Date	**14/10/2025**
Time	**09:30 - 13:00**
Location	**Microsoft Teams Meeting/ Ystwyth Boardroom; Ystwyth Board Room Avocor (Hywel Dda UHB - Generic Account)**

Audit & Risk Assurance Committee Meeting

HDD_Audit and Risk Committee

NHS Wales

Agenda - 14 October 2025

1		**1 Introductions** 09:30, 0 min
	1.1	**Apologies** 09:30, 0 min *Rhodri Evans (Hywel Dda UHB - Independent Member)*
	1.2	**Declaration of Interests** 09:30, 0 min
2		**Governance** 09:30, 0 min
	2.1	**Minutes of the Meeting held on 12 August 2025** 09:30, 0 min *Rhodri Evans (Hywel Dda UHB - Independent Member)*
	2.2	**Table of Actions** 09:30, 5 min *Rhodri Evans (Hywel Dda UHB - Independent Member)*
	2.3	**Matters Arising not on Agenda** 09:35, 0 min *Rhodri Evans (Hywel Dda UHB - Independent Member)*
	2.4	**Escalation Status Update Report** 09:35, 15 min *Philip Kloer (Hywel Dda UHB - Chief Executive), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Shaun Ayres (Hywel Dda UHB - Director of Delivery)*
	2.5	**All Wales NHS Audit Committee Chairs' Meeting Update** 09:50, 5 min *Rhodri Evans (Hywel Dda UHB - Independent Member)*

3 **Audit Wales**

09:55, 0 min

3.1 **Audit Wales Update Report**

09:55, 5 min
Anne Beegan, Urvisha Perez, david.williams@audit.wales

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

10:00, 20 min
Anne Beegan, Urvisha Perez, Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Gareth Cottrell (Hywel Dda UHB - Deputy Chief Operating Officer), Peter Skitt (Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine), Anna Chiffi (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality), Thomas Alexander (Hywel Dda UHB - Principal Programme Manager)

3.3 **Review of the Management of Outpatients**

10:20, 0 min
Anne Beegan, Urvisha Perez, Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

4 **Clinical Audit**

10:20, 0 min

4.1 **Clinical Audit Update**

10:20, 20 min
Mark Henwood (Hywel Dda UHB - Executive Medical Director), Ian Bebb (Hywel Dda UHB - Clinical Audit Manager)

BREAK

10:40, 10 min

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

10:50, 0 min

5.1 **Internal Audit Plan Progress Report**

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

5.2 Validation of Emergency Department Waiting Time Data (Limited Assurance)

11:00, 20 min
James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Gareth Cottrell (Hywel Dda UHB - Deputy Chief Operating Officer), Keith Jones (Hywel Dda UHB - Director of Operational Planning & Performance), Peter Skitt (Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine), Anna Chiffi (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality)

5.3 Human Tissue Authority (Limited Assurance)

11:20, 20 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)

5.4 Control of Contractors (Advisory Report)

11:40, 10 min
James Johns (NWSSP - Internal Audit), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)

5.5 Commissioning – Long Term Agreements (Reasonable Assurance)

11:50, 10 min
James Johns (NWSSP - Internal Audit), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Shaun Ayres (Hywel Dda UHB - Director of Delivery), Anne Simpson (Hywel Dda UHB - Head of Strategic Commissioning)

5.6 Capital Governance Arrangements (Advisory Report)

12:00, 10 min
Huw Richards (NWSSP - Audit and Assurance Services), Eifion Jones (NWSSP - Audit and Assurance Services), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Eldeg Rosser (Head of Capital Planning)

5.7 Vaccination and Immunisation

12:10, 0 min
James Johns (NWSSP - Internal Audit), Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health)

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6 Financial Focus

12:10, 0 min

6.1 Financial Assurance Report

12:10, 5 min
Huw Thomas (Hywel Dda UHB - Director of Finance)

6.2 Counter Fraud Update

12:15, 5 min
Benjamin Rees (Hywel Dda UHB - Local Counter Fraud Specialist)

7 Assurance and Risk

12:20, 0 min

7.1 Internal and External Recommendations and WHC Tracking Assurance Report

12:20, 10 min
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

8 For Information

12:30, 0 min

8.1 ARAC Workplan 2025/26

12:30, 0 min

9 Any Other Business

12:30, 0 min

10 Review of Meeting

12:30, 0 min

10.1 Matters and Risks for Escalation to the Board

12:30, 0 min

11 Date and Time of Next Meeting

12:30, 0 min

Table of contents

14/10/2025 09:30 - 13:00

1 - 1 Introductions 10

1.1 - Apologies 11

1.2 - Declaration of Interests 12

2 - Governance 13

2.1 - Minutes of the Meeting held on 12 August 2025 14

Attachments

2.1 Unapproved ARAC Minutes 12 August 2025 15

2.2 - Table of Actions 39

Attachments

2.2 Table of Actions ARAC 12 Aug 2025 40

2.3 - Matters Arising not on Agenda 47

2.4 - Escalation Status Update Report 48

Attachments

2.4 Escalation Status Update ARAC October 2025 49

2.4 2025-08-18 - JP to PK - following escalation meeting 30 July 2025 63

2.5 - All Wales NHS Audit Committee Chairs' Meeting Update 68

Attachments

2.5 2025-06-30 AWACC Minutes unconfirmed 69

2.5 Annual Report AWACC 2024-2025 79

3 - Audit Wales 89

3.1 - Audit Wales Update Report 90

Attachments

3.1 Audit Wales ARAC Update (14.10.25) 91

3.1 NFI Briefing Note - Hywel Dda University Health Board 103

3.2 - Review of Urgent and Emergency Care (Discharge Planning and Impact of Patient Flow) 112

Attachments

3.2 HDUHB Discharge Planning Progress Report 113

3.3 - Review of the Management of Outpatients 133

4 - Clinical Audit 134

4.1 - Clinical Audit Update 135

Attachments

4.1 Clinical Audit Update ARAC October 2025 136

4.1 Appendix 1 - National Clinical Audit and Outcome Review Programme 2025-~ 141

4.1 Appendix 2 - Clinical Audit Programme 2025-2026 (April-September) 143

5 - NWSSP – Audit and Assurance Services - Internal Audit 146

5.1 - Internal Audit Plan Progress Report 147

Attachments

5.1 SBAR IA Plan Progress Report October 2025 148

5.1 IA Plan Progress Report October 2025 152

5.2 - Validation of Emergency Department Waiting Time Data (Limited Assurance) 161

Attachments

5.2 Validation of ED Waiting Time Data Final IA Report 162

5.3 - Human Tissue Authority (Limited Assurance) 171

Attachments

5.3 HTA Final IA Report 172

5.4 - Control of Contractors (Advisory Report) 182

Attachments

5.4 Control of Contractors Final IA Advisory Report 183

5.5 - Commissioning – Long Term Agreements (Reasonable Assurance) 187

Attachments

5.5 Commissioning - LTAs Final IA Report 188

5.6 - Capital Governance Arrangements (Advisory Report) 195

Attachments

5.6 Capital Governance Final IA Advisory Report 196

5.7 - Vaccination and Immunisation 204

6 - Financial Focus 205

6.1 - Financial Assurance Report 206

Attachments

6.1 SBAR Financial Assurance Report ARAC October 2025 207

6.1 Financial Assurance Report ARAC October 2025 211

6.1 Appendices 1-4 - Financial Assurance Report ARAC October 2025 218

6.1 Appendix 5 - Financial Assurance Report ARAC October 2025 235

6.2 - Counter Fraud Update 251

Attachments

6.2 SBAR Counter Fraud Update ARAC October 2025 252

6.2 Counter Fraud Update ARAC October 2025 255

7 - Assurance and Risk 262

7.1 - Internal and External Recommendations and WHC Tracking Assurance Report 263

Attachments

7.1 Audit Tracker and WHC Report October 2025 264

8 - For Information 290

8.1 - ARAC Workplan 2025/26 291

Attachments

8.1 Audit Work Programme 2025-26 292

9 - Any Other Business 301

10 - Review of Meeting 302

10.1 - Matters and Risks for Escalation to the Board 303

11 - Date and Time of Next Meeting 304

1

09:30, 0 Mins

1 - 1 Introductions

1.1

09:30, 0 Mins

1.1 - Apologies

Rhodri Evans (Hywel Dda UHB - Independent Member)

For information

1.2 **09:30, 0 Mins**

1.2 - Declaration of Interests

All

For information

2

09:30, 0 Mins

2 - Governance

2.1

09:30, 0 Mins

2.1 - Minutes of the Meeting held on 12 August 2025

Rhodri Evans (Hywel Dda UHB - Independent Member)

For approval

Attachments

2.1 Unapproved ARAC Minutes 12 August 2025.pdf

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

Date of Meeting:	**10:00, Tuesday 12 August 2025**
Venue:	**Via Teams**

Present:	Mr Winston Weir, Independent Member (Committee Vice-Chair) (VC) Mr Maynard Davies, Independent Member (VC) Mrs Eleanor Marks, Vice-Chair, HDdUHB (VC)
In Attendance:	Ms Urvisha Perez, Audit Wales (VC) Mr David Williams, Audit Wales (VC) Mr James Johns, Head of Internal Audit, NWSSP (VC) Ms Sophie Corbett, Deputy Head of Internal Audit, NWSSP (VC) Miss Charlotte Wilmshurst, Assistant Director of Assurance and Risk (VC) (deputising for Mrs Joanne Wilson, Director of Corporate Governance) Mr Huw Thomas, Executive Director of Finance (VC) Ms Rachel Williams, Head of Assurance and Risk (VC) Mr Ben Rees, Head of Counter Fraud (VC) (part) Mr Shaun Ayres, Director of Delivery (VC) (part) Mr Andrew Carruthers, Chief Operating Officer (VC) (part) Ms Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience (VC) (part) Mrs Lisa Gostling, Executive Director of Workforce and OD/Deputy Chief Executive (VC) (part) Ms Jill Paterson, Director of Primary Care, Community and Long Term Care (VC) (part) Ms Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding (VC) (part) Ms Eldeg Rosser, Head of Capital Planning (deputising for Mr Lee Davies, Executive Director of Strategy and Planning) (VC) (part) Mr Julian Wheeler Jones, Discretionary Capital Projects Manager (VC) (part) Dr Bruce Bolam, Deputy Director Public Health (deputising for Dr Ardiana Gjini, Executive Director of Public Health) (VC) (part) Mr James Severs, Executive Director of Allied Health Professions and Health Science (VC) (part) Ms Elin Brock, Head of Research, Innovation and Improvement (VC) (part) Mr Peter Jones, Head of Facilities (VC) (part) Ms Paula Goode, Service Director for Planned and Specialist Care (VC) (part) Ms Victoria Coppack, Service Delivery Manager, Ophthalmology and Neurology (VC) (part) Ms Heather Hinkin, Assistant Director, People Management (VC) (part) Ms Janice Cole-Williams, Assistant Director of Nursing (VC) (part) Ms Amanda Legge, All Wales PPV Manager (VC) (part) Ms Sue Tillman, PPV Location Manager (VC) (part) Ms Clare Moorcroft, Committee Services Officer (minutes)

Minutes Ref.	Item	Action
AC(25)128	**Introductions and Apologies for Absence**	

Mr Winston Weir, Audit and Risk Assurance Committee (ARAC) Vice-Chair, welcomed everyone to the meeting. Apologies for absence were received from:

- Cllr. Rhodri Evans, Independent Member (Committee Chair)
- Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary
- Professor Philip Kloer, Chief Executive
- Mr Lee Davies, Executive Director of Strategy and Planning
- Dr Ardiana Gjini, Executive Director of Public Health
- Ms Helen Humphreys, Head of Nursing for Professional Standards and Regulation
- Mr Simon Chiffi, Head of Operations, Facilities

AC(25)129 **Declaration of Interests**

No declarations of interest were made.

AC(25)130 **Minutes of the Meeting held on 24 June 2025**

Decision: RESOLVED – the Minutes from the meeting held on 24 June 2025 were approved as an accurate record.

AC(25)131 **Table of Actions**

An update was provided on the Table of Actions from the meeting held on 24 June 2025 and confirmation received that outstanding actions had been progressed. In terms of matters arising:

AC(25)47 – Ms Sharon Daniel reminded Members that this action had arisen from a discussion on the Clinical Audit Plan, during which there had been a suggestion of a wider piece of work. For clarity, Members were advised that Clinical Audit now falls under the portfolio of the Executive Medical Director. Ms Daniel had, however, discussed, with the Chair of the Quality, Safety and Experience Committee (QSEC), the future role of that Committee in this regard. The proposal is that different clinical pathways would be taken through QSEC, with consideration of how clinical audit can be utilised in reviewing those pathways, as part of the proactive work of QSEC going forward. This work is in progress and Ms Daniel hoped that developments will be seen over the next few months.

AC(25)103 – Mr Andrew Carruthers advised that this action is being progressed. Discussions are taking place with the Executive Director of Workforce and OD around how to take forward Phase 2 of the Organisational Change Process (OCP). There are a couple of issues requiring consideration as part of Phase 2, and a report outlining these will be prepared. This may result in a delay to the process, meaning the dates provided to ARAC will require revisiting.

Noting that she had previously expressed concerns around this process, Mrs Eleanor Marks recognised that restructuring takes time and involves complex issues. Whilst she felt that the 'top layer' is relatively resolved, it was suggested that other staff are still feeling unsettled. Mrs Marks requested assurance regarding pace, together with more information on the issues causing delays. In response, Mr Carruthers advised that all Clinical Care Groups (CCGs) have received a draft of the next phase/tier of the process. Further work in terms of mapping is required for the Community and Integrated Medicine (CIM) CCG, particularly in regard to mapping community structures against existing management structures. Mr Carruthers is awaiting confirmation that this is complete. Consideration of possible gaps is also required, and some new posts have been introduced since the previous OCP. It is necessary to formalise aspects of this process, and it is preferable to undertake this once rather than multiple times. The CIM CCG element will probably take longest, given the move to the longer-term strategy around care closer to home, social model for health and wellbeing, etc.

Whilst welcoming this additional context, Mrs Marks reiterated her concerns that the Health Board is extremely dependent on the effectiveness of the new operational structure. She agreed that the approach should be a single process, rather than multiple times. However, the new structure was implemented in April; it is now August and the further work involved is likely to take until the end of the calendar year, meaning that it may be April next year before it is fully embedded. This is a longer timescale than was anticipated. Mr Weir understood that an update on this topic is due to be presented to the People, Organisational Development and Culture Committee (PODCC), and suggested that this also be copied to ARAC Members. **AC**

The Committee agreed to **ADVISE** the Board in relation to concerns around implementation of the new operational structure.

AC(25)108 – Mr Carruthers confirmed that this work is being taken forward. There are a couple of associated workstreams in progress; the accelerated Urgent and Emergency Care (UEC) work, together with a 60 day programme of work around ambulance handover. A number of the issues in relation to Discharge Management are linked to aspects of this work. The Chief Executive is keen for Clinical Executive colleagues to be more closely aligned into the UEC work, to provide additional executive oversight. There is a commitment to do so, as there is a need to make progress in this area, particularly with the upcoming change in ambulance handover target.

AC(25)118 – Members were informed that the ARAC Chair had discussed Planned Care attending a future meeting as a service of concern, being the only CCG at Level 3 for Governance at the present time. As an update, Miss Charlotte Wilmshurst advised that the service has shown improvement during the past month. It is hoped that this will be sustained; however, a decision can be

made when the Audit Tracker is next presented to the Committee, which is scheduled for October 2025. **RE/JW**

AC(25)120 – Mr Huw Thomas advised that he would issue the accounts addendum report, as soon as this is received from Audit Wales. Acknowledging the delay, Mr David Williams indicated that Audit Wales are in the process of finalising this document and that it would be available for the October 2025 meeting. In response to a query around whether this would impact on the Health Board's ability to declare their annual accounts at the Annual General Meeting in September 2025, Mr Thomas emphasised that all documents requiring finalisation had been approved by the Board in June 2025. The addendum report is not material and does not impact on the governance process, it simply considers best practice and any areas for improvement. Mr Williams confirmed that the report contains 'housekeeping' findings from the audit, none of which would impact on the audit opinion. **HT**

AC(25)132 Matters Arising not on Agenda

There were no other matters arising.

AC(25)133 Escalation Status Update Report

Mr Shaun Ayres and Ms Cathie Steele joined the Committee meeting.

Presenting the Escalation Status Update Report, Mr Shaun Ayres highlighted that a further iteration of the Escalation Framework has since been received. The main change was around Cancer services being de-escalated from Level 4 to Level 3, with a revised expectation of 63% for 3 months and a focus on the backlog. Another positive step was de-escalation of Child and Adolescent Mental Health Services (CAMHS) from Level 3 to Level 1 (Routine Monitoring). As previously mentioned, there has also been the addition of a requirement around concerns raised by Regulators, including Healthcare Inspectorate Wales (HIW). Overall, it is important to note from ARAC's perspective, that four of the six criteria are assessed as 'Assure'. The two exceptions are, firstly, the criteria around Programme and Performance Management Structure, assessed as 'Advise'. This status recognises the complexity and multiplicity of expectations and demands on staff and services, in terms of UEC, savings, planning processes, Clinical Services Plan, Primary Care and Social Model for Health and Wellbeing. The second is the criteria around Concerns Raised by Regulators, assessed as 'Alert'. Whilst it is not denied that the process around this is robust, the challenge is adherence to, and application of, the process. This includes identifying leads, time scales, milestones, and setting realistic expectations as to when the Health Board will be able to not only remedy the action set out within the HIW reports, but also share the learning, to ensure that actual practices change. For that reason, and because it was an additional amendment under Governance and Leadership, Mr Ayres had suggested the status of 'Alert'. Mitigation is via the Escalation Framework, the Executive Improving Together sessions and the recovery process.

Highlighting that Welsh Government have requested a response to the latest iteration of the Escalation Framework, Mr Thomas suggested that it remains draft in this respect. He expressed concern that the de-escalation criteria in relation to financial outturn has been altered from achievement of the Target Control Total of £31.5m deficit, to a £24m deficit; a unilateral shift. Whilst recognising that decreasing the deficit further should be and is the Health Board's ultimate aim, he suggested that introducing it as a de-escalation criteria now was somewhat unfair. The Health Board will be responding accordingly. Mr Ayres acknowledged this important point of factual accuracy. Whilst the addition of the criteria around HIW/Regulators has been accepted, along with changes to performance targets, this is not necessarily the case with regard to the financial target. Members should also be aware that the Health Board's Annual Plan was drafted on the basis of a £31.5m deficit. Any shift in this is material to the overarching Plan, and the wider implications should not be underestimated.

Mr Maynard Davies highlighted that an alteration of this magnitude to the financial outturn would involve identifying and delivering an additional £6m savings in just 7 months. This makes the need to enact potential options presented to Public Board in July 2025 more likely, no matter how 'unpalatable' they may be. In terms of the additional requirement around response to Regulators, Mr Davies enquired how this would alter the current process, suggesting that the organisation should already be making an effort to respond in a timely manner. Mr Thomas was not of the opinion that it would change the process per se, the criteria was more to recognise and emphasise the importance of compliance. With regard to the financial position, as stated during the Public Board meeting, the organisation had spent a great deal of time and effort developing the Annual Plan. The reduction in deficit represents a significant expectation in terms of improvement. To change this aspect of the Annual Plan at this stage will alter the balance, and impact on quality and equity. Whilst there may be certain options without detrimental impact, there are not many. Any option being considered will need to undergo Quality and Equality Impact Assessments. Members heard that an Extraordinary In-Committee Board meeting to discuss this matter in more detail will take place on 9 September 2025.

