Revisit	1154	406	35.18%	£4,288.99	£0.00	£4,288.99	Gonadorelin, Imms, NPT and DOAC/R			
Practice 3	Revisit	95	2	2.11%	£20.62	£0.00	£20.62	Imms			
Practice 4	Routine	389	37	9.51%	£1,937.22	£746.25	£2,683.47	Care Homes, Contraceptives, Denosumab, Flu, Insulin, Minor Surgery and DOAC/R. Duplicate recoveries on Insulin, Care Homes, Denosumab, Flu, Gonadorelin, Learning Disabilities and RSV			
Practice 5	Revisit	85	2	2.35%	£77.46	£0.00	£77.46	DOAC/R			
Practice 6	Routine	In progress									
Practice 7	Routine	In progress									
Practice 8	Routine	202	23	11.39%	£443.63	£75.20	£518.83	Flu, Imms, NPT, Pertussis and Treatment Room. Duplicate recoveries on DOAC/R			
Practice 9	Routine	In progress									
Practice 10	Routine	717	36	5.02%	£1,084.44	£1,024.05	£2,108.49	Care Homes, Flu, Learning Disabilities, Minor Surgery, NPT, DOAC/R, Transgender, Treatment Room and Warfarin. Duplicate recoveries on Care Homes, Flu, Gonadorelin, Insulin, Learning Disabilities, DOAC/R and Transgender			
Practice 11	Routine	248	27	10.89%	£1,427.20	£129.90	£1,557.10	Denosumab, Flu, Gonadorelin, Minor Surgery, NPT and Treatment Room. Duplicate			
Practice 12	Routine	332	25	7.53%	£946.00	£223.78	£1,169.78	Contraceptives, Flu, Gonadorelin, Imms, Insulin, Learning Disabilities, NPT and DOAC/R			
Practice 13	Routine	801	35	4.37%	£1,026.07	£165.12	£1,191.19	Care Homes, Flu, Gonadorelin, Imms, Insulin, Transgender and Treatment Room. Duplicate recoveries on Gonadorelin and DOAC/R			
Practice 14	Routine	In progress									
Practice 15	Revisit	219	7	3.20%	£413.18	£0.00	£413.18	Imms and DOAC/R			

Advisory Notes

- The planned visits were sent to the HB for 2025/26 Visit Plan. These are subject to change due to ad hoc visits or closures/mergers.
- All closed visit files have been authorised by the Health Board GMS team with any concerns/issues being addressed.
- The duplicate amount of recovery is due to the practice submitting certain additional claims for the same patient more than once. This is a new audit check by PPV and feedback and lessons learnt are being shared to reduce these errors.
- The Health Board have been advised of each recovery made in a detailed report and where necessary the Health Board will follow up directly with the practice/Local Counter Fraud regarding any concerns.
- PPV work collaboratively with Health Board managers and Local Counter Fraud to assist with any concerns that may arise.
- Training/support is given to practices by PPV after their visit when requested.
- Revisits are taking longer than expected due to 100% check of claims, which is expected to have higher claim error rates when checking 100% of claims.
- Revisits are triggered when the claim error % is 10% or over on any individual service in the routine visit sample, it is not based off the % recovery as a whole.
- Recovery % is based off the sample total and the claim errors made. The recovery % may look higher due to a smaller amount of claims being sampled.