Returning to the issue of HIW/Regulators, Ms Daniel advised that this was part of the de-escalation criteria last year; however, the requirement has been further emphasised. Whilst there has been a significant improvement in the Health Board's closure of recommendations, this needs to be fully evidenced. In addition, there are a number of recommendations which remain open, and due to the ongoing nature of the inspection process, further recommendations are constantly being added. Services also need to ensure that actions are SMART (Specific, Measurable, Achievable, Realistic/Relevant, Timely). Certain actions involve capital investment or issues with the Health Board's estate, and may require consideration in terms of risk tolerance. It had been

pleasing, however, that a recent assessment of the Health Board's maternity services had provided a positive outcome. As has been mentioned, the organisation has a number of programmes of work, including the Clinical Services Plan, Prince Philip Hospital Minor Injury Unit, CCG establishment and OCP. These are all potential areas of concern for staff, which they may then choose to raise with HIW. Members were assured that the Health Board has regular meetings with its nominated HIW Relationship Manager.

Ms Cathie Steele confirmed that the organisation is aware it has a number of open recommendations. It should be noted that this includes recommendations from national reports, against which the Health Board decided to assess itself. Others are local only. In terms of prioritisation, the more challenging recommendations are being considered first, together with those which are most overdue. Thought is given to how these might be mitigated or closed. Finally, it is important to recognise that HIW has recruited additional Inspection Managers, which will result in increased numbers of inspections and recommendations. This effect is already being seen.

Whilst recognising the sense of frustration around the revised financial target, Mrs Marks suggested that it has been set and the organisation should take steps to meet it if possible. She also felt that the Health Board and its staff have already achieved a great deal and these positive achievements should be acknowledged. Agreeing, Mr Weir reminded Members of the introduction to this item, which had identified de-escalation in Cancer services and CAMHS. Both of which would have been evidence-based, involving a significant amount of work. In terms of financial performance, it should be recognised that the Health Board over-delivered on the Target Control Total last year. It seems that Welsh Government have translated this into an expectation for future years. Whilst this does place more pressure on the organisation, Mr Weir's sense was that there is now better 'grip and control' in this area. Mr Thomas emphasised that the ambition to reduce the Health Board's deficit to £24m (and beyond) is not the issue; it is specifically the change to the financial de-escalation metric. This makes de-escalation more and more challenging for the organisation to achieve.

Concluding discussions, the role and remit of ARAC in considering the report and Escalation Framework were clarified.

<u>Decision</u>: The Committee **NOTED** the Escalation Status Update.

The Committee agreed to **ADVISE** the Board in relation to the Escalation Status Update; reflecting the additional criteria around Concerns Raised by Regulators and concerns around the change to the financial de-escalation criteria.

Mr Shaun Ayres, Mr Andrew Carruthers, Ms Sharon Daniel and Ms Cathie Steele left the Committee meeting.

AC(25)134 All Wales NHS Audit Committee Chairs' Meeting Update

DEFERRED to 14 October 2025 meeting

AC(25)135 Committee Self-Assessment

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

AC(25)136 NHS Wales Shared Services Partnership's Construction Framework for Swansea Bay and Hywel Dda University Health Boards

Ms Eldeg Rosser and Mr Julian Wheeler-Jones joined the Committee meeting.

Ms Eldeg Rosser introduced the report, advising Members of the background to this item. The report seeks to provide information around establishment and application of the NWSSP Construction Framework. Members heard that this is currently subject to an extension period, and that contracts are awarded on a rotational basis. There are various assurance processes in place, detailed within the report. Ms Rosser advised that 87 contracts have been let via the Framework. The Internal Audit of Capital Systems presented to ARAC in December 2024 had included consideration of this Framework and had returned an overall rating of Reasonable Assurance. Within the audit, specific objectives around 'Selection and Appointment', and 'Value for Money and Award' had both been rated as Substantial Assurance. Members were advised that work is underway to develop a new process and framework, for implementation following the end of the extension period.

Mr Weir clarified that the report had been requested by the Chair of the Health Board and the Chair of ARAC following a recent Chair's Action meeting to approve funding for works at Bronglais Hospital. A number of concerns had been expressed regarding the process. Mrs Marks thanked Ms Rosser for her report and the assurance it provides; whilst emphasising that an important tenet remains – no matter how robust the framework, any contract in excess of £1m requires Board approval.

Decision: The Committee **TOOK ASSURANCE** that the use of the framework and awarding of contracts is undertaken in line with procurement regulations and provides value for money.

Ms Eldeg Rosser and Mr Julian Wheeler-Jones left the Committee meeting.

AC(25)137 Audit Wales Update Report

Mr Andrew Carruthers, Ms Sharon Daniel and Dr Bruce Bolam joined the Committee meeting.

Presenting the report, Mr Williams advised that the Charitable Funds accounts audit work is being undertaken, with a planned

date for consideration of December 2025. With regard to performance audit, Ms Urvisha Perez indicated that reports in relation to UEC (Discharge Planning and Patient Flow) have been issued and are out for clearance. These have been issued to health boards and local authorities, with a request for a combined response from Regional Partnership Boards. An extended timescale has been agreed with the Health Board for the local Radiology review, to accommodate resource challenges in this area. Other reviews are still at the planning stage. The report includes reference to national work and reports, and Ms Perez wished to draw Members' attention to the letter included later on the agenda. This highlights changes to the way in which Audit Wales write their reports, with the new format being applied to reports which will be presented to future meetings.

Mr Weir requested assurance that reports will be delivered according to the planned timescales, and Ms Perez confirmed they would. In response to a query around the Radiology review timescale, Ms Perez advised that a meeting to discuss the scope had taken place. The draft project brief had been issued and was with the Health Board team for agreement. Mr Carruthers confirmed that this would occur, on return from annual leave of the relevant staff member.

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

AC(25)138 **Structured Assessment - Progress Update on Recommendations**

Miss Wilmshurst introduced the report, which provides an update on progress against recommendations made as part of the Structured Assessment process. All had been reviewed by the relevant Executive Leads, and ARAC was requested to consider the progress made.

In response to a query around Audit Wales' view on the response and progress, Ms Perez indicated that they are in the midst of fieldwork, so it would be inappropriate to comment at this stage. The latest Structured Assessment report will be submitted to the December 2025 meeting. Mr Weir recognised that this is 'work in progress', with interviews currently being conducted and thanked Audit Wales for their work. In respect of this year's Structured Assessment, Ms Perez advised that Audit Wales is undertaking a high-level review of the recommendations made in its Cost Savings and Workforce Planning reviews.

Decision: The Committee **DISCUSSED** and **CONSIDERED** progress made in respect of the recommendations from the Structured Assessments 2022, 2023 and 2024.

The Committee agreed to **ASSURE** the Board in relation to recommendations from the Structured Assessments.

Mr Andrew Carruthers, Ms Sharon Daniel and Dr Bruce Bolam left the Committee meeting.

AC(25)139 **Review of Urgent and Emergency Care (Discharge Planning and Impact of Patient Flow)**

DEFERRED to 14 October 2025 meeting.

AC(25)140 **Review of Investment in Digital Systems**

DEFERRED to 9 December 2025 meeting.

AC(25)141 **Review of the Management of Outpatients**

DEFERRED to 14 October 2025 meeting.

AC(25)142 **Internal Audit Plan Progress Report**

Mr James Johns introduced the Internal Audit Plan Progress Report, drawing Members' attention to Section 2, which details outcomes from finalised audits. Since the previous meeting, three audits have been finalised. Two of these, Nursing Management and Sickness Management, are rated as Limited Assurance. Mr Johns felt that the existence of linked issues within these reports should be recognised. He hoped that the Committee will see the 'read-across' between the points raised. In terms of a delivery update, this year's audit work is progressing well. A number of audits are in fieldwork and planning stages. There have been discussions with the Director of Corporate Governance around inclusion of further work around Cleaning Standards later in the year. It may be that this is incorporated by utilising some of the time allocated for estates and facilities work, and by including consideration of it in other planned audits.

Mr Weir enquired whether the two audits which have returned Limited Assurance ratings will be reaudited later in the year. In response, Mr Johns advised that there are two potential approaches. Progress against the recommendations could be reviewed as part of wider recommendation-tracking work; or more detailed audit work could be conducted if required.

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

AC(25)143 **Standards of Cleanliness Internal Audit - Action Plan Progress**

Mr James Severs, Ms Elin Brock and Mr Peter Jones joined the Committee meeting.

Ms Elin Brock presented the Standards of Cleanliness Progress update, reminding Members of the background and context, with audits in both 2023/24 and 2024/25 returning ratings of Limited Assurance. The six management actions requiring addressing by the Health Board are outlined within the report. The most pressing of these were Actions 4 and 5, which needed to be completed by 31 July 2025. Ms Brock was pleased to advise that these had

been completed and that a governance and reporting structure has been incorporated, to enable monitoring of compliance via the Estates and Facilities CCG structure. There are also two actions which are due for completion by 31 August 2025. Both are being worked on by the team, with progress reported on a weekly basis to the Cleaning Standards Sub-Group. The team is on track to complete these by the date specified, with compliance and progress monitored, again, via the Estates and Facilities CCG structure.

A Governance Review meeting was held on 11 August 2025, with the Executive Director of Allied Health Professions and Health Science and the Executive Director of Nursing, Quality and Patient Experience. This meeting had considered the process for reviewing governance and reporting structures for Infection Prevention and Control going forward, and the implications for terms of reference. A number of actions have been agreed between Facilities and Nursing teams, to ensure that the correct assurances around meeting cleaning standards and the relevant escalation processes are in place. Reports will continue on a weekly basis via the Cleaning Standards Sub-Group, and on a bi-weekly basis to the Estates and Facilities CCG, to ensure that actions are being progressed. Also included in the report is a brief summary of wider pieces of work currently being undertaken.

Mr Weir welcomed the positive report and thanked Mr James Severs and Ms Brock for their work. Recalling the need for additional resource identified at the previous meeting, he enquired whether this aspect has been resolved. Mr James Severs advised that an updated position statement on the audit as it stands is being taken to the Executive Team. As part of business planning for 2026/27, consideration is being given to the additional resource which might be needed. There is resource within the Facilities budget, which is being explored for the purposes of increasing supervision, as outlined on page 5 of the report. As a first step, Mr Severs will take the opportunity to examine this issue further over the next month or two. A discussion at Board Seminar is also scheduled, to consider the wider context of the Estates and Facilities function. Whilst he felt that he had sufficient support at this stage, he was also conscious that there is no Director of Estates and Facilities in post at present. Mr Severs is anticipating that a review of Estates and Facilities will be undertaken in the near future.

Noting that Estates and Facilities has been de-escalated from Level 3 to Level 2 for Governance, Mr Weir commended this positive achievement. Mr Severs stated that it was testament to the hard work and tenacity of the management team. The concern is sustaining this performance, hence the review of the senior leadership structure. Mr Davies noted that an Assistant Director has been seconded into the Facilities Service. He enquired whether this was the Consultant Practitioner of Infection Prevention (IP), or another individual. Also, their background and skillset. Secondly, with regard to Action 4 around developing

cleaning schedules, he enquired who these are agreed with in the clinical setting, to ensure they are adequate to meet requirements.

In response to the first query, Mr Severs advised that two individuals had been seconded. Ms Brock was the Assistant Director and he was confident she possesses the skills required. The Consultant Practitioner in IP is support provided with the assistance of the Executive Director of Nursing, Quality and Patient Experience. Mr Severs was, however, conscious that these roles are time-limited and progress is required in terms of substantive appointments. With regard to the second query, Ms Brock advised that there is a cleaning schedule compliance Standard Operating Procedure (SOP). This provides guidance around roles and responsibilities, duties and how compliance is monitored and measured. The SOP was agreed at the Environmental Hygiene Group in July 2025 and will be presented to the Infection Prevention Strategic Steering Group (IPSSG) this month. Colleagues in Infection Prevention and Control (IPC) sit on the Environmental Hygiene Group, and have provided advice from an IPC perspective. Whilst there are no responsibilities within the SOP for nursing, it is recognised that, as good practice, it should be discussed with nursing colleagues. This is currently in hand.

Mr Weir requested an update on progress recruiting to the Facilities Manager role. Welcoming the support which Mr Severs has already provided to the team, Mr Peter Jones advised that he and Ms Brock had met with the recruitment team. The post is now on the TRAC system and should be advertised fairly soon.

Decision: The Committee **TOOK ASSURANCE** that progress is being made to implement the actions arising from the 2024/25 internal audit report on Standards of Cleanliness.

Mr James Severs, Ms Elin Brock and Mr Peter Jones left the Committee meeting.

AC(25)144 Corporate Risk: Ophthalmology (Reasonable Assurance)

Mr Andrew Carruthers, Ms Paula Goode and Ms Victoria Coppack joined the Committee meeting.

Ms Sophie Corbett introduced the report from the Corporate Risk: Ophthalmology Internal Audit, which reviewed the key controls in place to manage and mitigate risk 1664 on the Corporate Risk Register, relating to the inability to provide a full range of Ophthalmology services across the Health Board. Progress has been made in the implementation of key controls, and actions to address and identify gaps in controls; although further work is required to fully address the risk, with 11 of the 17 controls at varying stages of implementation. No concerns were identified with the governance and oversight arrangements for the risk and identified controls. Reasonable Assurance had been concluded overall, with two medium priority actions relating to the need to review existing controls and gaps in controls, to eradicate any overlaps or discrepancies.

Mrs Marks requested confirmation that the target implementation dates for actions were achievable. She noted that Ophthalmology is an area of fragility for the Health Board and, whilst welcoming the progress identified within the report, enquired whether it will contribute positively towards this fragility. Mr Carruthers welcomed this question. Whilst it is helpful to receive an assessment of this specific corporate risk, it does not necessarily impact on the service risks. He was not able, at this stage, to provide assurance around these, or identify how this assurance might be obtained. More work is required in this regard, together with additional investment. Mr Carruthers was, however, cognisant that performance in this area is not at a sufficient level. Mrs Marks indicated that she has spent time with the Ophthalmology service at Glangwili Hospital (GGH) and received a great deal of feedback from staff there. She would welcome a further report and discussion on this area.

Members discussed which forum would be most appropriate for such a discussion, noting that the Finance and Performance Committee (FPC) or QSEC may be suitable, and that this topic is also on the agenda for the next Regional Joint Committee (RJC) meeting. It was agreed that the most appropriate forum would be determined by the relevant Executive Leads. In response to the first query, around the target implementation date, Ms Victoria Coppack advised that the risk assessment for risk 1664 has been updated, with a first draft prepared. It does, however, require discussion with the Head of Assurance and Risk. Certain of the actions within the risk are longer term, as they involve, for example, the regional programme, which will take time to develop and deliver. As such, there are no dates specified for those.

AC/JW

Decision: The Committee **NOTED** the Corporate Risk: Ophthalmology (Reasonable Assurance) Internal Audit report.

The Committee agreed to **ASSURE** the Board in relation to the Corporate Risk: Ophthalmology (Reasonable Assurance) Internal Audit report.

Mr Andrew Carruthers, Ms Paula Goode and Ms Victoria Coppack left the Committee meeting.

AC(25)145 **Sickness Management (Limited Assurance)**

Mrs Lisa Gostling and Ms Heather Hinkin joined the Committee meeting.

Ms Corbett introduced the Sickness Management Internal Audit report. This audit had reviewed the arrangements in place for managing sickness absence in compliance with the All Wales Managing Attendance at Work Policy, the training and support available to staff and line managers and the monitoring and reporting arrangements. On the basis of widespread non-compliance with the key requirements of the policy relating to Fit Notes, Return To Work (RTW) interviews and action taken in

relation to review prompts for frequent absences, the audit had concluded Limited Assurance overall. Staff interviewed as part of the audit were aware of the policy requirements, which suggests that non-compliance is due to capacity, culture or both. The policy requires periodic audits of implementation and, whilst ad hoc deep dive reviews are undertaken, these do not consider application of the policy. An action has been agreed, to develop a planned programme of service-led sickness absence reviews, to identify and address the root causes of non-compliance and ensure that service leads are held to account. The areas visited spoke highly of the support and engagement they received from the Workforce team. Whilst there is extensive information and training available, an action has been agreed to strengthen the promotion of resources and support service areas in identifying and addressing any training needs.

Mrs Lisa Gostling wished to clarify that, of the four objectives in the audit, two were rated as Reasonable Assurance, one as Substantial Assurance and one as Limited Assurance. Fundamentally, the issue was a lack of evidence that service areas were managing sickness absence appropriately in the workplace. It was confirmed in the audit that 81% of the records sampled did have the relevant documentation on file (meaning that 19% did not). 89% had completed a RTW interview. Mrs Gostling did not feel that this suggested a major problem across the whole of the organisation, particularly given the sample size. She did acknowledge, however, the need to ensure a planned programme of reviews within service areas. Since January 2025, Mrs Gostling has been contacting all of the services where there has been an improvement in the monthly sickness position, to establish the key actions undertaken which might have contributed to a reduced sickness rate.

Frequently, the feedback has been around the rigour of conducting a RTW sickness review, where service managers examine each of the cases with a member of the Workforce team, to ensure the relevant documentation is in place. She and Ms Heather Hinkin will work with service managers to establish this programme of activity. However, it is important that managers take responsibility for managing their workforce, rather than this being a centrally-led process. The centrally-led elements are those with Reasonable and Substantial Assurance. The area requiring focus will be managers meeting with staff to discuss their sickness absence, identify any support they might need, whether there is any likelihood of a recurrence, etc. In addition, via the Executive Improving Together sessions, there will be a focus on not only the sickness absence percentage, but compliance with the policy.

Ms Sharon Daniel, Ms Janice Cole-Williams and Mr Ben Rees joined the Committee meeting.

In terms of management support, Ms Heather Hinkin indicated that managers often do not have time to undertake long training programmes; their priority is the specific issue with which they are

dealing. The ‘bite-size’ training sessions will assist in this regard, with a suite of ten 5 minute sessions to support managers in managing sickness absence. A programme of work will be rolled-out over the next year, to help staff and managers to understand the process, the importance of timely intervention and the documentation. Currently, there are more than 200 live cases in which the operational Workforce team is involved. There will always be a certain level of sickness absence; however, the organisation is committed to providing all the support it reasonably can, for every case, to enable a return to work as soon as possible. If a return to the substantive role is not possible, this will include consideration of temporary redeployments. The team is also committed to learning from and sharing good practice. Ultimately, however, the Workforce team can only support service managers in supporting their staff.

Building on the comment around sample size, Mr Weir queried whether a sample size of 20 was considered sufficient and requested clarification around the sampling process. He also highlighted that 81% had the relevant documentation on file and 89% had completed a RTW interview. Ms Corbett explained that, whilst the sample consisted of 20 individuals, it involved 91 sickness absences. In response to the comment around percentages, she emphasised that the target for both is 100%. In terms of RTW interviews, nearly 30% of those that had been completed were not undertaken at the time. Some of them were completed several months after the individual had returned to work, which makes the value questionable. It is also important to highlight that, out of the 20 employees and 91 episodes, only 2 employees (8 episodes) were fully compliant with all the controls. Had the non-compliance been related to only a small number of controls, for example, the outcome may have been different.

Mrs Marks shared Mr Weir’s concerns around sample size, and remained concerned. She observed, for example, that no matter how many episodes, a sample of only 20 staff will involve the same managers. Mrs Marks would welcome a further explanation of how sample size is determined and was not convinced that assurance around the process can be taken, given the sample size in this instance. Ms Corbett reiterated that the sample size refers to the number of episodes. Sampling guidance recommends sample size, based on the frequency of a control operation. In this case, guidance suggested approximately 40, with the actual sample size being 91. Ideally, the number of staff sampled would have been larger; however, there are also time constraints in conducting the fieldwork for an audit. To support the approach taken, the same testing has been undertaken as part of the Nursing Management audit, but focused on nursing staff. The findings of the testing for both audits are consistent. Adding the two sample groups together produces a larger population which has been evaluated.

Referencing page 3 of the report, ‘Compliance with the All Wales Managing Attendance at Work Policy’ Mr Weir highlighted the

following: *Managers are required to proactively manage absence where the pattern or frequency gives rise to concern, with the Policy outlining three review prompts. 48% of the sickness episodes triggering a review prompt did not have evidence of appropriate action and escalation in line with Policy.* Noting that records can be both paper-based and electronic, he queried whether there had been any consideration of whether managers had actioned this via the Electronic Staff Record (ESR) system. In response, Ms Corbett indicated that, for these specific prompts, the expectation was for the evidence to be on the employee's file. For example, notes of review meetings held. There was no such evidence on file for the instances of non-compliance. For the other controls, for example RTW interviews, records on ESR had been considered. If there was no RTW form on the employee's file, checks were made to establish whether a RTW interview date was noted on ESR.

Mr Weir was of the opinion that this area was one which probably justified a follow-up audit later in the year. This view was echoed by Mrs Marks, who remained unconvinced by responses around sample size. Mr Weir agreed that the sample used for any future audit should be larger. It was suggested by Mr Thomas that there be a focus at a future meeting on the guidance and principles involved in determining sample size. Ms Hinkin highlighted that three wards were included within the Sickness Management audit, due to absence levels. Meaning that there was potentially some correlation between this sample and the Nursing Management audit.

JJ/SC

Decision: The Committee **NOTED** the Sickness Management (Limited Assurance) Internal Audit report

The Committee agreed to **ADVISE** the Board in relation to the Sickness Management (Limited Assurance) Internal Audit report.

AC(25)146 **Nursing Management (Limited Assurance)**

Ms Corbett introduced the report from the Nursing Management Internal Audit, which was a full re-audit following the Nursing Management review undertaken in 2024/25. The audit had focused on rostering processes and absence management, and had concluded Limited Assurance overall. Whilst the findings of this audit were broadly consistent with the 2024/25 review, an improving trend in rostering controls and practices was observed. The objective around absence management reflected a deterioration in sickness management and widespread non-compliance with key requirements of the All Wales Managing Attendance at Work Policy, and had concluded Limited Assurance. Following an earlier comment, Ms Corbett wished to clarify that the Sickness Management audit involved non-nursing staff, whilst this review involved nursing staff. Meaning that there are two distinct samples of staff; however, findings were consistent across the two reviews. For this reason, the same high priority action is included within both reports. Only 10% of the sample was fully compliant, all of which were based in Prince

Philip Hospital. The agreed action has, therefore, been extended to include process mapping good practice there into a guidance document for sharing more widely across the Health Board. Two medium priority findings were also identified, in relation to annual leave utilisation and the approval of agency requests.

Ms Daniel thanked the team for both undertaking the audit, and for the constructive conversation which had taken place as part of the feedback session. As indicated, the previous review had been finalised in November 2024 and this was a further full audit of the system and controls. Ms Daniel wished to highlight improving trends in rostering controls and practice, resulting in Reasonable Assurance for this objective. An improvement in the management of annual leave, with significantly less reliance on temporary staff to backfill was also identified, suggesting a greater stability in the establishment. An improving trend in relation to the review and scrutiny of rosters had resulted in Substantial Assurance for that objective. The Limited Assurance rating in terms of sickness absence is, however, disappointing.

Ms Janice Cole-Williams indicated that the audit had covered eight areas, across all sites, and had identified reasonably consistent practice. The agreed actions are ongoing actions to those already specified. The first, around annual leave utilisation, has been completed by means of an Availability Dashboard. This extends beyond annual leave to include study leave, parental leave and sick leave. Each area can view its own staff allocation and availability. The data is populated from the rostering system on a weekly basis and is, therefore, relatively 'live' in terms of its status. The system includes acceptable parameters and will highlight any deviation from these. Thereby identifying over- or under- allocation of annual leave, which places a pressure elsewhere in the rostering process. The dashboard went live at the beginning of August and is now available to all roster areas.

In terms of the next action, as part of the response to the first audit six months ago, an SOP has been developed around rostering and escalation of unfilled shifts to on-contract agency. This does involve escalation to the Head of Nursing or nominated deputy within the services, and work is underway to refine the authorisation process. It is not necessarily clear currently who adds the authorised shift to the Allocate system. The team is working on an electronic authorisation process, which will identify and confirm authorisation at each level and will also provide a clear and robust audit trail. It is anticipated this action will be completed within the agreed timescales.

The final action relates to the sickness and absence management, which the Committee has been discussing in more general terms. The sample size for this audit was 32 employees, a total of 183 episodes, resulting in a working sample of 148 following removal of the incomplete documentation. The Nursing and Workforce teams are working on training programmes and applying the QI methodology to identify and share good practice. Following the

first audit, there had been a focus on raising awareness of the process. The aim going forward is to ensure a focus on application of the process, as opposed to awareness.

Mr Weir noted that this was the second audit of this area which had received a rating of Limited Assurance. Whilst there appears to be 'buy in' from corporate nursing, he requested assurance that this exists within the operational parts of the organisation; in each hospital site and each senior nursing team. In response, Members heard that a Task and Finish Oversight Group has been established, which includes operational nursing representation at Head of Nursing and Assistant Director level. There is also a rostering group, aimed at roster managers and senior nurses. A more targeted approach has been taken to repeated issues around roster management during the last six months. With the new CCG structure, there is potential to focus it even further. Ms Daniel indicated that, in addition to the targeted approach, which will be continued, the 'appreciative inquiry' approach will also be utilised. This will identify where processes are working well and share that best practice across the organisation, focusing on continuous improvement.

Impressed that the Availability Dashboard has been implemented ahead of schedule, Mr Weir enquired whether this data is shared routinely with operational teams, to open a dialogue on this topic. Ms Cole-Williams advised that the data is available on a 'rolling' basis to roster managers and, additionally, a monthly report is produced. Returning to the issue around approval of agency requests, Mr Weir understood that agency usage is now intended to be low. In view of this, he queried whether it should, in fact be a relatively senior member of staff inputting agency requests, if their use is being discouraged. Ms Cole-Williams clarified that the process is in place for senior authorisation (by a Head of Nursing). The issue is the actual data entry of an approved shift on the roster, and whether this is an appropriate use of their time. Conversely, without this, there can be a perception that the shift has not been approved. Hence the work to make the authorisation process more transparent, and potentially electronic.

Regardless of debates around sample size, etc, Mr Davies highlighted that the organisation has received two Limited Assurance reports which have received that rating for one reason – sickness absence management. It was further highlighted that these will be reported to Welsh Government; there is a clear need for action. Mr Weir agreed, emphasising the common thread between the two reports, and queried how they should be taken forward. Mrs Marks shared these views, with the audits clearly indicating an issue around sickness management which must be recognised, 'owned' and addressed by the Health Board. Nevertheless, she remained concerned around sample size, and the fact that a Limited Assurance opinion has been extrapolated from this, which will be reported to Welsh Government.

In terms of how this matter will be progressed, it was suggested that it could be referred to PODCC. However, there was also a sense that there may need to be consideration of the operational controls in place such as SOPs, which may require a more audit-based approach. Ms Daniel emphasised that it is possible for the policy to be implemented as intended; as evidenced within the audit. She reiterated the value of the 'appreciative inquiry' and Quality Improvement approach, process-mapping examples of good practice. If upscaled within nursing areas alone, it would offer the opportunity to influence significant numbers. Mrs Gostling echoed this view, emphasising the need for a different focus – on the sickness absence and policy rather than percentages. She also highlighted that the policy actually states RTW interviews should be undertaken as soon as possible after the return, not a week; meaning that it might be longer, if (for example) a manager is on annual leave. This is an example of where there needs to be care to ensure that audits utilise the same metrics as policies, etc. The Health Board can work with Internal Audit to support this.

Decision: The Committee **NOTED** the Nursing Management (Limited Assurance) Internal Audit report.

The Committee agreed to **ADVISE** the Board in relation to the Nursing Management (Limited Assurance) Internal Audit report.

AC(25)147 **Financial Assurance Report**

Mr Thomas presented the Financial Assurance Report, highlighting that the format has been changed to reflect the reporting approach utilised for FPC and the Board. In terms of 'Advise' items, he drew Members' attention to breaches of Standing Financial Instructions (SFIs) and the use of retrospective Purchase Orders, reported in Appendix 1c. An active programme is in place to address these; however, they remain a challenge. He also wished to advise the Committee around the level of salary overpayments. Whilst the number has increased, the average recovery period continues to decrease compared to the last two months. The report also provides assurance around compliance with the No PO, No Pay Policy and Public Sector Payment Policy; management of Single Tender Actions (none since March 2024); and compliance with employment tax requirements.

Mr Weir welcomed the new report format and the clarity that it provides. Noting that breaches of SFIs were a concern for the Committee, he enquired whether these occur in the same, or different service areas. Whilst recognising the need to highlight these to ARAC, Mr Thomas emphasised that the SFIs reported are not material in nature. Generally, there is no consistency in their occurrence. However, if repeated breaches are evident, there is a programme of education in place. Observing that, despite working groups, etc, overpayments of salary are continuing to occur, Mr Weir requested assurance that there is progress in this area. In response, Mr Thomas suggested that there is limited scope for action, until a digital system is fully implemented. Members were reminded that a new ESR system is due for roll-

out. However, even with digitalisation, Mr Thomas was concerned that those areas where there are most issues will remain challenging. As explained previously, one of these is Estates and Facilities, where there is a small number of supervisors (not senior managers) for large numbers of Band 2 and 3 staff. The latter are extremely ‘mobile’ in terms of skillset and notice period required, and sometimes leave without working their notice. It is, therefore, challenging to manage the processes associated with this workforce. The team will, however, continue to explore opportunities for improvement.

Decision: The Committee:

- **DISCUSSED** the breaches of SFIs as detailed.
- **DISCUSSED** the staff overpayments as detailed and **TOOK ASSURANCE** that actions to control them are sufficiently embedded.
- **DISCUSSED** losses as detailed, noting that there were none requiring approval.
- **TOOK ASSURANCE** from the actions taken to reduce the instances of non-compliance with the No PO, No Pay policy; to ensure Public Sector Payment Policy (PSPP) compliance; to manage Single Tender Actions (STAs) and to ensure National Minimum Wage (NMW) compliance.
- **SCRUTINISED** the award of contracts listed.

The Committee agreed to **ADVISE** the Board in relation to Breaches of SFIs.

AC(25)148 **Counter Fraud Update**

Mr Ben Rees introduced the Counter Fraud Update report, drawing Members’ attention to the ‘Inform and Involve’ section. An increase in staff reading Counter Fraud alerts via Viva Engage has been noted, with more than 5,000 individuals viewing the posts. As a result, the team is planning to adopt an approach to raising awareness which will consist of ‘bite-size’ information issued via this platform, similar to Instagram or Facebook. In terms of ‘Prevent and Deter’, a proactive exercise has been conducted around Nursing and Healthcare Support Workers (HCSW) agency and Bank staff; in response to a Fraud Prevention Notice and identified risk. This had involved the verification of ward-based procedures and identification checks. Further detail is included as part of the In-Committee report, and a full report will be provided to the next meeting.

Members also heard that the Counter Fraud team is taking steps to develop further data analytics, to identify potential fraud trends. This will assist in identifying areas of weakness, proactive work and actions required. Appendix A outlines some of the data collated since 1 April 2024. The report is in its infancy, and the team will work with others to develop it further to make the format more accessible. Ultimately, the intention would be to utilise the data in developing future fraud prevention activities, and ideally in

addressing risks before they arise. It may identify patterns in certain types of fraud or behaviour, for example. Finally, Mr Rees advised that a review of the Counter Fraud, Bribery and Corruption Policy has been undertaken, this being the next agenda item.

Mr Weir commended the proactive exercise undertaken, and welcomed the move to include more data analytics; especially the presentation of the latter, and the potential it offers to identify areas of concern. He noted, for example, that the graph outlining Fraud Cases by Site Location highlighted higher numbers at GGH than the other hospital sites. Mr Rees agreed that the intended use of analytics will allow detailed consideration of data such as this, to establish whether targeted work is required.

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

AC(25)149 **Counter Fraud, Bribery and Corruption Policy Review**

Members were advised that the Policy had been reviewed and amended to reflect recent changes in legislation. It had also been subject to the required consultation process, and as a result, further minor amendments had been made.

Decision: The Committee **REVIEWED** and **APPROVED** the Health Board's Counter Fraud, Bribery and Corruption Policy (815).

Mr Ben Rees left the Committee meeting.

AC(25)150 **Risk Assurance Report**

Miss Wilmshurst introduced the Risk Assurance Report, noting that this is intended to provide assurance on the effectiveness of the Risk Management Framework and implementation of the Risk Management Strategy. The figures in the report are as at the end of June 2025; there are 579 open risks on DATIX, with Estates and Facilities and Planned Care reporting the most risks. There has been an improvement in risk reviews, a concern previously raised by the Committee, with very few overdue by more than a month. However, there will continue to be a focus on this area. In terms of Planned Care (previously in escalation for risk management), as at the end of June this service area has reached 95% compliance. There are improvements in terms of the average age of a risk, with 21% of these being pre COVID-19 and the average risk age being approximately 3 years and 5 months. Most of the older risks on DATIX are in Facilities and Estates; however, they are reviewing their risk register and undertaking a cleanse of risks. The majority of risks relate to the aging infrastructure and equipment, with an inability to address these due to limited capital and other priorities. Since introduction of the mandatory requirement around rationale for Target Risk Score (TRS) and the date services expect to achieve this, many are citing the lack of available funds as a barrier to setting and achieving a lower TRS.

Mr Davies noted that the Target Risk Score for Risk 1032 (Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity) has increased from 16 to 20. He enquired regarding the process in terms of that risk, once the TRS is achieved. In response, Miss Wilmshurst advised that once the TRS is reached, there should be consideration of whether the service is satisfied with it being set at that level, or whether it needs to be further treated or escalated, if this is not within its gift to manage. This specific issue was highlighted by the Executive Team (ET) during their risk session at the beginning of the month. Mr Carruthers had committed to speak to the service and establish whether there are any further actions which can be taken, to set a lower TRS. Mr Thomas confirmed this discussion, emphasising that ET had not been satisfied with the response and had requested this be considered further. It should be recognised as a positive, however, that the Health Board is participating in more mature discussions around risk.

Mrs Marks highlighted page 11 of the report, and the 'Level 3 – No Assurance' section around Planned and Specialist Care. In view of the obvious issues in this area, she would have welcomed a comment from the relevant Executive Lead and team, to provide assurance around how they will improve this level. She requested that this feedback be flagged to the Chief Operating Officer. Mr Weir suggested that the data on page 10 of the report is extremely powerful and that it reflects earlier comments around the organisation undertaking more mature discussions regarding risk. Whilst the risk might not necessarily diminish or disappear, it is being examined in a more integrated way. He enquired regarding risk management training across the organisation and whether the 'Four T's' approach (Treat, Tolerate, Terminate, Transfer) is embedded and understood. In other words, whether risks are recognised, owned and managed by services; as opposed to being simply added to a risk register. Whilst accepting that there is always more which could be done, Miss Wilmshurst emphasised that the Assurance and Risk team does provide this type of support to services.

CW

With regard to Mr Davies' comment around high TRS, Miss Wilmshurst indicated that this type of issue requires services to undertake further discussion to determine the approach to be taken in managing the risk. Whether they will try to access more treatment, or whether they accept that risk score and escalate it through their corporate governance or operational governance structures, up through IQFPD to ET and to the Board. The team also support services with this aspect. In response to Mrs Marks' comment, and in terms of action taken, the escalation criteria has been strengthened. In addition to the number of reviews being undertaken or compliance figures; it is recognised that there are risks being managed by CCGs or executive functions which are not on risk registers. Consideration is also given to whether risks are being escalated through governance structures, where there are concerns. As indicated by Mr Thomas, this forms part of a

general approach of establishing a more intelligent dialogue with services about their risk management.

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

AC(25)151 Risk Management Framework and Strategy

Miss Wilmshurst presented the Risk Management Framework, which has been amended to reflect changes to the operational structure and includes a training needs analysis. This has been considered by ET and subject to the Written Control Document process, with suggested amendments incorporated.

Decision: The Committee **APPROVED** the Risk Management Framework, prior to its submission to the Board for onward ratification on 25 September 2025.

Miss Wilmshurst presented the Risk Management Strategy, to which three new risk management objectives have been added. This will be supported by an implementation plan and updates on progress will be provided through the Risk Assurance report going forward. Again, this has been considered by ET.

Decision: The Committee **APPROVED** the Risk Management Strategy, prior to its submission to the Board for onward ratification on 25 September 2025.

AC(25)152 Post Payment Verification (PPV) Annual Report

Ms Amanda Legge, Ms Sue Tillman and Ms Jill Paterson joined the Committee meeting.

Mr Thomas and Ms Amanda Legge introduced the Post Payment Verification (PPV) Annual Report. Ms Legge advised that a significant programme of work had been undertaken in 2024/25, in recognition of the need to address outstanding visits, an issue nationally. Whilst this has been achieved for the routine visits that were due, a recovery plan for the revisits is being explored. PPV teams have been requested by Welsh Government to undertake new service checks in relation to COVID-19 and Respiratory Syncytial Virus (RSV) vaccinations. Programmes of work for Ophthalmic and Pharmacy services are generally up to date. There has been a reform in relation to the Welsh General Ophthalmic Services (WGOS), resulting in new service checks for WGOS 4; glaucoma and retinal reviews. Information on urgent prescribing for independent prescribers will be included on reports going forward, as there will be potential recoveries this financial year. New national initiatives to avoid clinical waste and save money are being explored. Locally, training continues with all relevant parties, and there is close working with Counter Fraud. As indicated in the report, there were two significant recoveries, which were in the same practice (Practice 1 and Practice 16). The

Health Board is aware of the issue and there has been liaison with Counter Fraud.

Mr Davies queried the variation in amount recovered between Practice 1, 5 and 16. In Practice 1, there were 178 errors and a recovery of 99.4%; in Practice 5, there were 245 errors, but a recovery of only 7.83%; in Practice 16, there were 243 errors, with a recovery of 62.95%. In response, Ms Legge advised that revisits will always check 100% of the service that was flagged as an over 10% error rate during a routine visit. A high error rate generally indicates an issue in terms of learning or education required; it may be a new specification, for example. Practice 1 was such a revisit, checking only the minor surgery specification. Of the 179 minor surgeries checked, only 1 was correct and appropriately claimed and paid, the other 178 were erroneous. Ms Legge agreed that this was exceptionally high, and understood that discussions are taking place between the Health Board and practice to clarify the issue.