GOS Summary											
PRACTICE	Routine or Revisit	Overall Sample size	Claim errors	Error % recovery	Value of recovery	Breakdown of Recoveries and individual services with 10% or more error rate					
Practice 1	Routine	103	3	2.91%	£54.00	Claim recovery under 10% per service					
Practice 2	Routine	103	2	1.94%	£62.02	Claim recovery under 10% per service					
Practice 3	Routine	9	0	0.00%	£0.00	All claims verified					
Practice 4	Routine	103	4	3.88%	£145.00	Claim recovery under 10% per service					
Practice 5	Routine	103	2	1.94%	£50.02	Claim recovery under 10% per service					
Practice 6	Routine	103	19	18.45%	£1,053.46	GOS 3 and GOS 4 claims					
Practice 7	Routine	103	1	0.97%	£4.06	Claim recovery under 10% per service					
Practice 8	Routine	103	0	0.00%	£0.00	All claims verified					
Practice 9	Routine	103	4	3.88%	£80.31	Claim recovery under 10% per service					
Practice 10	Routine	103	4	3.88%	£109.00	Claim recovery under 10% per service					
Practice 11	Routine	103	5	4.85%	£178.00	GOS 4 claims					
Practice 12	Routine	103	7	6.80%	£423.00	GOS 4 claims					
Practice 13	Routine	103	6	5.83%	£259.57	GOS 4 and WGOS 5 claims					
Practice 14	Routine	103	1	0.97%	£97.63	Claim recovery under 10% per service					
Practice 15	Routine	103	13	12.62%	£285.51	GOS 4, EHEW and WGOS 4 claims					
Practice 16	Routine	103	11	10.68%	£251.00	GOS 4 claims					

Advisory Notes

- The planned visits were sent to the HB for 2025/26 Visit Plan. Numbers are subject to change due to ad hoc visits or closures/mergers.
- As contractors are transitioning to electronic records, remote access and physical visits are progressing well

Practice 17	Routine	103	0	0.00%	£0.00
Practice 18	Revisit	103		In Progress	
Practice 19	Routine	103		In Progress	

All claims verified

GPS Summary

PRACTICE	In progress	Closed	Value of recovery
Practice 1		Y	£0.00
Practice 2		Y	£0.00
Practice 3		Y	£0.00
Practice 4		Y	£0.00
Practice 5		Y	£0.00
Practice 6		Y	£0.00
Practice 7		Y	£0.00
Practice 8		Y	£0.00
Practice 9		Y	£0.00
Practice 10		Y	£0.00
Practice 11		Y	£0.00
Practice 12		Y	£0.00
Practice 13		Y	£0.00
Practice 14		Y	£0.00
Practice 15		Y	£0.00
Practice 16		Y	£0.00
Practice 17		Y	£0.00
Practice 18	Y		
Practice 19	Y		
Practice 20	Y		
Practice 21	Y		
Practice 22	Y		
Practice 23	Y		
Practice 24	Y		
Practice 25	Y		
Practice 26	Y		
Practice 27	Y		
Practice 28	Y		
Practice 29	Y		
Practice 30	Y		

Advisory Notes

No recoveries have yet been made in the last financial year as we are awaiting evidence and HB responses.

8.2

12:25, 5 Mins

8.2 - Primary Care PPV Report

Andrew Carruthers
(Hywel Dda UHB -
Chief Operating
Officer), Rhian Bond
(Hywel Dda UHB -
Assistant Director of
Primary Care)

| For assurance

Attachments

[8.2 Primary Care PPV Report ARAC April 2026.pdf](#)



PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	14 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Primary Care Post Payment Verification Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Director of Operations
SWYDDOG ADRODD: REPORTING OFFICER:	Amanda Whiting, Head of General Medical Services and Community Pharmacy (Contracting & Performance)

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

This report provides an updated position on Post Payment Verification (PPV) for the following areas:

- General Medical Services for the period July 2025 – December 2025
- Community Pharmacy for the period July 2025 – December 2025

Cefndir / Background

The PPV team planned to undertake a total of 28 visits to GP Practices during 2025/26. To date both routine and revisits have been undertaken within the GMS visiting cycle. Duplicate claim recoveries are reported separately to the PPV audited claims within this report.

The PPV team planned to undertake 31 Collaborative Working Scheme & Quality and Safety Scheme Community Pharmacy remote visits in 2025/26.