The team was requested by the Health Board (based on a high error percentage) to undertake another routine visit within the year; recorded as Practice 16. Being a routine visit, the 243 was a set from each actual individual service specification. The overall (the 62.95%) was in relation to minor surgery. Ms Sue Tillman, who had undertaken this visit, was asked to clarify further. She confirmed that this was correct, adding that the recovery percentage is taken out of the amount of what is visited. So in reference to Practice 5, the reason for a recovery of 7.83% was that out of 3,127 claims checked, there were 245 errors. Recognising that this query had arisen from a misinterpretation of the figures, Mr Thomas suggested that the relevant column title be changed in future reports to read 'Error Percentage'.

Mr Weir further suggested that future reports adopt the '3As' format utilised in other Health Board and ARAC reports. Also, that year-end reports include a trend analysis across the year, to assess whether there have been improvements. These changes would assist the Committee in judging whether it can take assurance in this area. Ms Legge committed to consider and act on all feedback. She suggested that the increased workload within Primary and Community Care could also be reflected in the year-end report, by the addition of a comparison between years. **AL/ST**

Decision: The Committee **NOTED** and **TOOK ASSURANCE** from the contents of the Post Payment Verification (PPV) Annual Report.

AC(25)153 **Primary Care PPV Report**

Ms Jill Paterson presented the Primary Care PPV Report, emphasising that figures are consistent between this and the wider PPV report discussed under the previous item. The Primary Care PPV Report, however, provides additional context around training, development and educational activities undertaken, etc. One of the common themes within the reports is a lack of

supporting evidence for claims. This is a key area of work for the Primary Care team to pursue with practices. Ms Paterson wished to assure Members that learning from PPV visits and reports is recognised and addressed. The report also highlights that there have been a number of Community Pharmacy PPV visits with no recoveries, and a small number of recoveries for General Ophthalmic Services. As mentioned in the previous item, the new Eye Care pathways were implemented in October 2024. The next round of visits in ophthalmic services will begin to reflect those new pathways and the associated claims.

Referencing the issue noted on page 15 of the report around practice migrations from VISION to EMIS, Mr Davies enquired whether this is being addressed for future migrations. Ms Paterson advised that a great deal of learning is being obtained from previous migrations. Whilst she was not aware of a recurrent theme in terms of this particular issue, she assured Members that it would be monitored. Mr Weir thanked Ms Legge, Ms Tillman and Ms Paterson for their contributions.

Decision: The Committee:

- **NOTED** the information contained within the Primary Care PPV Report.
- **NOTED** 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.
- **TOOK ASSURANCE** that appropriate liaison is undertaken with the Counter Fraud Team when there are any concerns, or information needs to be queried.

Ms Amanda Legge, Ms Sue Tillman and Ms Jill Paterson left the Committee meeting.

AC(25)154 Audit Wales - Letter regarding Future Report Writing Style

Discussed under AC(25)137, Audit Wales Update Report.

AC(25)155 ARAC Workplan 2025/26

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

AC(25)156 Any Other Business

There was no other business reported.

AC(25)157 Matters and Risks for Escalation to the Board

As noted.

AC(25)158 Date and Time of Next Meeting

9.30am, 14 October 2025

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 12 Aug 2025.pdf

Audit & Risk Assurance Committee
TABLE OF ACTIONS
Arising from Meeting held on 12 August 2025

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
AC(25)47	**15/04/2025**	**Clinical Audit Update**	To consider how Clinical Audit might contribute to a wider piece of work around inefficiencies in Patient/ Clinical Pathways and to discuss this with the Chair of QSEC	**SD**	**~~June~~ August 2025**	24 June 2025 **In Progress** Meeting scheduled for 16 June 2025. 12 August 2025 **Complete** Verbal update provided.
AC(25)96	**24/06/2025**	**Table of Actions**	**AC(25)47** – to provide a further update to the August 2025 meeting	**SD**	**August 2025**	See **AC(25)47**, above.
AC(25)103	**24/06/2025**	**Review of Urgent and Emergency Care**	To provide an update on progress to the next meeting, via the Table of Actions	**AC**	**~~August~~ October 2025**	12 August 2025 **In Progress** Intention to share finalised plan for Phase 2 OCP with Executive Team by 20 August 2025, with any required OCP consultation commencing before 29 August 2025, to allow progress to be made. 14 October 2025 Following the completion of phase 1 of the OCP/restructure, the second phase will commence shortly; however, this must first be subject to appropriate scrutiny and approval at Formal Executive Team. Furthermore, a detailed update will be provided to the next People,

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
						Organisational Development and Culture Committee (PODCC) meeting, due to the ongoing concerns raised by Independent Members and staff within the Health Board, relating to the length of time this has taken to implement. This matter will be closed at ARAC as this is being monitored by PODCC.
AC(25)108	**24/06/2025**	**Discharge Management Follow-up (Advisory Report)**	For Mr Andrew Carruthers and Mrs Eleanor Marks to discuss the disparity in closing times between Discharge Lounges and hospital Pharmacies outside the meeting	**AC**	**~~August~~ October 2025**	12 August 2025 **In Progress** A meeting to discuss this issue specifically has not yet taken place. However, these matters are areas of focus for the Ambulance Handover Improvement Plan over the next 60 days. 14 October 2025 There are currently active discharge lounges in three of our four acute hospitals: **PPH – Open 8am-6pm (Mon to Fri)** - The opening hours in PPH have been extended from 10am to 6pm following the recommendations set out within the Discharge Planning Progress Report audit.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
						GGH – Open 8am-6pm (Mon to Fri) **WGH – Open 9am-6pm (Mon to Fri)** - Ongoing plans to extend the opening hours from 8am in line with the Carmarthenshire sites. **BGH – No current provision** - No current provision due to availability of space. Following a series of fire safety work scheduled over the coming months, a location has been identified to use as a discharge lounge facility. As an interim solution, staff are being actively encouraged to follow discharge lounge protocols by identifying suitable spaces within the ward environment where patients who can sit out are transferred from their bed space on the morning of discharge whilst final arrangements and transport are completed. Week commencing Monday 8th September 2025, the Health Board

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
						initiated a 'reset week' with a focus on patient flow, processes and discharge. An element of this exercise was to concentrate on increasing the number of patients being discharged before midday, supported using our discharge lounges. This work continues as "business as usual" and has enabled us to capture and develop criteria for patients suitable for transfer to the discharge lounge and address some of the perceived constraints in relation to this.
			To provide an update to the next meeting, via the Table of Actions, on progress towards achieving the outstanding actions	**AC**	~~**August**~~ **October 2025**	12 August 2025 **In Progress** This action is being reviewed in the context of the Accelerated Urgent Emergency Care Actions and the new 60-day focus on handover improvement, and alignment of clinical executive support to assist with oversight and implementation. A further verbal update will be provided at the next ARAC. 14 October 2025 **Recommendation two - Developing and embedding policies** A significant amount of training has commenced pertaining to discharge

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
						to culturally influence and develop professional understanding, accountability and ownership. Specifically, this training includes Discharge to Recover and Assess alongside Criteria Led Discharge. The SharePoint page now holds a toolkit specifically appropriate to hospital discharge. This includes an individual page holding a suite of information concerning discharge lounges plus detailed information to support clinically led discharges. Relevant documentation is accessible from this area and includes forms such as an SBAR transfer document that aims to facilitate and expedite the transfer in a safe and efficient manner. A WelshPAS transfer to discharge guide also simplifies the process for updating the patient location in a timely approach
AC(25)112	**24/06/2025**	**Contract Management (Advisory Report)**	To provide an update on progress to the next meeting	**HT**	~~**August**~~ **December 2025**	12 August 2025 **In Progress** Raised nationally, but not as yet discussed by the Directors of Finance peer group. A request has been submitted to include this on the workplan.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
						Suggest that this action is deferred for a response by December 2025, to allow a fuller response. (Update Due in December 2025)
AC(25)118	**24/06/2025**	**Audit Tracker**	To consider scheduling a discussion with the services of concern at a future meeting	**RE/JW**	~~**August**~~ **October 2025**	12 August 2025 This will be considered as part of the next Audit, inspection and regulatory Assurance Report, scheduled for the October 2025 meeting. 14 October **CLOSED**
AC(25)120	**24/06/2025**	**Final Accounts for 2024/25**	To share the Audit Wales accounts addendum report with Members when received	**HT**	~~**August**~~ **October 2025**	12 August 2025 **In Progress** Not yet received from Audit Wales. 14 October 2025 **Completed** Attached as appendix to Financial Assurance Report.
AC(25)131	**12/08/2025**	**Table of Actions**	**AC(25)103** – to copy to ARAC Members the update presented to PODCC on the operational structure	**AC**	**October 2025**	See, **AC(25)103**, above.
			AC(25)118 – to determine, when the Audit Tracker is next presented, whether Planned Care should attend a future meeting	**RE/JW**	**October 2025**	See **AC(25)118**, above.
			AC(25)120 – to issue the accounts addendum report	**HT**	**October 2025**	See **AC(25)120**, above.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
AC(25)144	**12/08/2025**	**Corporate Risk: Ophthalmology (Reasonable Assurance)**	For Executive Leads to determine the most appropriate forum for further discussion of fragilities in Ophthalmology	**AC/JW**	**October 2025**	The Corporate risk relating to Ophthalmology is discussed at the risk session which forms part of the Formal Executive team. From an Assurance perspective, this is through the Quality, Safety and Experience Committee.
AC(25)145	**12/08/2025**	**Sickness Management (Limited Assurance)**	To focus at a future meeting on the guidance and principles involved in determining sample size for internal audits	**JJ/SC**	**October 2025**	**Complete** Will be included as part of the progress report for October ARAC.
AC(25)150	**12/08/2025**	**Risk Assurance Report**	To flag to the Chief Operating Officer feedback around the 'Level 3 – No Assurance' in Planned and Specialist Care and a request for context and detail of planned mitigations	**CW**	**October 2025**	**Complete** Planned Care have significantly improved their compliance in respect of implementation of audits and inspection recommendations and are at 89% compliance (as at 31 August 2025) and therefore no longer meet Level 3 criteria for audits and inspections.
AC(25)152	**12/08/2025**	**Post Payment Verification (PPV) Annual Report**	To incorporate the following changes into future reports: • Change column title to 'Error Percentage' • Adopt the '3As' format • Include in year-end reports a trend analysis across the year and a comparison between years	**AL/ST**	**February 2026**	**Complete** The PPV team will review their reporting processes across Wales, with a view to incorporating changes into the next report, due February 2026.

2.3

09:35, 0 Mins

2.3 - Matters Arising not on Agenda

Rhodri Evans (Hywel Dda UHB - Independent Member)

For discussion

2.4

09:35, 15 Mins

2.4 - Escalation Status Update Report

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

For assurance

Attachments

2.4 Escalation Status Update ARAC October 2025.pdf

2.4 2025-08-18 - JP to PK - following escalation meeting 30 July 2025.pdf

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board
Canolfan Staff 1
Staff Base 1
ARAC Escalation De-escalation - Governance and Leadership Criteria – Evidence and Assessment (14th October 2025)

Overview of ARAC Criterion

- The purpose of this paper is to focus on the changes to Escalation Framework between March 24 and September 2025
- For assurance, all criterion aligned to ARAC remains on-track with no changes since the Committee last met in August 2025
- Therefore, this paper will focus on the escalation changes which naturally impact criteria 43

Criterion	Requirement	Current Status
Criteria 41	Revised standard operating processes in place following the organisational restructure assessed as effective by internal audit	**Assure** - Partially complete - Internal Audit review scheduled for Q3 2025/26 (due 31/12/2025)
Criteria 42	Effective oversight and scrutiny of current service provision consistently being provided by the Board and the appropriate Committee(s) as demonstrated by Committee and Board papers, including evidence of Board considering the Duty of Quality to inform their decision making	**Assure -** Fully complete (approved) - Duty of Quality now embedded in Board decision templates; Structured Assessment 2024 confirmed effective oversight
Criteria 43	Effective programme and performance management structure is in place, with effective Board oversight and a clear performance and delivery framework that drives improvement	**Advise** - Partially complete (overdue) - IPAR tracking 42 KPIs; Internal Audit Substantial Assurance (April 2025); Board Maturity Matrix rates "Delivery of Outcomes" at Level 2 only
Criteria 44	Board is sighted on key risks and areas of concern on a regular basis and is able to offer constructive scrutiny on performance and effective oversight and scrutiny	**Assure** - Fully complete (approved) - BAF and Corporate Risk Register received quarterly; Risk Appetite Statement refreshed January 2025; Board Maturity Matrix rates risk management at Level 4
Criteria 45	Clear governance and assurance systems in place with issues escalated appropriately through clear structures and processes	**Assure -** Partially complete (overdue) - Triple-A escalation model (Alert/Advise/Assure) implemented January 2025; ToRs refreshed; six-monthly review scheduled December 2025
Criteria 49	Self-assessment against the governance and leadership maturity matrix with evidence the agreed level	**Assure -** Partially complete (overdue) - Board self-assessment completed April 2025; externally benchmarked; endorsed by ARAC May 2025; Welsh Government content with processes
Criteria 51	The Board acts on, and addresses appropriately, concerns raised through NHS regulators such as HIW	**Advise** - Partially complete (overdue) - 17 HIW recommendations outstanding (down from 51 in Feb 2024); concerns remain regarding pace of closure on high-risk items; new WG criterion added July 2025 requiring robust escalation, tracking, closure and organisational learning. However, there is clear progress being made.

Introduction

Executive Summary for Committee

The escalation framework governing the health board has undergone substantive evolution across multiple documented versions between March 2024 and September 2025. Importantly, the health board achieved significant positive progress during this period - de-escalating from whole-organisation Level 4 in January 2024 to a varied position by September 2025, with planned care, cancer, and governance/leadership at Level 3, and CAMHS fully de-escalated to Level 1 (routine monitoring). This represents considerable organisational achievement and should be recognised as such.

However, the framework itself has evolved alongside these improvements. Criteria have been refined, baselines clarified, and new requirements introduced. Some changes represent increased specificity that strengthens auditability (such as explicit monthly case limits for Healthcare Acquired Infections rather than percentage reductions from varying baselines). Other changes represent additional expectations (such as the introduction of urgent and emergency care enabling metrics in September 2025). Some criteria moved in one direction and then adjusted back (Healthcare Acquired Infections percentage reductions were recalibrated between draft and final versions in spring 2025).

This raises governance considerations for ARAC about maintaining stable planning assumptions whilst expectations are refined. The committee oversees whether the Health Board maintains "effective programme and performance management structure in place (Criteria 43), with effective Board oversight and a clear performance and delivery framework that drives improvement." The health board has achieved Substantial Assurance from Internal Audit on its performance management arrangements, and the Integrated Performance Assurance Report now tracks forty-two key performance indicators with twenty-eight benchmarked nationally. However, when the external framework against which performance is measured is amended; this raises governance considerations for ARAC about maintaining stable planning assumptions and aligning evidence accordingly to any refinement.

Documentary Evidence: The Framework Versions Reconciled

The papers provided to the committee, cross-referenced with the formal ARAC paper timeline, contain these versions:

Escalation Framework - March 2024 - Initial targeted intervention document setting out the whole-organisation Level 4 escalation, with broad domain expectations and initial de-escalation criteria. For example, urgent and emergency care baselines were set from October to December 2023 data, and planned care targets included a requirement that eighty percent of open pathways should be waiting less than fifty-two weeks.

Escalation Framework - Draft (4 March 2025) - Following successful de-escalation of planned care, CAMHS, and governance/leadership from Level 4 to Level 3, this draft proposed revised de-escalation thresholds. Healthcare Acquired Infections were specified as requiring C. diff forty percent reduction, Staph aureus twenty-five percent reduction, and E. coli twenty percent reduction from an agreed baseline (the baseline date was not yet specified in this draft). Fragile services included a requirement that sixty-eight percent of R1 ophthalmology pathways should be within or no longer than twenty-five percent of their target date, maintained for three months.

Escalation Framework – Revised (following health board comments) - This version responded to health board feedback on the March draft. Healthcare Acquired Infections thresholds were reset to twenty-five percent for C. diff (reduced from the draft's forty percent), thirty-three percent for Staph aureus (increased from the draft's twenty-five percent), and twenty-five percent for E. coli (increased from the draft's twenty percent). Critically, this version introduced explicit baseline dating - Quarter 3 of 2023/24 - and translated percentage reductions into monthly case maxima. For example, C. diff was specified as reducing from an average of eight cases in Q3 2023/24 to no more than six cases per month. The R1 ophthalmology target was adjusted from 68% back to 65% (in line with the original 2024 framework).

Escalation Framework - Final (30 June 2025) -The health board formally agreed this version. The document control table records that amendments were made, including governance de-escalation criteria updated on 12th June 2025. This represents the stable (final) framework following the March 2025 de-escalation decisions.

Documentary Evidence: The Framework Versions Reconciled

Escalation Framework - July 2025 - Following further assessment, cancer moved from Level 4 to Level 3, and CAMHS moved from Level 3 to Level 1 (routine monitoring - a recorded change in status). The framework now specified that Level 4 escalation remained for finance, strategy and planning, urgent and emergency care, Healthcare Acquired Infections, and fragile services. Level 3 applied to planned care, cancer, and governance/leadership. This version added several new requirements. Urgent and emergency care gained a requirement to "deliver the UEC enabling actions in the 2025-28 planning guidance" - a programme delivery expectation that was not present in earlier versions. The governance of the escalation process was refined, specifying that quarterly escalation meetings would continue but May and November meetings would be aligned with Joint Executive Team meetings. Cancer, now at Level 3, had its de-escalation threshold increased from sixty percent (the Level 4 standard) to a minimum of sixty-three percent sustained for three months to reflect the new level 3 status.

Escalation Framework - September 2025 - This version introduced significant process and metric additions whilst escalation levels remained unchanged. A new de-escalation section described two approaches to de-escalation. The first approach maintained the previous model where Welsh Government coordinates monitoring and review, with de-escalation occurring when sufficient improvement is demonstrated (even if all criteria are not yet met, provided there is a credible plan to maintain improvements). The second approach introduced an automatic trigger mechanism for domains with quantifiable outcomes and targets. When an NHS organisation meets de-escalation criteria for a specific domain and sustains that performance for the agreed period, de-escalation to the next level would be automatically triggered outside the normal quarterly escalation cycle, confirmed in writing. This represented a material change in process that creates opportunity for faster de-escalation if sustained performance can be demonstrated. Urgent and emergency care gained two entirely new enabling metrics: a requirement for sustained monthly reductions of at least five percent in the number of people admitted as emergencies who remain in hospital over twenty-one days since admission (baselined to November 2023), and sustained monthly reductions of at least five percent in pathways of care with assessment issues (also baselined to November 2023). Both metrics require three consecutive months of five percent monthly reduction before they enable de-escalation consideration.

The organisational change from NHS Wales Executive to NHS Wales Performance & Intervention (NHS P&I) as the named intervention body directing support occurred during this period, altering the formal engagement routes and evidence submission formats.

Finance Expectations Evolution: Material Changes by Framework Version

March 2024 Framework (Original Level 4)

Context - Whole organisation escalated to Level 4 in January 2024.