Asesiad / Assessment

PPV Visits for GMS

Summary of GMS PPV visits completed between July 2025 and December 2025

Practice	Routine or Revisit	Claim Errors	% Recovery	Value of Recovery
Practice 1	Routine	36	5.5%	£764.98
Practice 2	Routine	27	10.89%	£1,427.20
Practice 3	Routine	33	6.47%	£2,078.68
Practice 4	Routine	36	5.02%	£1,084.44

Practice 5	Routine	23	11.39%	£443.63
Practice 6	Revisit	2	2.11%	£20.62
Practice 7	Revisit	2	2.35%	£77.46
Practice 8	Revisit	7	3.20%	£413.18

In summary, overall recovery rates have reduced when compared to the previous reporting period. This is primarily attributable to the prior period including two significant, one-off recoveries, which disproportionately increased recovery values. During the current reporting period, recovery rates ranged from 2.11% to 11.39%, compared with a much wider range of 0% to 96% in the previous report.

All individual practice outcome reports produced by the PPV team are routinely shared with both the Primary Care Team and the Counter Fraud Team to support transparency and appropriate oversight. Where concerns arise that indicate a potential risk of fraudulent activity, these may be raised either by the PPV Team or the Primary Care Team. Such concerns could include significant outlier recovery rates, repeated non-compliance or indicators of intentional inappropriate claiming. In these circumstances, cases are escalated to the Counter Fraud Team for consideration and potential investigation. Referrals to Counter Fraud are made on an exception-only basis, informed by the practice outcome report demonstrating significant recovery values or patterns of concern.

Where the PPV process identifies issues that extend beyond administrative or specification-based error, such as repeated claiming issues despite prior intervention, high-value recoveries associated with insufficient evidence, patterns suggestive of intentional inappropriate claiming, or specific anomalies identified during extended visits, the case is escalated to the NHS Counter Fraud Service in accordance with Health Board fraud referral procedures. All referrals are risk-based and proportionate. The Counter Fraud Team determines whether further investigation is required and provides feedback to the PPV and Primary Care teams. Outcomes are recorded and, where appropriate, inform future PPV activity or contractual action.

There have been no escalations to Counter Fraud arising from this reporting period.

Analysis of PPV findings indicates that the predominant themes within claiming errors during this period relate to lack of supporting documentation, incomplete or inappropriate clinical coding and insufficient evidence to support eligibility criteria. These errors are overwhelmingly administrative in nature and have not been assessed as deliberate. The most frequently affected service areas remain Treatment Room, Immunisations, Care Homes, Near Patient Testing, and NOAC/DOAC services. These themes are consistent with those identified in the previous reporting period and are likely reflective of the complexity of enhanced service specifications rather than evidence of isolated poor practice.

Revisit activity demonstrates that, following PPV intervention, practices have shown improvement, with files being closed after the completion of revisit reviews. This provides assurance that learning has taken place and that corrective action has been effective.

Summary of Recoveries and Action Taken:

Practice 1 (36 Claim Errors) – Routine

Total recovery of £764.98 which is made up as follows:

Routine	Number of claim Errors
Care Homes	16
Immunisations	6
Near Patient Testing	6
NOAC/NOAR/DOAC/DOAR	4
Substance Misuse	3
Treatment Room	1
Total	36

The sample of claims taken from the routine visit were from December 2023 to November 2024. During this period, a total of 8,194 claims were submitted with a value of £17,311.99.

655 claims were analysed across all services, of these claims 36 errors were found. The administrative error rate was 0% and the overall claim error rate was 5.5%.

In addition, there were 2 duplicate claims identified relating to immunisations with a value of £20.80.

The Practice has been advised to be mindful to ensure the accurate submission of enhanced service claims as per the specification requirements and that they should continue to develop and implement robust administrative procedures to ensure the accurate submission of Enhanced Service claims.

PPV will make a full recovery of £764.98 for the routine audit and £20.80 for the additional recoveries relating to duplicate claims. A revisit is recommended to further review Care Homes, Immunisations (Non-Routine and Unscheduled only), NOAC/NOAR/DOAC/DOAR (Annual Reviews only) and Substance Misuse Enhanced Service claims.