Key Finance De-escalation Criteria:

1. Demonstrate robust financial governance and control environment
2. Substantial progress delivering the targeted intervention action plan
3. Annual plan demonstrating substantial financial improvement trajectory to deliver as a minimum the target control total (TCT)

Implications for Assurance - The health board needed to show it could meet the annually-set financial target (Target Control Total) that Welsh Government assigned. Focus was on annual delivery.

March 2025 Framework (Following partial de-escalation)

Context - Health board de-escalated to Level 3 for planned care, CAMHS, and governance/leadership in March 2025. Finance remained at Level 4.

Material Change:

- No substantive change to finance de-escalation criteria at this point
- Finance expectations remained focused on "target control total" delivery

Implications for Assurance - Despite other areas improving, finance expectations stayed the same, reinforcing that the fundamental financial challenges persisted and the TCT remained the key focus for the Health Board.

Finance Expectations Evolution: Material Changes by Framework Version

July 2025 Framework (Following cancer de-escalation)

Context - Cancer moved from Level 4 to Level 3; CAMHS de-escalated to Level 1.

Material Finance Changes:

1. Baseline Reference Point Changed

- Before - "deliver as a minimum the target control total“
- After: "deliver as a minimum the 2024/25 outturn position set for the health board"

Why this matters – Changes the planning reference point to the 2024/25 outturn (minimum) and introduces a three-year trajectory to in-year balance.

2. Trajectory Timeframe Extended

- Before "significant progress towards delivery of the target control total“
- After: "significant progress towards in-year financial balance over the next three years"

Why this matters - Sets a three-year strategic horizon whilst maintaining expectation of continuous improvement.

Finance Expectations Evolution: Material Changes by Framework Version

3. De-escalation Criterion 3 Reformed

- Before: "Annual plan developed with board approval demonstrating a substantial financial improvement trajectory to deliver as a minimum the target control total.“
- After: "Demonstrate a substantial financial improvement trajectory to deliver as a minimum the outturn position of 2024/25, and three-year trajectory to in-year financial balance."

Why this matters:

- WG believe the TCT would represent a backward step from 2024/25 financial performance (the floor)
- Credible plan showing path to balance over three years (the destination)
- Annual plan is anchored to the target control total

4. Terminology Alignment

- Before: "targeted intervention action plan“
- After: "level 4 action plan“
- **Why this matters**: Minor but aligns with framework language consistently.

Finance Expectations Evolution: Material Changes by Framework Version

September 2025 Framework (Current)

- **Context:** No further de-escalations. Finance remains Level 4.

Refinements (minimal changes from July):

- July wording: "outturn position of 2024/25, and three-year trajectory“
- September wording: "outturn position of 2024/25 and progress towards three-year trajectory"

Why this matters: wording clarified to "progress towards" the three-year trajectory rather than implying the full trajectory must be in place immediately. However, the fundamental expectation remains unchanged: demonstrate continuous improvement from the 2024/25 baseline toward in-year balance within three years.

Urgent and Emergency Care

Urgent and emergency care demonstrates how requirements can accumulate through successive framework versions, with each addition representing legitimate policy development but cumulatively increasing the evidence burden for de-escalation.

Escalation Framework - March 2024 set out four core de-escalation criteria:

- Continuous reduction of ambulance handovers over one hour of at least eleven percent in three consecutive months, maintained for three months (baseline: October-December 2023)
- Continuous improvement towards no more than seven percent of patients waiting over twelve hours at each site and across the health board
- Median time from arrival at emergency department to assessment by clinical decision maker should not exceed sixty minutes
- Continuous reduction in delayed pathways of care of five percent for three consecutive months and then maintained (baseline: October-December 2023)

These four criteria established the performance expectations against which urgent and emergency care would be assessed for de-escalation readiness.

Escalation Framework - July 2025

Added a fifth requirement: "Delivery of the UEC enabling actions in the 2025-28 planning guidance." This represented a shift from pure performance metrics to include programme delivery expectations. The organisation must now demonstrate not only that waiting times, handovers, and flow are improving, but also that it is implementing the specific pathway redesigns, workforce models, and system changes prescribed by the enabling actions set out under the 25-28 planning guidance. This broadens the evidence base required for de-escalation beyond quantitative thresholds into qualitative programme implementation.

Urgent and Emergency Care

Escalation Framework - September 2025 introduced a sixth and seventh requirement through a new section titled "The enabling metrics for de-escalation are:" followed by two additional criteria:

- "A three-month continuous reduction of at least five percent in each month (from the November 2023 baseline) in the number of people admitted as an emergency who remain in hospital over twenty-one days since admission.“
- "A three-month continuous reduction of at least five percent in each month in pathways of care assessments issues (from the November 2023 baseline)."

The committee should understand what "continuous reduction of at least five percent in each month" means mathematically. If November 2023 had 100 staying over twenty-one days, the first month requires achieving 95 (a five percent reduction from one hundred). The second month requires five percent reduction from 95, reaching 90/91 patients. The third month requires five percent reduction from that figure circa 85/86 patients. Over three months, this compounds to approximately a fourteen to fifteen percent total reduction from the November 2023 baseline.

The consequence for urgent and emergency care is that the organisation now has seven distinct requirements (four original performance criteria, one programme delivery criterion, and two enabling metrics) that must all be achieved before de-escalation can be considered. Each addition individually represents a reasonable expectation. Cumulatively, they require the Health Board to demonstrate improvement across performance, programme delivery, and system partnership dimensions simultaneously, with sustained delivery over three-month windows and specific monthly reduction trajectories.

Why Fixed Reference Points Matter for Escalation

Why Fixed Reference Points Matter for Planning

Annual planning requires stable reference points against which to make resource allocation decisions. When the Board approves the annual plan each March, it commits finite transformation resource, approves specific savings schemes, and sets executive objectives based on defined escalation criteria. Whilst, planning will always be iterative and continuous, a level of continuity around the assumptions and the measures of success remain consistent throughout. This in turn, allows the Health Board to design work, allocate resources, and track progress against known targets.

This is not about rigidity but about the practical realities of delivery. Research undertaken by the Health Foundation suggested health organisations needed around 17 months minimum to embed measurable improvements. This is further reinforced by where the research found that "having too many targets can lead to 'priority thickets', where the number of competing priorities causes confusion about what really matters" Savings schemes require time to implement and deliver benefits. Performance improvement needs sustained focus and resource commitment. When the criteria against which success is measured change midway through the delivery cycle, it creates genuine questions about whether the original resource allocation, programme design, and trajectories remain fit for purpose.

How Criteria Changes Create Governance Challenges

Two domains remained at Level 4 throughout 2024/25 but experienced material changes to their de-escalation criteria, illustrating the governance challenges that arise when planning reference points shift.

Finance provides the clearest example of how in-year target changes affect planning assumptions. The Health Board planned to deliver a deficit of £31.5m (the target control total). Through the year, this target was revised, with the Health Board ultimately delivering an outturn position of £24.1m. This represents a material movement to the annual plan, which sought to address and manage resources across all aspects of the escalation framework, ministerial priorities and the planning and performance frameworks.

Why Fixed Reference Points Matter for Escalation

Governance consideration - Where national expectations are refined during the year, ARAC oversees a formal criteria change control: we record the old and new wording with dates, confirm baselines, re-base trajectories and risks, re-sequence resources, and reset the evidence requirements (including any enabling actions/metrics and automatic de-escalation triggers). The Committee then applies two tests: (1) no material deterioration against the previously agreed measure; and (2) credible, sustained progress against the revised requirement. This preserves transparency for the public record, ensures fair comparison across periods, and keeps the Board aligned to the evolving framework, consistent with Criterion 43 on effective programme and performance management

Recommendations

ARAC - Recommendations (Escalation Framework)

- **NOTE** the documented movements to the Escalation Framework (clarified baselines, enabling actions/metrics, automatic de-escalation route) and their assurance consequences.
- **ACKNOWLEDGE** (Criterion 43) that where measures change in-year, progress will be judged on two tests: (i) no deterioration against the previous measure; (ii) sustained progress against the revised requirement within existing resources.
- **RECEIVE** future Escalation Framework returns with a simple Change Note (old→new wording, date, baseline) and a compact Change Log, plus sustained-delivery flags where additional resources are going to be required or there is a material deviation to the annual plan

Cyfarwyddwr Cyffredinol Grŵp Iechyd, Gofal Cymdeithasol a'r Blynyddoedd Cynnar / Prif Weithredwr GIG Cymru

Director General Health, Social Care & Early Years Group / NHS Wales Chief Executive

Dr Philip Kloer
Chief Executive
Hywel Dda University Health Board

philip.kloer@wales.nhs.uk

Our Ref: JP/MR/HP

18 August 2025

Dear Phil

Quarterly escalation meeting

Thank you for attending the quarterly escalation meeting on the 29 July 2025, along with members of your Executive team, and for providing the slides which provided a helpful overview ahead of the meeting. These slides form an important part of the meeting record.

This was our first escalation meeting since the recent de-escalation announcements when we confirmed the following escalation status:

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

The changes in the escalation status are in line with our improving confidence in the organisation and that the Board is able to implement the required changes. It is essential that this improvement journey continues. A refreshed escalation framework has been shared with you for comment.

Apologies were noted from Huw Thomas, Sharon Daniel, Ardiana Gjini, Mark Henwood and James Severs from the health board and Sue Tranka, Helen Arthur, Samia Edmonds and Olivia Shorrocks from Welsh Government.

All actions from the previous meeting had been completed or would be picked up in this discussion

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Finance and planning

Your initial plan aimed to deliver the control total of £31.5m, which included £44m of savings. You have been able to de-risk some elements during quarter 1 and are taking a paper to your July Board advising of a revised end of year position of £30m deficit. Whilst this is positive progress, it does remain above the expectation of delivery of the 2024/25 outturn of a £24m deficit as a minimum. You continue to drive savings, including reduction in agency spend, and your green savings plan was at £22m in month 3. You recognise there is a continued reliance on non-recurrent savings. You are working with colleagues in NHS P&I to develop a plan that delivers balance in three years.

Our assessment is that the £24m deficit position is deliverable and expect confirmation on how you will deliver that by 31 July. You highlighted there were a few schemes in place, but a full impact assessment was required before confirmation could be provided and you were trying to strike the right balance between finance, performance, quality and workforce. It is important that you set out the steps you are taking to confirm the outturn as soon as possible. We require clarity on your outturn for this year by 11 September.

You confirmed the reassessment against the planning maturity matrix had been completed and will be presented to the July Board meeting. Since the last review, the score for strategy development had reduced, noting there was still no long-term plan for health services across west Wales. There had been a good discussion at the planning committee and the maturity matrix will be used to support Board seminars.

You have started the 2026/27 planning process with the intention of agreeing a three-year IMTP.

Your assessment against the enabling actions, is that the majority have been assessed as either green or amber, with two red related to theatres and ambulance handover. On theatres, there are workforce issues in Glangwili, as well as sickness and this is an area you are focussing on. On ambulance handover, you recognise there is further work to do around streaming and redirection of patients. Plans have been developed, and you are expecting both areas to move to amber and green in due course.

The Clinical Services Plan (CSP) consultation has reached the mid-point review with over 1,600 responses, with a similar number attending health board events. There have been over 600 staff attending engagement sessions. The outcomes at present include some alternative options coming through, which will be tested once the consultation period closes. The main areas of concern relate to how far patients will have to travel and timeliness of access to services.

As part of the CSP, you have been in close contact with Swansea Bay UHB regarding the development of regional services with the next joint Committee scheduled for the middle of August. You also have input from the Mid Wales Committee, and you have recently taken the CEO lead for the Mid Wales Executive.

The Prince Philip MIU consultation has now closed, with over 700 responses received. Both Llais and the local action group SOSPAN have been involved from the start. You will be taking proposals to the September Board meeting.

Urgent and Emergency Care (UEC)

UEC is the most challenged performance area and is a significant area of focus for the health board for both performance and quality and patient experience. There are a number

of actions in place to improve ambulance handover, and there has been some improvement seen in Bronglais, but challenges are considerable in Withybush and Glangwili. Handover performance in Glangwili is one of the worst in Wales. This is an area you are looking to learn from others on and have been in contact with colleagues from Swansea Bay and Cwm Taf Morgannwg University Health Boards.

The length of time patients spend in the emergency department is also of concern. There is good clinical leadership, and you recognise there are a number of patients that could be managed differently. A paper went to the July Board on UEC transformation, including extending the SDEC model to 12 hours a day, 365 days a year and to develop a seven-day streaming model. There has been progress on workforce stabilisation, though not in delayed pathways of care. You confirmed a round table discussion with local authority partners was scheduled for the start of September to discuss winter and agree a memorandum of understanding.

Fragile Services

Stroke is part of the CSP discussion, and you are having discussions with Powys teaching Health Board, Swansea Bay University Health Board and Betsi Cadwaladr University Health Board about the appropriate patient flows, pathways and the comprehensive stroke unit for the region.

The aim is to deliver high quality services and the CSP had prompted a lot of debate, with the public recognising that having four units does not provide the right care. There has been a geographical divide on the responses received at present, with different views being offered. You recognise the current provision is not ideal and there is further work to do.

Quality and Safety

The health board continues to report an improved position for HCAIs, but above the de-escalation criteria. There are detailed plans in place and an intensive focus on IPC. It was noted there is a seasonality issue with c-difficile and a time lag in relation to when antibiotics were used and the impact of c-difficile. There has been an issue with accessing FMT over the last couple of months and you are in discussions around setting up a FMT manufacturing plant in Wales. You are exploring the opportunity of using technical hygienists, particularly in the ED and Welsh Government colleagues are interested to discuss this further. You expected to see improvements in HCAIs from September.

You continue to work collaboratively with Swansea Bay on hand hygiene and have changed the disinfectant being used across the health board. You reported there are two areas of work on-going, one with Dr Mike Simmons around the introduction of probiotic cleaners and with Tri Tech and University of Dundee around the introduction of UV222. We will be interested to hear the progress of this work.

Performance and outcomes

It was disappointing to see there were 104-week breaches at the end of June. There are pressures in orthopaedics and recovery plans are in place and you expect to achieve zero breaches at the end of quarter 2, although there are challenges in a couple of specialities. There has been progress in radiology, though there are still nearly 3,500 open pathways over eight weeks. There has also been an improvement in reporting times. There is a challenge in flexi-cystoscopy from urgent cancer referrals, but all other endoscopy was at eight weeks.

Cancer performance is being maintained over 60%. The backlog reduction has not had as much impact as I would like to see and there must be a focus in this area.

Governance and Leadership

There is now a full Executive team in place following the appointment of the Medical Director. The operational structure is now in place, with the senior posts in place with the exception of the Associate Medical Directors, which are to be advertised shortly. You are now moving on to phase 2 and to the filling of the roles below. The Clinical Care Groups are at an early stage of development. The early observations are this structure has been welcomed by staff, though there had been some reservation, and the new structure is supported by an OD programme of work. You highlighted you are open to receiving and listening to feedback from staff.

Summary

There has been progress seen in some areas that resulted in the recent de-escalation. The main areas of concern and challenge remain around finance and UEC. It is important on the finance side that you deliver the Cabinet Secretary's ask and the presentation of your savings as per Hywel's request. On UEC, you recognise the challenge over the coming 60 days in preparation for 45-minute handover from October and in improving the flow in the EDs and preparing the staff. I will be keen to see an improving position for HCAIs in the coming months.

We agreed the following actions:

- Clarity on 2025/26 outturn by 11 September 2025.
- Robust plans for delivering the 45 minute handover from October.
- Focus on reducing the backlog of patients waiting over 62 days for the cancer treatment to commence.
- An update on the plans to reduce delayed pathways of care and winter preparations following the round table discussion with local authority partners.

I look forward to seeing further progress at the next meeting.

Yours sincerely

Judith Paget

Judith Paget CBE

Attendance

List of attendees and noted apologies	
Health Board	**Welsh Government**
Dr Philip Kloer	Judith Paget - Chair
Andrew Carruthers	Nick Wood
Helen Mitchell	Jeremy Griffith
Shaun Ayres	Hywel Jones
Andrew Spratt	Jamie Kaijaks
Lee Davies	Gillian Knight
Lisa Gostling	Martyn Rees
Joanne Wilson	Gaynor Evans
Tracey Gauci	
Bethan Lewis	
Apologies	
Mark Henwood	Helen Arthur
Sharon Daniel	Samia Edmonds
James Severs	Olivia Shorrocks
Huw Thomas	Sue Tranka
Ardiana Gjini	

2.5

09:50, 5 Mins

2.5 - All Wales NHS Audit Committee Chairs' Meeting Update

Rhodri Evans (Hywel Dda UHB - Independent Member)

For information

Attachments

2.5 2025-06-30 AWACC Minutes unconfirmed.pdf

2.5 Annual Report AWACC 2024-2025.pdf

ALL WALES GROUP REPORT

ALL WALES AUDIT COMMITTEE CHAIRS (AWACC) MEETING HIGHLIGHT REPORT

Date of Meeting	**30 June 2025**
Chair Name ***Chair Organisation***	Nuria Zolle Independent Member, Chair Swansea Bay University Health Board
Secretariat ***Secretariat Organisation***	Amelia Cole Swansea Bay University Health Board

In Attendance:	
Peter Curran (PC)	Welsh Ambulance Service NHS Trust
Chris Darling (CD)	Digital Health Care Wales
Graham Dainty (GD)	NWSSP – NHSCFS Wales
Andrew Doughton (AD)	Audit Wales
Matthew Evans (ME)	Swansea Bay University Health Board
Urtha Felda (UF)	ARAC – Vice Chair
Stephen Elliot (SE)	PTHB – Independent Member
Rhodri Evans (RE)	Hywel Dda UHB – Independent Member
Simon Cookson (SC)	Audit Wales
Rhian Thomas (RT)	Cardiff and Vale University Health Board
Sara Utley (SU)	Audit Wales
Anthony Veale (AV)	Audit Wales
Jayne Sadgrove (JS)	HEIW – Independent Member
Apologies:	
Karen Balmer (KB)	BCUHB – Independent Member
Anne Beegan (AB)	Audit Wales
Gareth Jones (GJ)	Velindre – Independent Member
Patsy Roseblade (PR)	Cwm Taf Morgannwg – Corporate Services

The following is a summary of the main issues discussed at the meeting
1. Welcome and apologies The chair opened the meeting and welcomed all. The Committee noted apologies above.

The following is a summary of the main issues discussed at the meeting

2. **Minutes from the 10/12/2024**

   The minutes were **received** and **confirmed** as a true and accurate record.

3. **Highlight report including action log**

The action log was **received** and **noted.**

NZ mentioned that an Annual update of the Group's activities throughout the year had been prepared. This update would be distributed to all members by the end of the week, allowing everyone to review and provide comments. The second outstanding item was the discussion regarding the Chair of the Group. This topic was scheduled to be addressed under Any Other Business at the end of the session.

4. **Matters arising not otherwise on the agenda**

   The were no other matters arising.

5. **Board Assurance Framework**

CD updated on the Peer Group discussions from 6 June and outlined the agenda for 4 July. The June meeting featured an informative presentation from NHS Wales Shared Services Partnership (NWSSP) Legal and Risk Services. CD explained the Peer Group requested refreshed training materials for new Board members and agreed to quarterly horizon scanning sessions with NWSSP. Discussions included shadowing opportunities for Board Secretaries, updates on NWSSP governance and accountability review, and the development of a governance community of practice. The meeting also covered the pre-election period and partnership governance, with insights from the NHS Wales Confederation and the Southeast Joint Committee. CD informed the Group for the 4 July meeting, a colleague from Scotland would discuss public accountability forums, and there would be a session on Risk Management and Risk Dashboards.

CD emphasised the importance of a common understanding of strategic objectives, risk appetite, principal risks, controls, and assurances. The Board Assurance Framework (BAF) was designed to clarify strategic objectives, identify principal risks, and establish controls and assurances. CD differentiated between the BAF and the Corporate Risk Register. The BAF was a top-down approach focusing on strategic, organisational-wide

The following is a summary of the main issues discussed at the meeting
risks, while the Corporate Risk Register was a bottom-up approach that includes both strategic and operational risks. CD explained that the BAF dashboard included several key components: a Risk Appetite Statement, a Principal Risks Heat map, a Risk Assurance summary, and detailed slides for each strategic objective. CD explained that each strategic objective had an assigned Risk Appetite. CD explained that the Board conducted an Annual Review of the Risk Appetite. The BAF dashboard was presented biannually to the Board, and it informed Committee agenda setting, including deep dives into specific areas of the BAF. CD informed the group that the BAF was instrumental in achieving strategic objectives by effectively managing risks. It was crucial to link Risk Appetite to tangible actions and controls to ensure that the organisation can take calculated risks while maintaining control. Continuous improvement and refinement of the BAF process were essential to adapt to changing circumstances and enhance its effectiveness. NZ invited questions: PC raised several questions regarding the BAF, firstly if the organisation was still on a journey in terms of developing their BAF, highlighting that their own process was expected to take about two years. PC highlighted the challenge of separating factors within their control from those outside their control, particularly concerning their highest risks related to patient harm and fatality. PC emphasised the importance of delineating these factors for better mitigation and assurance. Additionally, PC questioned the Committee structure and the role of the Audit Committee in checking and challenging the development of the BAF. CD responded to PC's questions by acknowledging that developing the BAF had indeed been a journey, involving significant Audit Committee and Board development time over the years. CD mentioned that the BAF had matured and been refined over time, with the Board recognising the importance of understanding the Risk Appetites of their partners, as their own risk appetite alone was not sufficient. CD emphasised the need to consider what was within their control and what was within their sphere of influence. CD also highlighted the challenge of balancing Committee structures to reflect the preferences of Independent and Executive members, and the difficulty of removing Committees once they were established. CD confirmed that the Audit Committee acted as a guardian for the BAF process, with the Board focusing more on the BAF dashboard. SE explained that in March Powys Teaching Health Board approved the new Risk Management Framework and were in the process of splitting their old corporate Risk Register into a Strategic Risk Register, which

The following is a summary of the main issues discussed at the meeting
would be focused on at the Board level, and an Operational Risk Register, which would be managed by the Executive Committee. SE highlighted that they had also reviewed their Risk Appetite, particularly around Financial Risk, and had split finance into three sub-risks. SE expressed interest in whether similar issues had arisen in Digital Health Care Wales (DHCW), particularly regarding the identification of Strategic Risks that may not have received much attention at the board level. SE also enquired about how DHCW links Risk Appetite to controls, as this was an area they have not fully addressed yet. CD responded to SE by emphasising that the BAF was as much about strategic objectives as it was about risks. CD mentioned that the BAF forced the Board to focus on areas that are often neglected, ensuring that they revisit their long-term strategy and assess progress towards their strategic objectives. CD highlighted that the BAF helped the Board understand what might prevent them from achieving their objectives and whether their Risk Appetite was appropriate. CD confirmed that the BAF had led to more focused discussions at the Board level, particularly on strategic objectives that may not have received much attention previously. Regarding linking risk appetite to controls, CD explained that they had defined what Risk Appetite meant for them and linked it back to controls. For example, if they were open in a particular area, they would take more risks and have fewer controls in place, empowering staff to make decisions. Conversely, if they were cautious, there would be more controls, such as policies and procedures, in place. CD offered to share information on how they had linked controls to Risk Appetite. AD shared his reflections based on years of undertaking governance reviews. AD emphasised the importance of the quality of the wording of corporate objectives, highlighting that high-level objectives can make it difficult to hook assurances to them. AD mentioned that specific objectives related to Planned Care or Unscheduled Care activities were easier to manage, while broader objectives like improving healthy life expectancy were more challenging. AD highlighted that BAFs could become complex quickly, so it was essential to keep them proportionate and fit for purpose. AD stressed the importance of BAFs being live documents that inform agenda setting for the Board and Committees, ensuring coverage of the most important organisational objectives. Finally, AD highlighted that achieving a perfect BAF was unlikely, the focus would be on the journey of improving and strengthening arrangements. Nuria Zolle suggested having a conversation with CD to share the presentation and explore whether the dashboard and the thinking behind

The following is a summary of the main issues discussed at the meeting

it could be shared with colleagues in different Health Boards and Trusts. NZ emphasised the importance of exploring the Risk Appetite further, as it had been a topic of discussion in the past. NZ proposed considering this in another Group meeting, where they could discuss it in a more interactive way. NZ highlighted the need to dig deep into partnerships and their Risk Appetite, as well as the rest of the NHS, since they were part of a system.

6. Update from Audit Wales

AV provided an update on the submission of audited accounts. AV mentioned that 11 out of the 12 NHS bodies had their accounts submitted to Welsh Government and signed by the deadline. The exception was Powys Health Board, which faced some issues that needed to be resolved, AV expressed hope that these would be resolved soon. AV highlighted that the 11 NHS accounts were submitted on the 27 June.

AV highlighted the outcomes and challenges related to the audit process for the NHS bodies:

- All 12 Health Bodies received a clean, true, and fair opinion on their financial statements;
- The seven Health Boards failed their first financial duty to break even over a three-year period;
- Six of the Health Boards failed the second duty to get an approved Integrated Medium-Term Plan (IMTP) in place for the financial year, with Cwm Taf Morgannwg being the exception;
- The two strategic Health Authorities and the three NHS trusts received a clean bill of health from both a true and fair opinion and a regularity opinion;
- Qualified regularity opinions were placed on the accounts of the seven Health Boards due to financial pressures and their inability to break even over the three-year period. A substantive report was issued to explain this position;
- The Senior officer remuneration continues to be a recurring issue, particularly around the nuances of senior pay, which causes problems year after year;
- This year, the issues were more related to interim appointments rather than senior officers in substantive, permanent roles.

AV highlighted several issues and recommendations related to interim appointments and senior remuneration:

- Interim appointments that extend beyond their initial period required Welsh Government approval. In some cases, this approval

The following is a summary of the main issues discussed at the meeting

was not in place, leading to issues reported in the accounts and audit reports;
- A checklist was issued to Health Boards in March to provide guidance on senior remuneration, as the guidance is complex and comes from multiple sources, including the manual for accounts, standanding orders, and Welsh health circulars;
- A recommendation would be made to Welsh Government to consolidate this guidance to make it easier to follow;
- Health Bodies were advised to be careful with senior pay, ensuring proper due process and obtaining necessary approvals, especially for payments that could be considered novel and contentious;
- Some audits were running close to the deadline, prompting a review of the audit process. There is a consideration to conduct more audit work at the interim stage (January to March) and to avoid leaving complicated areas of the audit until the last minute;

AV discussed several points related to future improvements and upcoming initiatives:
- Once the Powys accounts were finalised, the NHS data tool would be issued, typically through a press release. This tool was valuable for Health Boards and Committees to compare and contrast major expenditure and income across health boards and trusts;
- There would be a review of the governance arrangements for hosted services in Velindre, with potential learnings for other Health Boards with hosted services;
- The 30 June deadline for accounts felt appropriate, providing adequate preparation time for NHS bodies and a 5-week period for the audit process. This would be subject to future debate, but it seemed to work well based on feedback from heads of finance and chief accountants;
- The group would continue to liaise with the NHS Directory of Service (DOs) Group and Welsh Government throughout the year. Feedback and ideas to improve and make the accounts process more efficient were welcomed.

NZ invited questions:

PC asked about the ongoing journey of developing the BAF, emphasising the importance of taking time to evolve the framework; the challenge of separating factors within their control from those outside their control, particularly for high risks like patient harm and fatality, and how to delineate these factors clearly in the Risk Register; the appropriate number of Committees, potential duplication, and the Terms of Reference for Committees, particularly regarding where Risk reports and Internal

The following is a summary of the main issues discussed at the meeting
Audit reports should go; and whether the Audit Committee acts as the guardian for checking and challenging the development of the BAF, as it does for the Welsh Ambulance Service. NZ acknowledged PC's point about the challenges related to time frames and the finance team being overworked, especially when working on both the end-of-year and next year's accounts simultaneously. NZ welcomed discussions with the Directors of Finance (DoFs) to find improvements in this area and emphasised the importance of consolidating guidance related to workforce and what goes to the Board and Remuneration and Terms of Service Committee (RATs). NZ highlighted that this topic has been discussed multiple times in the forum and that clarity on this matter is highly appreciated. SE noted, like PC, concerns about late account submissions after one organisation missed the deadline. SE questioned whether earlier detection of balance errors could have prevented delays, especially with this year's deadline moved up by several weeks. SE stressed the importance of timely submissions and hoped future deadlines would be met. NZ asked AV about the use of AI in Audit, specifically in relation to finances. NZ enquired whether Audit Wales was currently using AI, their position on it, and if they were working on incorporating AI into their processes. AV explained that Audit Wales was developing a new strategy that included the use of data analytics and artificial intelligence (AI) to make audit work more efficient. They were already using AI to some extent, such as summarising papers. Although they had taken a cautious approach so far, they planned to expand their use of AI significantly over the next three to four years. This expansion could range from simple tasks like reviewing accounts to more complex applications. NZ suggested adding the topic of AI and the data analytics tool to a future meeting agenda. NZ expressed interest in exploring the tool and its potential insights for their work. NZ also proposed inviting Independent Members (IM's) from the Performance and Finance Committees to join the discussion, as their input could be valuable in understanding and comparing the analytics. NZ acknowledged that this approach might not apply to all Committees but could be beneficial for some. AD provided an update on the ongoing and upcoming work of Audit Wales. Following the cost savings reviews conducted over the past 12 months, a

The following is a summary of the main issues discussed at the meeting

short weblog and a Board member checklist were published in early June to help Board members understand and implement cost-saving measures. Audit Wales was at the beginning stages of work around Board member walkarounds, addressing the variability in their implementation to standardise and improve their effectiveness. There was also an ongoing effort to enhance the quality of reporting and report writing for Boards and Committees, which was still in the planning stages. The reviews on Planned and Unscheduled Care were nearing completion, with draft reports issued or about to be issued, and the intention was to produce an output that consolidates key themes and messages at a national level based on the findings. Additionally, a report on the well-being of future generations was issued in May, fulfilling a duty to report every five years. Following this, a good practice event was scheduled for July, with sessions in South Wales on the 15 July and North Wales on the 17 July. Cost Savings Blog and Checklist Good Practice Event.

7. Internal Audit

SC from NWSSP Internal Audit discussed several key points during the meeting. SC highlighted the use of AI tools like Copilot to enhance the efficiency of Internal Audit processes, including scoping work, testing, and report writing. SC mentioned the introduction of new Global Internal Audit standards that replaced the UK public sector Internal Audit standards, emphasising the increased prescriptiveness and the need for Internal Audit to demonstrate compliance with these standards. SC also discussed changes in their approach to follow-up work, focusing more on action plans for high-priority findings and assessing the impact of revised implementation dates on risk. SC highlighted that around 15% of recommendations miss their original deadlines, with a higher incidence in Health Boards compared to trusts. Additionally, SC mentioned their efforts to provide updates to the Welsh Government's Executive Team, focusing on key themes rather than performance comparisons, and highlighted the importance of consultant job planning reviews.

8. Counter Fraud Update

ME provided an update on the current state of Counter Fraud efforts within NHS Wales. ME emphasised that the Counter Fraud community was in a strong position, with strategic direction from the steering group and support from the All Wales Directors of Finance (AWDof) group. ME highlighted the importance of Fraud Risk Management, highlighting that

The following is a summary of the main issues discussed at the meeting
all Counter Fraud work was now based on this approach. ME expressed concerns about the NHS Counter Fraud Authority's push for preventative figures, which involve extrapolating identified fraud over a 12-month period. ME argued that this method lacked substance and may not effectively contribute to fraud prevention. Instead, ME advocated for focusing on tangible successes in reducing Fraud Risk. ME also mentioned the rise in cases involving AI in job applications and dual working since COVID-19, stressing the need to stay ahead of criminals using advanced technologies. ME concluded by highlighting the positive impact of the newly established Liaison Group for intelligence sharing among Counter Fraud specialists in Wales. NZ invited questions: RE enquired about common themes in Counter Fraud activities across different Health Boards and the evolving tactics used by individuals to circumvent controls. ME responded by noting that while there are no specific common themes to highlight at this stage, the newly established Liaison Group was actively working on intelligence sharing to identify and address emerging trends. ME mentioned that the use of AI in job applications and dual working has been on the rise since COVID-19, presenting new challenges for Counter Fraud efforts. ME emphasised the importance of staying ahead of criminals who are increasingly using advanced technologies and highlighted the ongoing efforts to monitor and address these Risks through the Liaison Group. GD mentioned that the NHS Counter Fraud Authority (CFA) had secured an investment of £12m from central government for Project Athena. This project focuses on data analytics to enhance Counter Fraud efforts. The investment aims to achieve a fivefold return in savings, highlighting the importance of data analytics in identifying and preventing fraud. GD emphasised the need for investment in data analytics within NHS Wales, either by adopting services from the NHS CFA or establishing a dedicated Data Analytics Unit within NWSSP or another entity in Wales. NZ emphasised the importance of adopting a risk-based approach to the Counter Fraud agenda at SBUHB. This approach helped to identify and address issues related to internal controls and determine who need to be involved in the work. It also highlighted what was outside the organisation's control, particularly in cases involving NHS-wide issues and

The following is a summary of the main issues discussed at the meeting
staff movement at a UK level. NZ stressed the need for a focused lens on these aspects to effectively manage and mitigate fraud risks. ME highlighted the importance of focusing on controls to manage and reduce fraud cases, particularly those involving dual working, which had increased since the onset of remote working during COVID-19. ME emphasised the need to stay ahead of these risks rather than reacting to them after they occur. ME also highlighted that both internal and external disciplinary measures were available to address such issues. **9. Open learning and meeting Effectiveness** RT volunteered to represent the group at the Welsh Risk Pool meetings and would report back on key themes and learning. **10. Any other business:** NZ announced that PC expressed interest in taking over as Chair of the All-Wales Audit Committee group, and the group endorsed his appointment. **11. Date of next meeting:** There is currently no date scheduled for the next meeting.

Actions:

- Audit Wales Data Tool - AV to share the NHS data tool once the Powys accounts are finalised.
- AI in Audit - AV to discuss with colleagues and potentially present to the group on the use of AI in audit processes.
- Counter Fraud Developments - AR to update the group on Project Athena and other Counter Fraud initiatives after the next Counter Fraud Steering Group meeting on September 9th.
- Welsh Risk Pool Updates - RT to report back to the group on the main themes and learning from the Welsh Risk Pool meetings.

2004/25

REPORT BACK

All Wales NHS Audit Committee Chairs Group

TABLE OF CONTENTS

Forward 3

- Summary of key issues discussed 4
- Operating arrangements 6
- Supporting our work and looking forwards 8

Group membership 10

> *"a vibrant community where we reflect, learn, and support each other. It is a place of curiosity, innovation, and connectivity, where ideas flourish, and collaboration thrives."*

Audit committee chairs in the NHS oversee the governance arrangements for the NHS' £10 billion plus budget in Wales. We help to ensure that money is spent wisely to benefit our communities. How do we do that? We rigorously review the effectiveness of our systems of controls and governance, driven by a commitment to excellence.

For instance, we ensure robust financial reporting and control mechanisms that supports transparency and accountability in the allocation of public funds. We check that we all have comprehensive risk management frameworks designed to proactively identify and mitigate potential threats, including to patient safety and service delivery. We also help to ensure that the NHS learns and acts on lessons from external and internal audit.

The role of audit committees continues to evolve. It is not just about core financial accounts and systems of control. As a group we've discussed the growing challenges around new threats, such as counter fraud as well as the challenges of balancing risk management with innovation and transformation.

The All-Wales NHS Audit Committee Chairs Group provides a vibrant community where we reflect, learn, and support each other. It is a place of curiosity, innovation, and connectivity, where ideas flourish, and collaboration thrives. I hope this summary report serves as a reminder of the pivotal role audit committee chairs play across the NHS.

Nuria Zolle, Chair of the All-Wales NHS Audit Committee Group

Summary of key issues discussed in 2024-25

We’re getting the system back on track after the pandemic

During the pandemic a lot of work was postponed or delayed, including audit work. As a result, the timetable for producing, auditing and signing off accounts across the NHS slipped backwards. Over recent years there has been a concerted effort from Audit Wales and finance teams across the NHS to get things back on track. Audit committees have welcomed the extra efforts being made across the system, and the resulting pressures for everybody. A huge thank you to everybody!

Ensuring our risk and assurance frameworks incentivise the right behaviours

Across Wales risk management and board assurance frameworks continue to evolve. Each body is at a different level of maturity. Overall, the level of risk across the NHS, post pandemic remains high. The danger is that this leads to a defensive ‘fire-fighting’ mindset. While of course, we must manage risk and prevent harm we also need our systems to incentivise transformation and innovation for the long-term. Getting that balance right is a growing focus of audit committees, not least in the context of our duties to future generations.

Navigating governance arrangements across public bodies

The governance landscape in which NHS bodies operate grows ever more complex. Audit committees oversee board governance arrangements that interact with regional and national NHS systems, including commissioning. The role also involves overseeing multi sectorial partnership governance arrangements and agreements. Keeping on top of these and ensuring everything is aligned and coherent is a growing challenge for audit committees.

Counter fraud and cybersecurity are evolving areas of work

Across the UK, the NHS is vulnerable to £1.316 billion worth of fraud each year. The threat of counter fraud and cybersecurity has become an increasing risk for the NHS. As the threats evolves so do the NHS counter fraud arrangements. Shared learning and shared systems of assurance across NHS Wales are enhancing local control arrangements.

Applying the learning from audit inspections and reviews

Audit and inspection are a key part of our governance system. Audit committees are noticing growing strain across the system in delivering a timely response to recommendations. We recognise that there are competing priorities with pressure to deliver on day-to-day service issues. And there can also be challenges where local action depends on national systems, like IT systems which can be delayed.

However, audit recommendations are often a means to addressing systemic issues that hamper effective and efficient service delivery in the long-run. Audit committees are increasingly focussing on:

(a) challenging our organisations to set realistic timescales for implementing recommendations and prioritise action to deliver within those timeframes; and

(b) holding executives to account for not delivering on time and pressing for clear action, especially in those areas that relate to patient outcomes.

Operating arrangements of the NHS all Wales audit committee chairs group

The chairs of the Audit Committee Group was established to provide an opportunity for Wales-wide discussions on emerging issues on governance, risk management, financial controls, cyber security and counter fraud.