Practice 2 (15 Claim Errors) - Routine

Total recovery of £1,427.20 which is made up as follows:

Routine	Number of claim Errors
Denosumab	5
Flu	4
Gonadorelins	1
Minor Surgery	8
Near Patient Testing	2
Treatment Room	7
Total	27

The sample of claims taken from the routine visit were from December 2023 to November 2024. During this period, a total of 1,997 claims were submitted with a value of £33,043.73.

248 claims were analysed across all services, of these claims 27 errors were found. The administrative error rate was 4.44% and the overall claim error rate was 10.89%.

In addition, there were 6 duplicate claims identified relating to Gonadorelins Quarterly & Pneumococcal Age 65 & Over with a value of £129.90.

The Practice has been advised to be mindful to ensure the accurate submission of enhanced service claims as per the specification requirements and that they should continue to develop and implement robust administrative procedures to ensure the accurate submission of Enhanced Service claims.

PPV will make a full recovery of £1,427.20.98 for the routine audit and £129.90 for the additional recoveries relating to duplicate claims. A revisit is recommended in the next twelve months to further review Denosumab, Flu, Minor Surgery and Treatment Room claims.

Practice 3 (33 Claim Errors) – Routine

Total recovery of £2,078.68 which is made up as follows:

Routine	Number of claim Errors
Care Homes	9
Immunisations	2
Insulin	2
Learning Disabilities	15
Near Patient Testing	2
NOAC/NOAR/DOAC/DOAR	2
Treatment Room	1
Total	33

The sample of claims taken from the routine visit were from December 2023 to November 2024. During this period, a total of 5,442 claims were submitted with a value of £2,078.68.

510 claims were analysed across all services, of these claims 33 errors were found. The administrative error rate was 0.59% and the overall claim error rate was 6.47%.

There were no duplicate claims identified.

The Practice has been advised to be mindful to ensure the accurate submission of enhanced service claims as per the specification requirements and that they should continue to develop and implement robust administrative procedures to ensure the accurate submission of Enhanced Service claims.

PPV will make a full recovery of £2,078.68 for the routine audit. An extended visit is recommended during the next routine visit to further review the Learning Disabilities Enhanced Service claims. It was noted that the Learning Disability Enhanced Service ceased in March

2025 and became core service provision so any revisit will only review activity up until 31st March 2025.

Practice 4 (36 Claim Errors) - Routine

Total recovery of £1,084.44 which is made up as follows:

Routine	Number of claim Errors
Care Homes	11
Flu	1
Learning Disabilities	1
Minor Surgery	3
Near Patient Testing	4
NOAC/NOAR/DOAC/DOAR	3
Transgender	2
Treatment Room	7
Warfarin	4
Total	36

The sample of claims taken from the routine visit were from December 2023 to November 2024. During this period, a total of 8,787 claims were submitted with a value of £166,151.82.

717 claims were analysed across all services, of these claims 36 errors were found. The administrative error rate was 0% and the overall claim error rate was 5.02%.

In addition, there were 37 duplicate claims identified relating to Care Homes, Flu, Gonadorelins, Insulin, Learning Disabilities, NOAC/NOAR/DOAC/DOAR & Transgender Enhanced Services with a value of £1,024.05.

The Practice has been advised to be mindful to ensure the accurate submission of enhanced service claims as per the specification requirements and that they should continue to develop and implement robust administrative procedures to ensure the accurate submission of Enhanced Service claims.

PPV will make a full recovery of £1,084.44 for the routine audit and £1,024.05 for the additional recoveries relating to duplicate claims. A revisit is recommended to further review NOAC/NOAR/DOAC/DOAR (Annual Reviews only) and Treatment Room (Level 6 only) claims.

Practice 5 (23 Claim Errors) – Routine

Total recovery of £443.63 which is made up as follows:

Routine	Number of claim Errors
Flu	1
Immunisations	1
Near Patient Testing	2
Pertussis	1
Treatment Room	18
Total	23

The sample of claims taken from the routine visit were from December 2023 to November 2024. During this period, a total of 1,068 claims were submitted with a value of £15,017.20.

202 claims were analysed across all services, of these claims 23 errors were found. The administrative error rate was 0% and the overall claim error rate was 11.39%.

In addition, there were 2 duplicate claims identified relating to NOAC/NOAR/DOAC/DOAR with a value of £75.20.

The Practice has been advised to be mindful to ensure the accurate submission of enhanced service claims as per the specification requirements and that they should continue to develop and implement robust administrative procedures to ensure the accurate submission of Enhanced Service claims.

PPV will make a full recovery of £443.63 for the routine audit and £75.20 for the additional recoveries relating to duplicate claims. A revisit is recommended in the next twelve months to further review Treatment Room (Level 9 only) claims.

Practice 6 (2 Claim errors) – Revisit

Total recovery of £20.62 which is made up as follows:

Revisit	Number of claim Errors
Immunisations	2
Total	2

The sample of claims taken from the revisit were from September 2024 to August 2025. During this period, a total of 95 claims were submitted with a value of £979.45.

As this was a revisit 100% of claims were verified for accuracy. 95 immunisation claims were analysed, of these claims 2 errors were found. The administrative error rate was 0% and the overall claim error rate was 2.11%.

PPV will make a recovery of £20.62 and the file was closed.

Practice 7 (2 Claim Errors) – Revisit

Total recovery of £77.46 which is made up as follows:

Revisit	Number of claim Errors
NOAC/NOAR/DOAC/DOAR (Annual Reviews Only)	85
Totals	85

The sample of claims taken from the revisit were from September 2024 to August 2025. During this period, a total of 85 claims were submitted with a value of £3,324.82.

As this was a revisit 100% of claims were verified for accuracy. 85 NOAC/NOAR/DOAC/DOAR (Annual Reviews Only) claims were analysed, of these claims 2 errors were found. The administrative error rate was 0% and the overall claim error rate was 2.35%.

PPV will make a recovery of £77.46 and the file was closed.

Practice 8 (7 Claim Errors) – Revisit

Total recovery of £413.18 which is made up as follows:

Revisit	Number of claim Errors
Immunisations	1
NOAC/NOAR/DOAC/DOAR	6
Total	7

The sample of claims taken from the revisit were from October 2024 to September 2025. During this period, a total of 219 claims were submitted with a value of £9,527.43.

As this was a revisit 100% of claims were verified for accuracy. 219 claims were analysed, of these claims 7 errors were found. The administrative error rate was 0.91% and the overall claim error rate was 3.20%.

PPV will make a recovery of £413.18 and the file was closed.

PPV Visits for Community Pharmacies

Summary of PPV Visits for Community Pharmacies completed between July 2025 and December 2025

Pharmacy	Quality & Safety Scheme – Compliant Y/N	Collaborative Working Scheme – Compliant Y/N	Total Recovery
Pharmacy 1	N	N/A – no claims submitted	£1,218
Pharmacy 2	N	N/A – no claims submitted	£1,218
Pharmacy 3	N	Y	£609
Pharmacy 4	N	Y	£609
Pharmacy 5	Y	N	£2,216.77
Pharmacy 6	Y	N	£277.10
Pharmacy 7	Y	Y	£0
Pharmacy 8	Y	Y	£0
Pharmacy 9	Y	Y	£0
Pharmacy 10	Y	Y	£0
Pharmacy 11	Y	Y	£0
Pharmacy 12	Y	Y	£0

Pharmacy 1

Quality & Safety Scheme Report for 2023/24 – the Pharmacy did not submit the required copies of training certificates to evidence compliance with Mental Health First Aid and Mental Health e-learning and therefore a recovery of £1,218 was enacted.

Pharmacy 2

Quality & Safety Scheme Report for 2023/24 – the Pharmacy did not submit the required copies of training certificates to evidence compliance with Mental Health First Aid and Mental Health e-learning and therefore a recovery of £1,218 was enacted.

Pharmacy 3

Quality & Safety Scheme Report for 2023/24 – the Pharmacy did not submit the required copies of training certificates to evidence compliance with Mental Health e-learning and therefore a recovery of £609 was enacted.