Scope and duties

The scope and duties of the group will comprise:

- Discussion of common issues arising from internal and external audit reviews.
- Discussion of the highest risks relating to governance, nationally and locally.
- Sharing cultural and thematic challenges and good practice and learning.

Items to be placed on the agenda will be informed by the group's action plan but can come from several sources such as those below but are not limited to:

- Group members.
- Board or trust committees.
- Chair, vice-chair and other members of the boards.
- Directors of Corporate Governance/board secretaries' network or other all-Wales peer groups.
- Audit Wales and Internal Audit.
- NHS Counter Fraud authority.

Membership

The membership will comprise chairs of Audit committees across Wales.

Should an NHS body Audit Committee Chair be unable to attend, a representative from the organisations will be identified by the body's Audit Chair.

Meetings

Hosting

The hosting organisation of the group will rotate every year.

Quorum

At least six members must be present to ensure the quorum.

Chair

The group will nominate a member to chair and this will rotate on a yearly basis.

Secretariat

The Director of Corporate Governance/Board Secretary of the hosting organisation will determine the secretarial and support arrangements for the group.

Frequency of Meetings

Meetings shall be held quarterly. Thematic working groups will be convened as and when required.

Committee Meetings

A standard agenda will be used as the basis for discussion at each meeting. Notes prepared following a meeting shall be circulated to members and retained by the relevant Director of Corporate Governance/Board Secretary as a formal record of the decision making for a period of seven years.

Withdrawal of individuals in attendance

The group may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion on any matter.

Last reviewed in July 2024

Big thanks!

Thank you to those who have supported the work of the committee

Commissioning arrangements

Chairs would like to thank Abi Harris who was Chief Executive of the NHS Commissioning Service for sharing an oversight of the new governance arrangements.

Audit Wales and Internal Audit

Chairs would like to thank Simon Cookson, Anne Beagan, Dave Thomas and Anthony Veale and Andrew Doughton for providing regular insights and updates. These included updates and insights in relation to new accounting systems and methodologies, risk management, thematics and analysis on areas of limited assurance, as well as findings from local and national reviews.

Audit Trackers

Chairs would like to thank Joanne Wilson and colleagues in Hywel Dda Health Board for openly sharing ideas and progress in relation to the development and implementation of their audit tracker.

Counter fraud activity

Chairs would like to thank Matthew Evans and colleagues for updates in relation to new national initiatives and activities as well as key learning from counter fraud activity in relation to detection and prevention.

Board Governance and oversight

Chairs would like to thank Hazel Lloyd for providing regular updates to the group in relation to the All Wales Director of Governance agenda and insights. We would also like to thank board directors for agreeing to review the training and development offered to Audit Committee Chairs across the NHS.

Board Assurance Framework

Chairs would like to thank Chris Darling for sharing Digital and Health Care Wales board assurance framework.

2024/ 25 Sharing learning and practice

Chairs also discussed and shared ideas on several areas including but not limited to; balancing competing priorities, time commitments, efficiency reviews, HMCA guidance reports, system improvements and NHS finances, committee reviews.

Looking forwards

A new work plan for 2024/ 25 is in the process of being agreed areas for discussion are likely to include:

- Financial savings, sustainability and recovery
- New counter fraud arrangements and directives
- Partnership governance arrangements

Group Membership

Health Boards

Iwan Jones, Aneurin Bevan University Health Board

Karen Balmer, Betsi Cadwaladr University Health Board

Dr RhianThomas, Cardiff and Vale University Health Board

Patsy Roseblade, Cwm Taf Morgannwg University Health Board

Rhodri Evans, Hywel Dda University Health Board

Steve Elliot, Powys Teaching Health Board

Nuria Zolle, Swansea Bay University Health Board

All-Wales NHS Trusts

Marian Wyn Jones,Digital Health and Care Wales

Jayne Sadgrove, Health Improvement Wales

Peter Curran, Welsh Ambulance Services

Gareth Jones, Velindre University Trust

Nick Elliot, Public Health Wales

3

09:55, 0 Mins

3 - Audit Wales

3.1

09:55, 5 Mins

3.1 - Audit Wales Update Report

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

For assurance

Attachments

3.1 Audit Wales ARAC Update (14.10.25).pdf

3.1 NFI Briefing Note - Hywel Dda University Health Board.pdf

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

Date issued: October 2025

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

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Contents

Audit and Risk Assurance Committee Update

About this document 4

Accounts audit update 5

Performance audit update 6

Other relevant publications 10

Additional information 10

Audit and Risk Assurance Committee Update

About this document

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

2 We also provide additional information on:

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

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

Accounts audit update

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

Exhibit 1 – accounts audit work

Area of work	Executive Lead	Focus of the work	Status	Planned date for consideration
Audit of the 2024-25 Charitable Funds Accounts	Director of Finance	To provide an audit opinion on the 2024-25 Health Boards Charitable Funds Accounts.	Planning	December 2025
Audit of the 2024-25 Annual Report and Accounts	Director of Finance	To provide an audit opinion on the Health Board's 2024-25 Annual Report and Accounts.	Complete	June 2025

Performance audit update

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

Exhibit 2 – performance audit work

Area of work	Executive Lead	Focus of the work	Status	Planned date for consideration
Structured Assessment 2025 – core	Board Secretary	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2025 Structured Assessment will review: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements.	Fieldwork underway	December 2025
Review of urgent and emergency care	Director of Operations	This work has examined different aspects of the urgent and emergency care system and includes analysis of national data sets to present a high-level picture of how the urgent and emergency care system is currently working.	Blog and data tool published in April 2022	

Area of work	Executive Lead	Focus of the work	Status	Planned date for consideration
		The work has examined the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow (Part 1). We have also reviewed progress being made in managing urgent and emergency care demand by helping patients access services which are most appropriate for their care needs (Part 2).	Part 1 – Local report final. Regional report still in clearance. Part 2 – complete	October 2025 (Local report) Presented to the committee in June 2025
Structured Assessment 2024 Deep Dive - review of investment in digital systems	Director of Finance	This review will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Fieldwork underway	February 2026
Review of the management of outpatients (Local work 2024)	Director of Operations	This work has examined the management of outpatients, including assessing the Health Board's progress on the recommendations made in our 2015 and 2018 Review of Follow-up Outpatient Appointments.	Report being drafted	December 2025

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

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

Other relevant publications

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

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

Title	Publication Date
NHS Wales Finances Data Tool	**September 2025**
Temporary Accommodation, long-term crisis?	July 2025
Cost Savings Arrangements – A checklist for NHS Board Members	June 2025
The Wales Infrastructure Investment Strategy	May 2025

Additional information

7 Exhibit 4 provides information on corporate documents published by Audit Wales since the last committee update.

Exhibit 4: corporate documents published by Audit Wales

Title	Publication Date
Welsh Language Report 2024-25	**September 2025**
Annual Report and Accounts 2024-25	**June 2025**

8 There are no relevant Audit Wales consultations currently underway.

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

National Fraud Initiative 2024-25: update for Hywel Dda University Health Board

About the National Fraud Initiative

1 The National Fraud Initiative (NFI) is a biennial UK-wide counter-fraud exercise. It helps prevent and detect fraud by electronically sharing and matching data sets. **Appendix 1** provides further information on how the NFI works.

2 In Wales, the NFI operates under the Auditor General's statutory powers. Participation is mandatory for unitary local authorities, NHS bodies, police forces, and fire and rescue authorities. Participating on a voluntary basis in the latest exercise are the Welsh Government, some Welsh Government arm's length bodies (Natural Resources Wales, Arts Council of Wales, Sport Wales, National Library of Wales, Transport for Wales), and South East Wales Corporate Joint Committee.

3 This briefing note provides an update on the latest NFI 2024-25 exercise at a national level and as at 31 July 2025. It also provides some local level data for your organisation, although we are encouraging those charged with governance to seek further local detail from lead officers.

Data submission for 2024-25

4 The NFI 2024-25 exercise is underway. Participants submitted data for the biennial batch data matching exercise in October 2024. This included data on housing benefits, housing tenants and waiting lists, blue badge parking permits, licences, and various payments such as creditor payments, payroll, and pensions.

5 The UK Public Sector Fraud Authority released most data match reports to participants by the end of December 2024. Council tax and electoral register data are submitted annually. The most recent deadline for submitting this data was February 2025.

6 Supplementary data runs take place during the exercise to process new, incomplete or missing data submissions. For example, progress is being made to amend the Public Audit (Wales) Act 2004 through a Legislative Reform Order which will enable the NFI to resume the matching of adult social care data during the NFI 2024-25 exercise.

National update

Data matches and investigation

7 To date, almost 440,000 data matches have been identified for the Welsh NFI 2024-25 exercise participants. **Exhibit 1** shows that most of these matches are for unitary authorities and health bodies.

Exhibit 1: NFI 2024-25 Welsh participant data matches by type of organisation, at end of July 2025

Type of organisation	Number of data matches	% of data matches
Unitary authority	373,114	84.9
Health	50,409	11.5
Police	2,641	0.6
Fire and rescue	740	0.2
Other	12,749	2.9
Total	**439,653**	**100.0**

Source: Audit Wales analysis of NFI web-application data

Note: % total does not match the sum of the parts due to rounding.

8 Data matching identifies potentially fraudulent or erroneous claims and payments. No assumption can be made about whether there is fraud, error, or another explanation until an investigation is carried out. There can, for example, be false positives around creditor payments if bodies are deliberately making staged payments of the same amount.

9 We recognise it is not practical to investigate all data matches, particularly for bodies with large numbers of matches. Bodies are encouraged to take a risk-based approach to assessing data match reports and deciding what type of, and how many, data matches they review.

10 By the end of July 2025, five participating bodies had not yet closed any data matches. Some participants are making good progress with reviewing NFI 2024-25 data matches, while others have made limited progress.

11 **Exhibit 2** shows the total number of data matches for each data match area. It also shows the number of data matches closed in a data match area, along with the number of participants that have matches in that area.

The absence of closed matches indicates that the participant has not reviewed any matches in that area.

Exhibit 2: NFI 2024-25 Welsh participant data matches processed and closed, at end of July 2025

Data match area	Data matches	Data matches closed	Participants with data matches	Participants with no closed statuses for their matches
Council tax single person discount	198,146	5,385	22	11
Creditors	187,228	19,791	48	16
Council tax reduction scheme	16,578	3,547	22	1
Blue badges	10,377	5,849	22	3
Payroll	8,150	1,705	46	6
Housing waiting lists	6,359	1,392	18	5
Housing tenants	4,636	879	11	2
Pensions	2,962	1,098	12	4
Resident parking	2,405	2,368	8	1
Procurement	1,985	400	42	28
Housing benefit	826	483	22	2
Taxi drivers	1	1	1	0
Total	**439,653**	**42,898**	**49**	**5**

Source: Audit Wales analysis of NFI web-application data

Note: After risk assessing data match reports and any subsequent investigations, each data match should be ‘closed’ and given a match status. There are a range of ‘closed’ statuses. Matches not investigated should be given the status ‘Closed – Not selected for investigation’. Assigning match statuses to data matches can be done individually or by bulk selection.

Outcomes

12 Welsh participants recorded outcomes of £4.7 million for the period 1 April 2024 to 31 July 2025. **Exhibit 3** shows which matching process the outcomes relate to.

Exhibit 3: Welsh participant reported NFI outcomes, 1 April 2024 to 31 July 2025

NFI exercise	Outcomes (£s)
NFI 2024-25 biennial exercise	1,719,037
Late savings from the NFI 2022-23 biennial exercise	867,157
Annual council tax data matching exercises	2,080,831
Total	**4,667,025**

Source: Audit Wales analysis of NFI web-application data

Note: Outcomes are made up of (i) actual amounts participants have recorded as fraud or error; and (ii) estimated elements which seek to capture the value of loss from a fraud or error detected, and the value of any future losses that bodies may have incurred without intervention following an NFI match. Most datasets have a methodology to calculate estimated savings. All methodologies are reviewed by the Cabinet Office's NFI Governance Board and approved by the Cabinet Office's Fraud Prevention Panel.

Local update

13 Data matches are released in data match reports. Each report has a different purpose and compares data from two or more datasets. The reports are broken down into dataset types: for example, housing benefit, payroll, or creditors.

14 An organisation's risk assessment of the data match reports should determine the types and numbers of data matches to be investigated. To aid risk assessment, the NFI web application flags some data match reports as 'key reports' with historically high success rates in identifying fraud or error. Also, most individual data matches are assigned a fraud risk score.

15 **Exhibit 4** shows the total number of data matches identified for Hywel Dda University Health Board, along with those recorded in key reports. **Appendix 2** provides some further analysis of these data matches by fraud risk score.

Exhibit 4: Hywel Dda University Health Board's NFI 2024-25 data matches, at end of July 2025

Data match area	Data matches in all reports	Data matches in key reports with historically high success rates
Creditors	6,065	4,705
Payroll	220	107
Procurement	49	49
Total	**6,334**	**4,861**

Source: Audit Wales analysis of NFI web-application data

Note: Council tax single person discount data match reports are not formally designated as 'key reports' but are treated as such in practice.

16 Various factors can influence which data match reports are reviewed and when this takes place. For example, an organisation may prioritise looking at data match reports linked to areas where it has concerns about internal controls or where there is a history of fraud or error. Also, local resourcing will dictate the pace of progress. For these reasons, this general update does not provide further detail on where processing work and outcomes are recorded by your organisation at this stage.

17 The NFI web application features a dashboard and provides various reports on outcomes and processing activity. We encourage those charged with governance to seek more detailed updates on processing work and outcomes recorded from their NFI Senior Responsible Officer and NFI Key Contact.

Future Audit Wales work

18 For this NFI exercise we will carry out a high-level assessment of participants' governance and follow-up arrangements. We will engage with bodies over the autumn/early winter to consider issues covered in our NFI self-appraisal checklist.[1] We will also analyse the risk assessment and data

[1] In December 2024, we shared the updated checklist with NFI senior responsible officers and key contacts. We encouraged all bodies to complete it and share it with those charged with governance.

match processing work carried out, and the outcomes recorded by participants, as reflected in the NFI web application.

19 This work will help us understand the factors influencing the outcomes reported by individual bodies and the variations between them. Findings from this assessment will inform our next national report in autumn 2026.

Appendix 1 – The National Fraud Initiative

The NFI uses data matching to detect and prevent fraud. It electronically compares sets of data against other records held by the same and other bodies, to see to what extent they match.

The data matching flags anomalies or inconsistencies that indicate potential fraud or error. Indicators of potential fraud are reported to the participants, who are responsible for following up these matches.

The effectiveness of the NFI depends on the thoroughness of the assessment and investigation of matches and recording of outcomes.

Bodies record the outcomes in the NFI web application. Each participant body has a nominated Senior Responsible Owner and Key Contact for the NFI, who in some cases may be the same individual.

The UK Public Sector Fraud Authority, part of the UK Government's Cabinet Office and HM Treasury, oversees the NFI across the UK. Audit Wales leads the exercise in Wales under the Auditor General's powers in the Public Audit (Wales) Act 2004. The Auditor General's Code of Data Matching Practice summarises the key legislation, and controls, governing the exercise in Wales.

We published a report on the outcomes from the 2022-23 NFI exercise in October 2024. Reports on the NFI for other parts of the UK are produced by the Public Sector Fraud Authority, Audit Scotland, and the Northern Ireland Audit Office.

There is no direct cost to participants for taking part in the exercise. Audit Wales receives funding, through the Welsh Consolidated Fund, to pay for bodies to participate in the NFI. This covers the central data matching processing for the biennial exercise, as well as the annual exercise for council tax and electoral register datasets. This remained the case for the NFI 2024-25 exercise. The main costs to participants are, therefore, the resources used to submit data and conduct follow-up work once data matches are released.

Appendix 2 – Analysis of data matches by fraud risk score for Hywel Dda University Health Board

The NFI assigns a fraud risk score of very high risk, high risk, or medium risk to most, but not all, data matches. This risk score is based on a combination of two factors:

- Risk logic – a set of criteria for each dataset combination that, when met, indicates a fraudulent outcome is more likely to occur.
- Footprint score – the number of times an individual in a match appears at the address across all NFI data. It is an indicator of whether that person resides at that address.

Exhibit 5 and **Exhibit 6** provide further analysis of Hywel Dda University Health Board's data matches by risk score for data matches in all data match reports and those in key reports. This analysis builds on **Exhibit 4** in the main body of this briefing note. Not all data matches are formally assigned a risk score. Council tax single person discount data matches and matches in key reports that are not formally assigned a risk score should generally be treated as 'very high risk' in practice.

Exhibit 5: Hywel Dda University Health Board's NFI 2024-25 data matches by risk score for data matches in all reports, at end of July 2025

Data match area	All data matches	Very high risk	High risk	Medium risk	No risk score
Creditors	6,065	605	5,460	0	0
Payroll	220	17	112	49	42
Procurement	49	0	0	0	49
Total	**6,334**	**622**	**5,572**	**49**	**91**

Source: Audit Wales analysis of NFI web-application data

Exhibit 6: Hywel Dda University Health Board's NFI 2024-25 data matches by risk score for data matches in key reports, at end of July 2025

Data match area	All data matches	Very high risk	High risk	Medium risk	No risk score
Creditors	4,705	593	4,112	0	0
Payroll	107	16	19	33	39
Procurement	49	0	0	0	49
Total number of data matches	**4,861**	**609**	**4,131**	**33**	**88**

Source: Audit Wales analysis of NFI web-application data

3.2 **10:00, 20 Mins**

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

Anne Beegan, Urvisha Perez, Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Gareth Cottrell (Hywel Dda UHB - Deputy Chief Operating Officer), Peter Skitt (Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine), Anna Chiffi (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality), Thomas Alexander (Hywel Dda UHB - Principal Programme Manager)

For assurance

Attachments

3.2 HDUHB Discharge Planning Progress Report.pdf

Discharge Planning Progress Update – Hywel Dda University Health Board

Date issued: August 2025

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

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

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

Contents

Summary report

About this report 4

Key findings 4

Recommendations 5

Detailed report

Implementation of previous audit recommendations 7

Appendices

Appendix 1 – audit methods 12

Appendix 2 – summary of progress against our 2017 recommendations 14

Appendix 3 – management response 17

Summary report

About this report

1 In 2017, the Auditor General reviewed discharge planning across all health boards in Wales. That work focused on strategic planning, arrangements for monitoring and reporting on discharge planning, and action being taken to manage discharge planning and secure improvements.

2 Our 2017 report on discharge planning for Hywel Dda University Health Board (the Health Board) found that there was **“some improvement in key performance measures but it will be some time before initiatives to improve discharge planning and patient flow take full effect’**. We made several recommendations for the Health Board to address.

3 The Auditor General has been undertaking a programme of work across Wales which has examined whole system issues affecting urgent and emergency care services. This has included a review of health boards’ and local authorities’ arrangements to ensure the timely discharge of patients out of hospital. The findings from this work in the West Wales region are set out in a separate report to the Health Board and its local authority partners. The regional report will be made available on our website once considered by the appropriate Health Board and local authority committees.

4 As part of our regional review, we have also looked to assess the progress made by the Health Board in addressing the recommendations set out in our 2017 discharge planning report. This report sets out the findings with respect to progress against the recommendations. The approach we adopted to deliver our work is set out in **Appendix 1**.