Pharmacy 4

Quality & Safety Scheme Report for 2023/24 – the Pharmacy did not submit the required copies of training certificates to evidence compliance with Mental Health e-learning and therefore a recovery of £609 was enacted.

Pharmacy 5

Collaborative Working Scheme Report for 2023/24 – the Pharmacy did not submit the required reports required to evidence attendance at three out of four Collaborative Lead arranged meetings and one out of three collaborative meetings attended and therefore a recovery of £2,216.77 was enacted.

Pharmacy 6

Collaborative Working Scheme Report for 2023/24 – the Pharmacy did not submit the required report required to evidence attendance at one collaborative meeting attended and therefore a recovery of £277.10 was enacted.

Pharmacy 7

No issues or errors were identified during the visit.

Pharmacy 8

No issues or errors were identified during the visit.

Pharmacy 9

No issues or errors were identified during the visit.

Pharmacy 10

No issues or errors were identified during the visit.

Pharmacy 11

No issues or errors were identified during the visit.

Pharmacy 12

No issues or errors were identified during the visit.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to:

- **NOTE** the information contained within this report
- **NOTE** that the Primary Care team continues to work with all contractors and their professional representative bodies on the quality of claiming and continues to respond to individual claiming queries from the outset. PPV is discussed at GMS Contractual Assurance visits and training is offered by the PPV Team
- **TAKE ASSURANCE** that appropriate liaison is undertaken with the Counter Fraud Team when there are any concerns, or information needs to be queried

Amcanion: (rhaid cwblhau)**Objectives: (must be completed)**

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.14 Receive an assurance on Post Payment Verification Audits through bi-annual reporting to the committee
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	3. Effective 4. Efficient 5. Equitable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	3. Data to knowledge

Amcanion Strategol y BIP: UHB Strategic Objectives:	6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	2 Financial recovery and route map
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termiau: Glossary of Terms:	NOAC – Non-vitamin K antagonist Oral Anticoagulant NOAR – Non-vitamin K antagonist Oral Anticoagulant Reversal DOAC - Direct Oral Anticoagulants DOAR – Direct Oral Anticoagulant Reversal
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	PPV Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Assurance around appropriate and proper use of funding provided by GMS Enhanced Services
Ansawdd / Gofal Claf: Quality / Patient Care:	N/A
Gweithlu: Workforce:	N/A
Risg: Risk:	Assurance around appropriate and proper use of funding provided by GMS Enhanced Services
Cyfreithiol: Legal:	Application of Statement of Financial Entitlement under the terms of the General Medical Services Contract
Enw Da: Reputational:	N/A
Gyfrinachedd: Privacy:	N/A
Cydraddoldeb: Equality:	N/A

9 - For Information

9.1

12:30, 0 Mins

9.1 - ARAC Workplan 2026/27

| For information

Attachments

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

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

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

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

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

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	14 April 2026
AUDIT WALES									
Review External Audit Plan via update reports	Audit Wales	✓		✓	✓	✓	✓	✓	✓
Approve External Audit Strategy & Annual Audit Plan (designed to implement the strategy) & assoc fees	Audit Wales	✓							✓
Review of External Audit Reports including results & the adequacy of executive & mgmt responses to any issues identified and ensure that the other Cttees monitor & report back	Audit Wales	✓		✓	✓	✓	✓	✓	✓
Consider any Audit Wales National Value for Money Examinations & Performance Reports	Audit Wales	✓		✓	✓	✓	✓	✓	✓
Receive the Auditor's General report to those charged with governance (Year-end)	Audit Wales		✓						
Structured Assessment 2024 Management Response Update	Audit Wales/JW				✓				✓
Structured Assessment 2025	Audit Wales						✓		✓
Review of Urgent and Emergency Care (Part 1 and Part 2)	Audit Wales/AC	D		✓	D	✓	✓		
Planned Care Review	Audit Wales/AC	D		✓					
Review of Capital Investment Prioritisation	Audit Wales/LD			✓					
Cancer Services in Wales: A review of the strategic approach to improving the timeliness of diagnosis and treatment	Audit Wales/AC	✓							
Review of the Management of Outpatients	Audit Wales/AC				D	D	D	D	✓
Deep Dive - Review of Investment in Digital Systems	Audit Wales/HT				D		D	D	D

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	14 April 2026
Review of Radiology Services	Audit Wales/AC							D	D
Deep Dive - Review of the Arrangements to Manage Estates	Audit Wales/JS								D
Review of Cancer Services	Audit Wales/AC								D
National Fraud Initiative Briefing Note	Audit Wales					✓			
Audit Fees Consultation 2026/27	Audit Wales						✓		
INTERNAL AUDIT									
Internal Audit: Audit Plan Progress Report	JJ	✓	✓	✓	✓	✓	✓	✓	✓
Review and approve Annual Internal Audit Plan	JJ	✓							✓
Review of Internal Audit Reports including results & the adequacy of executive & management responses to any issues identified and ensuring that they are acted upon	JJ	✓	✓	✓	✓	✓	✓	✓	✓
Review and approve Internal Audit terms of reference (charter) and the effectiveness of internal audit	JJ	✓							
Standards of Cleanliness IA Update and Action Plan	JS				✓				
Learning Lessons (Reasonable Assurance)	JJ/SD	✓							
Elective Waiting List Management (Substantial Assurance)	JJ/AC	✓							
Consultant Job Planning Follow-up (Reasonable Assurance)	JJ/MH	✓							
Financial Management (Reasonable Assurance)	JJ/HT	✓							
Performance Management (Substantial Assurance)	JJ/HT	✓							

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	14 April 2026
Executive Team Governance (Substantial Assurance)	JJ/PK/JW	D	✓						
Annual Planning (Reasonable Assurance)	JJ/LD	D	✓						
Digital Strategic Partner (Substantial Assurance)	JJ/HT		✓						
Discharge Management Follow-up (Advisory Report)	JJ/AC			✓					
Standards of Cleanliness Follow-up (Limited Assurance)	JJ/AC/JS	D	D	✓					
Withybush Hospital (WGH) RAAC (Reasonable Assurance)	JJ/AC/JS	D	D	✓					
Continuing Healthcare – Database Maintenance and Finance Processes (Substantial Assurance)	JJ/HT	D	D	✓					
Contract Management (Advisory Report)	JJ/HT			✓					
Follow Up Review (Reasonable Assurance)	JJ/JW			✓					
Corporate Risk: Ophthalmology (Reasonable Assurance)	JJ/AC				✓				
Sickness Management (Limited Assurance)	JJ/LG				✓				
Nursing Management (Limited Assurance)	JJ/SD				✓				
Validation of Emergency Department Waiting Time Data (Limited Assurance)	JJ/AC					✓			
Control of Contractors (Advisory Report)	JJ/JS					✓			
Human Tissue Authority (Limited Assurance)	JJ/JS					✓			
Commissioning – Long Term Agreements (Reasonable Assurance)	JJ/LD					✓			
Capital Governance Arrangements (Advisory Report)	HR/EJ/LD					✓			

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	14 April 2026
Medical Devices Regulations (Substantial Assurance)	JJ/AC						✓		
Escalation Governance (Substantial Assurance)	JJ/PK/JW							✓	
Managed Practices (Reasonable Assurance)	JJ/AC						D	✓	
Vaccination and Immunisation (Limited Assurance)	JJ/AG					D	D	✓	
Patient Experience (Reasonable Assurance)	JJ/SD							✓	
Cyber Security (IC) (Substantial Assurance)	JJ/HT						D	✓	
Operational Governance Arrangements (Limited Assurance)	JJ/AC						D	D	✓
Level 3 / 4 Directorates (Limited Assurance)	JJ/HT						D	D	✓
Estates Assurance – Space Utilisation (Advisory Report)	JJ/LD							D	✓
Human Tissue Authority Follow-up (Review)	JJ/JS								✓
Shadow IT (IC) (Reasonable Assur)	JJ/HT							D	✓
GP Out of Hours	JJ/AC								D
Major Infrastructure Investment Plan	JJ/LD								D
Decision Making for High Cost Drugs	JJ/HT							D	D
Wellsky System	JJ/HT								D
Joint Committee with SBUHB	JJ/PK								D
Medical Workforce Stabilisation	JJ/MH								D
Commissioning – Third Sector	JJ/AC								
Sickness Management Follow-up	JJ/LG								
Infection Prevention & Control	JJ/SD								D
Theatre Stock System Implementation	JJ/AC							D	D
Estates/Facilities Directorate – Cleaning Standards	JJ/JS								D
Validation of Emergency Department Waiting Time Data Follow-up	JJ/AC								D

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	14 April 2026
Follow up and agreed Action Implementation Tracking -	JJ/JW								
Integrated Audit & Assurance Plans (SSU) – Withybush General Hospital Fire – Phase 2	EJ/LD								
Glangwili General Hospital Fire – Phase 2	EJ/LD								
CLINICAL AUDIT									
Review annual forward clinical audit plan and terms of reference	SD	✓				✓			✓
Review the effectiveness of clinical audit – consider recs from the ECPG on suggested areas of activity for review by internal audit	SD	✓				✓			✓
FINANCIAL FOCUS									
Review risks and controls around financial management (via Financial Assurance Report)	HT	✓		✓	✓	✓	✓	✓	✓
Review Annual Summary of Single Tender Actions (STAs)	HT			✓					
Annual statement of financial procedures	HT							✓	
Immaterial over and underpayment of salaries (IC)	HT							✓	
Receive Post Payment Verification (PPV) report	HT			D	✓			D	✓
Receive PPV annual report	HT			D	✓				
Receive Primary Care PPV report	JP			D	✓			D	✓
Review of Schedule of Losses & Compensation*	HT								
Receive reports which record the basis of decisions where the HB awards additional funding to contractors outside the terms of the contract *	HT								

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	14 April 2026
COUNTER FRAUD									
Review work plan & results from Counter Fraud activities, including anti fraud policies, etc.	CFO	✓		✓	✓	✓	✓	✓	✓
To provide an update on the cases highlighted as part of the counter fraud update report (In-Committee)	CFO	✓		✓	✓	✓	✓	✓	✓
Review and approve Counter Fraud Annual Report	CFO	✓							✓
Review and approve annual forward work plan for Counter Fraud activities	CFO	✓							✓
NHS CF Authority SRT Return	CFO	✓							✓
Right To Work Governance and Checks (In-Committee)	AC/RE	✓		✓					
Annual Review of Requisitions (as part of main Counter Fraud update)	CFO							✓	
Counter Fraud, Bribery and Corruption Policy Review (3 yearly)	CFO				✓				
Review the Health Board's assessment against NHS Protect Qualitative Assessment Reviews*	CFO								
ASSURANCE AND RISK									
External Recommendations and WHC Assurance Report	JW/CW			✓		✓		✓	
Risk Assurance Report	JW/CW	✓			✓		✓		✓
Risk Management Framework and Strategy	JW/CW				✓				
Scrutiny of Outstanding Impr Plans *	JW/CW								
DEEP DIVE									
TBC *									
FOR INFORMATION									
ARAC Work Programme 2025/26	Chair	✓		✓	✓	✓	✓	✓	✓
Audit Wales Letter regarding Future Report Writing Style					✓				
National Internal Audit Reports *									

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	14 April 2026
REVIEW OF THE MEETING									
Matters & Risks for Escalation to the Board	Chair/JW	✓		✓	✓	✓	✓	✓	✓

* To be included on agenda as applicable

Initials

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

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

* Separate meeting

10 - Any Other Business

11 - Review of Meeting

11.1

12:30, 0 Mins

11.1 - Matters and Risks for Escalation to the Board

| For discussion

12 - Date and Time of Next Meeting

9.30am, 7 May 2026 (Review of Draft Annual Accounts and Accountability Report)
9.30am, 23 June 2026