5 The Auditor General’s work on urgent and emergency care aims to help discharge his statutory duty to be satisfied that NHS bodies and local authorities have proper arrangements in place to secure efficient, effective, and economical use of resources..

6 To support our previous work on discharge planning, we produced ‘What’s the hold up? Discharging patients in Wales’ which sets out important issues that board members should be sighted of when seeking assurance that patients are discharged from hospital in safe and timely ways. Many of the issues identified are still relevant and should be considered alongside the findings of this report.

Key findings

7 Data from April 2025 showed that across the Health Board’s main hospital sites, there were 222 patients whose discharge had been delayed beyond 48 hours. Approximately 26% of these delays related to discharge planning issues within the Health Board, including the completion of clinical assessments.

8 In overall terms, the Health Board has made slow progress in addressing the previous recommendations we made in 2017 to help improve discharge planning.

Our 2017 report made six recommendations that set out 12 specific actions for the Health Board. Noting that the Health Board had accepted these recommendations, our follow up work found that:

- no progress has been made against four of the actions;
- work is still on-going against four of the actions;
- one of the actions has been superseded by other developments;
- three of the actions have been implemented.

9 Specifically, our follow up work found that:

- until recently the Health Board has lacked an organisation-wide discharge policy. A new policy was launched in 2025 which covers many of the areas we previously raised as well as how performance will be monitored.
- there has been no consistent approach to discharge planning training within the Health Board or in partnership with local authority colleagues, although training is now planned as part of the rollout of the new discharge policy.
- there is an inconsistent approach to the use of discharge lounges and limited monitoring of their impact to improve patient flow.
- performance reporting has changed significantly in line with new national models and programmes, and the Health Board's current arrangements for performance reporting are strong.
- since our original work the Health Board has implemented a digital platform to help better manage the discharge process, however, there have been issues with the accuracy of the information contained in the platform.

10 The following sections of the report set out our follow up findings in more detail and **Appendix 2** summarises our assessment of progress against each of the actions identified in our 2017 report.

Recommendations

11 Our follow up work and wider regional report on patient flow have identified two fresh recommendations on discharge planning for the Health Board, and where relevant, its local authority partners. These have replaced the outstanding recommendations from our 2017 work that are shown in **Appendix 2**.

12 The recommendation arising specifically from this follow up work is set out in **Exhibit 1**. The Health Board's response to this recommendation is captured in **Appendix 3**.

Exhibit 1: new recommendation arising from this follow up work

Recommendation
Improving use of discharge lounges R1 To make more effective use of its discharge lounges, the Health Board should: 1.1. actively promote the use of discharge lounges in its discharge planning process and associated training; 1.2. undertake work to understand why patients appropriate for discharge lounges are not being moved to the discharge lounge; and 1.3. monitor the use of discharge lounges, including the length of time patients remain in discharge lounges.

Exhibit source: Audit Wales

13 The recommendation arising from our wider regional work on patient flow is set out in **Exhibit 2**. The Health Board's response to this recommendation is included in the regional report.

Exhibit 2: recommendation included in the regional report on discharge planning replacing previous 2017 recommendations

Regional recommendation
Developing and embedding policies R6 To embed a consistent approach to discharge planning, the Health Board and local authorities should ensure processes are in place to communicate the new discharge planning guidance to all relevant health and social services staff, including those working on a temporary basis. Roll out of the guidance should be supported by an ongoing programme of refresher training and induction training for new staff

Exhibit source: Audit Wales

Detailed report

Implementation of previous audit recommendations

14 We considered the Health Board's progress in implementing our 2017 audit recommendations. These focus on:

- discharge and transfer of care policy (2017 Recommendations 1 and 2);
- training on discharge planning (2017 Recommendations 3a, b, c, and d);
- discharge lounge (2017 Recommendations 4a, b, c, and d); and
- performance reporting (2017 Recommendation 5); and
- performance monitoring (2017 Recommendation 6).

15 Overall, we found that **the Health Board has been slow to address our previous recommendations with a new discharge policy only recently approved. A new digital platform is now in place, with strong performance reporting but gaps remain in staff training and there is a need for more consistent use of discharge lounges across the Health Board.**

Discharge and Transfer of Care Policy

16 We considered whether the Health Board:

- in reviewing its discharge policy, has included:
  - the patient discharge leaflet;
  - the discharge pathways;
  - a discharge checklist;
  - reference or web links to the Home of Choice policy;
  - typical escalation procedures;
  - arrangements for patients discharged from A&E departments or medical/clinical assessment units; and
  - roles and responsibilities of ward staff (2017 Recommendation 1).
- has clear indicators for monitoring the impact of its discharge policy, which avoid duplication (2017 Recommendation 2).

17 We found that **until recently the Health Board has lacked an organisation-wide discharge policy. A new policy was launched in 2025 which covers many of the areas we previously raised as well as how performance will be monitored.**

18 The Health Board committed to a review of its discharge policy during May 2018. This did not happen and as a result different policy approaches were being used across the Health Board. Some sites were using the previously issued Welsh Government discharge policy and others were developing a standardised policy. Following a limited assurance Internal Audit review of discharge planning in 2024, the Health Board developed and approved an organisation-wide policy in April

2025. This builds on the updated Welsh Government discharge planning guidance first issued in September 2024.

19 The Health Board's policy covers many aspects of the good practice that we raised in our 2017 review. The policy now provides clear signposting to other relevant policies and information to support discharge planning. This includes patient information, and the care home of choice policy. The Health Board has also developed a Discharge Toolkit SharePoint page which brings together all relevant information in one place, improving access for staff. Discharge pathways have since been updated to reflect the national implementation of the Discharge to Recover and Assess (D2RA) policy, and these are referenced in the updated Welsh Government guidance. The roles and responsibilities of ward staff are also clearly set out in the Health Board's policy.

20 While there is reference to escalation, the policy does not clearly set out escalation procedures although it does refer to governance and escalation processes for delayed packages of care and discharges from acute settings in relation to Health Board roles and responsibilities. Overall, we consider **recommendation 1 has been substantially implemented,** although there is a need for the Health Board to set out arrangements for discharge from its emergency departments and assessment units in future iterations of the policy.

21 The Health Board's policy clearly sets out that it is the responsibility of the System Service Group Managers, in the new operational structure, to monitor performance associated with discharge, and the impact of the discharge policy. This includes reducing average length of stay, 'delayed transfers of care', bed capacity and patient flow. We consider **recommendation 2 has been implemented**,

Training on discharge planning

22 We considered whether the Health Board has:

- included training on discharge planning in induction programmes for staff who will be involved in making discharge arrangements (2017 Recommendation 3a);
- offered regular refresher training on discharge planning (2017 Recommendation 3b);
- explored opportunities for including the use of the Decision Support Tool in training on discharge planning (2017 Recommendation 3c); and
- provided simple guidance for bank and agency nursing staff to enable them to contribute effectively to discharge planning arrangements (2017 Recommendation 3d).

23 We found that **there has been no consistent approach to discharge planning training within the Health Board or in partnership with local authority colleagues, although training is now planned as part of the rollout of the new discharge policy.**

24 Our review found that there has been an inconsistent approach to training within the Health Board, and a lack of joint training with relevant social service staff. We found that staff recognised that there are training requirements for everyone involved in discharge to better understand the process, and roles and responsibilities at each stage. For example, we heard how some patients are over promised packages of care by clinical staff which they may not get or need. This affects patient and family expectations which can delay patient discharge. Following the approval of the Health Board's new discharge policy in April 2025, the Health Board has set out its intentions to provide training to all healthcare professionals. We therefore consider that there is **ongoing action to address recommendations 3a and 3b.** We have however recommended in our regional review that training should also include social services staff **(replaced with 2025 Regional Recommendation 6).**

25 A reasonable assurance Internal Audit review of continuing healthcare arrangements in 2023 found that the Health Board has improved the use of the Decision Support Tool for the continuing healthcare funding process, with the tool completed appropriately in all samples of active care packages reviewed. The Health Board's new discharge policy refers to its continuing healthcare operational policy, which should be covered as part of its planned training. We therefore consider there is **ongoing action to address recommendation 3c (replaced with 2025 Regional Recommendation 6).**

26 Our review found that the use of agency nursing staff at the Health Board has reduced substantially since August 2024. In March 2025, the cost of agency nurse staffing accounted for 1.9% of the total nursing pay bill compared to 6.9% in August 2024. The use of bank staff however has increased, with the cost of bank nurse staffing accounting for 6.5% of the total nursing bill in March 2025. Training for bank and agency staff should be a key consideration of the Health Board's planned programme of communication and training following the approval of its new discharge policy. We therefore consider there is **ongoing action to address recommendation 3d (replaced with 2025 Regional Recommendation 6).**

Discharge lounges

27 We considered whether the Health Board has:

- actively promoted the use of discharge lounges (2017 Recommendation 4a);
- ensured patients being discharged are moved to discharge lounges as soon as they open (2017 Recommendation 4b);
- found out what prevents more patients being moved to the lounges on the day of discharge (2017 Recommendation 4c); and
- reviewed how long patients remain in discharge lounges to ensure the lounges do not get blocked with patients waiting to leave (2017 Recommendation 4d).

28 We found that **there is an inconsistent approach to the use of discharge lounges and limited monitoring of their impact to improve patient flow.**

29 Our review found that there was an inconsistent approach to the use of discharge lounges across the Health Board. Discharge lounges are located in Glangwili, Withybush and Prince Philip Hospitals. There is recognition in performance update reports that discharge lounges improve flow, but the Health Board lacks a corporate approach to ensuring they are used effectively. Our review also found limited evidence that discharge lounge activity is measured and monitored for impact. This means that opportunities are being lost to improve patient flow and free up beds. We therefore consider that **no action has been taken on recommendations 4a, 4b, 4c or 4d (replaced with 2025 Recommendation 1).**

Performance reporting

30 We considered whether the Health Board has included a summary of the impact of the unscheduled care campaign in the Integrated Performance Report in March 2018 (2017 Recommendation 5).

31 We found that **performance reporting has changed significantly in line with new national models and programmes, and the Health Board's current arrangements for performance reporting are strong.**

32 Since our original review, there have been several changes to the national guidance for urgent and emergency care, including the introduction of the Discharge to Recover then Assess (D2RA) model in 2018 and the introduction of the Six Goals for Urgent and Emergency Care Programme (Six Goals Programme) in 2021. The way performance is measured has also changed to align with these national policies and programmes.

33 Our recent review found that the Health Board has robust reporting and monitoring arrangements, aligned to the requirements of the Welsh Government's Six Goals Programme. Transforming Urgent and Emergency Care was one of the Health Board's Planning Objectives for 2024-25, which is monitored through the Strategy and Planning Committee. Progress against the Six Goals Programme is also monitored through the Health Board's Integrated Quality, Finance and Performance Delivery (IOFPD) mechanism set up in response to the Health Board's escalation status. Regular performance monitoring of urgent and emergency care indicators is also undertaken as part of the Integrated Performance and Assurance Report presented to the Board and the new Finance and Performance Committee[1]. We therefore consider **recommendation 5 has been superseded and can be closed.**

[1] Prior to 1st April, responsibility for oversight and scrutiny of performance was with the Strategic Development and Operational Delivery Committee.

Discharge information

34 We considered whether the Health Board has assessed if the patient administration system can be used to capture additional data items, such as whether a discharge is simple or complex and the date a patient is ‘medically fit’ for discharge (2017 Recommendation 6).

35 We found that **since our original work the Health Board has implemented a digital platform to help better manage the discharge process, however, there have been issues with the accuracy of the information contained in the platform.**

36 Since our 2017 review, the Health Board has implemented ‘Frontier’, a digital discharge platform which enables patient details, including an expected date of discharge to be recorded. Simple and complex discharges are now captured through the allocation of the relevant D2RA pathway category. However, the limited assurance Internal Audit review of discharge planning in 2024 found that information contained within the Frontier system was often incomplete and inaccurate. The review found that the relevant D2RA pathway had not always been assigned, or was incorrect on the system, and the expected date of discharge was sometimes missing. The Health Board has since undertaken work to ensure that information contained on the Frontier system is accurate, with compliance reported at a ward level. Where compliance falls short, additional training is provided to relevant ward staff. We therefore consider **recommendation 6 has been implemented**.

Appendix 1

Audit methods

Exhibit 3 sets out the methods we used to deliver this work. The methods formed part of the audit methods used to deliver our wider regional review.

Exhibit 3: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Board and committee papers • Operational and strategic plans relating to urgent and emergency care • Updates on the six goals programme and urgent and emergency care to committees; and • Discharge procedure
Interviews	We interviewed the following: • Chief Operating Officer; • Deputy Director of Nursing; • Director of Primary Care, Community and Long-Term Care; • County Directors for Pembrokeshire, Ceredigion, and Carmarthenshire; • General Managers for Bronglais, Glangwili, and Withybush Hospitals; and • Programme Manager for Six Goals.
Observations	We observed Discharge Liaison Nurses at Glangwili and Withybush Hospitals.
Data analysis	We analysed StatsWales data. We also analysed data provided by the Health Board relating to all emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died).

Element of audit methods	Description
Self-assessment	We asked the Health Board to complete and submit a self-assessment, setting out its view of progress against our 2017 recommendations.

Source: Audit Wales

Appendix 2

A summary of progress against our 2017 recommendations

Exhibit 4 sets out the recommendations we made in 2017 and our summary of progress

Recommendations	Progress
Discharge and Transfer of Care Policy R1 Our assessment of the Health Board's policy indicates that it could be strengthened when it is next scheduled to be reviewed and updated. The Health Board should include: • the patient discharge leaflet; • the discharge pathways; • a discharge checklist; • reference or web links to the Home of Choice policy; • typical escalation procedures; • arrangements for patients discharged from A&E departments or medical/clinical assessment units; and • roles and responsibilities of ward staff.	**implemented** – see paragraphs 18 - 20
Discharge and Transfer of Care Policy R2 One of the indicators for monitoring the impact of the policy is the percentage of patients discharged before 11 am, while the success of the SAFER patient flow model is assessed on discharging 33% of patients from inpatient wards before midday. The Health	**implemented** – see paragraph 21

Recommendations	Progress
Board should clarify whether the timeframe for the purpose of monitoring needs to be the same or different, and if so ensure the ability to monitor two separate indicators.	
Training on discharge planning R3 The Discharge and Transfer of Care Policy indicates that all frontline staff should have access to appropriate training. However, there is no regular training on discharge planning and its inclusion in induction programmes is inconsistent, while agency staff are unfamiliar with the discharge process. Meanwhile, several staff felt more training is needed on the Decision Support Tool for the continuing healthcare funding process, which would, in turn, inform discharge planning arrangements. The Health Board should:	
a) include training on discharge planning in induction programmes for staff who will be involved in making discharge arrangements;	**ongoing** – see paragraph 24
b) offer regular refresher training on discharge planning;	**ongoing** – see paragraph 24
c) explore opportunities for including the use of the Decision Support Tool in training on discharge planning; and	**ongoing** – see paragraph 25
d) provide simple guidance for bank and agency nursing staff to enable them to contribute effectively to discharge planning arrangements	**ongoing** – see paragraph 26 (Replaced with 2025 Regional Recommendation 6)
Discharge lounges R4 Discharge lounges appear to support fewer patients than might be expected given their overall capacity and operational hours. Meanwhile, some patients are waiting 12 or more hours overnight in A&E until beds become available. The Health Board should:	
a) actively promote the use of the discharge lounge;	**no action** – see paragraph 28
b) ensure patients being discharged are moved to the discharge lounge as soon it opens;	**no action** – see paragraph 28

Recommendations	Progress
c) find out what prevents more patients being moved to the lounge on the day of discharge; and d) collate information on the length of time patients remain in the discharge lounge before leaving the hospital to assess whether slow turnover is preventing patients from being moved to the lounge on the day of discharge	**no action** – see paragraph 28 **no action** – see paragraph 28 (Replaced with 2025 Recommendation 1)
Performance reporting R5 The Health Board has recently launched its unscheduled care campaign. The Health Board should include a summary of the impact of the campaign in the Integrated Performance Report in March 2018.	**superseded** – see paragraphs 32 - 33
Discharge information R6 The patient administration system does not capture data items that could support monitoring and reporting of compliance with discharge standards and policies. The Health Board should assess if the patient administration system can be used to capture additional data items, such as whether a discharge is simple or complex and the date a patient is ‘medically fit’ for discharge.	**implemented** – see paragraph 36

Exhibit source: Audit Wales

Appendix 3

Management response to audit recommendations

Exhibit 5 sets out the Health Board's response to our audit recommendations.

Exhibit 5: management response

Recommendation	Management response	Completion date	Responsible officer (title)
R1 To make more effective use of its discharge lounges, the Health Board should: 1.1. actively promote the use of discharge lounges in its discharge planning process and associated training; 1.2. undertake work to understand why patients appropriate for discharge lounges are not being moved	We currently have active discharge lounges in three of our four acute hospitals. **PPH – Open 8am – 6pm (Mon to Fri) -** The opening hours in PPH have been extended from 10am to 6pm following the recommendations set out within this audit. **GGH – Open 8am – 6pm (Mon to Fri)** **WGH – Open 9am – 6pm (Mon to Fri) -** Ongoing plans to extend the opening hours from 8am in line with the Carmarthenshire sites. **BGH** – No current provision due to availability of space. Following a series of fire safety work scheduled over the coming months, a location has been identified to use as a discharge lounge facility. As an interim solution, staff are being actively encouraged to follow discharge lounge protocols by identifying suitable spaces within the ward environment where patients who can sit out are transferred from their bed space on the morning discharge while final arrangements and transport are completed.	Complete	Assistant Director of Nursing (Community and Integrated Medicine Clinical Care Group)

Recommendation	Management response	Completion date	Responsible officer (title)
to the discharge lounge; and 1.3. monitor the use of discharge lounges, including the length of time patients remain in discharge lounges.	On the week commencing 8 September 2025, we are undertaking a 'reset week' with a focus on patient flow, processes and discharge. An element of this exercise is to concentrate on increasing the number of patients being discharged before midday, supported using our discharge lounges. The targeted approach will enable us to capture and develop criteria for patients suitable for transfer to the discharge lounge alongside some of the perceived constraints in relation to this.	October 2025	Assistant Director of Nursing (Community and Integrated Medicine Clinical Care Group)
	Historically, it has been believed that for a patient to be conveyed to a discharge lounge that all elements of the discharge checklist must be complete and the discharge lounge is a waiting room for transport only. We have commenced a significant amount of training pertaining to discharge to culturally influence and develop professional understanding, accountability and ownership. Specifically, this training includes Discharge to Recover and Assess alongside Criteria Led Discharge. Our training percentage is currently demonstrating low compliance in these areas; therefore, the target is to reach a minimum of 80% within our registered nurses and Allied Health Professional workforce.	March 2026	Assistant Director of Nursing (Community and Integrated Medicine Clinical Care Group)
	The Health Board has recognised that there is a requirement for a competency profile review for nursing staff working in our discharge lounges to enable patients that require final clinical interventions to have these completed in the discharge lounge. Examples of these competencies include dressings and IV administration.	December 2025	Assistant Director of Nursing (Community and Integrated Medicine Clinical Care Group)
	Our SharePoint page now holds a toolkit specifically appropriate to hospital discharge. This includes an individual page holding a suite of information concerning discharge lounges. Relevant	October 2025	Assistant Director of Nursing

Recommendation	Management response	Completion date	Responsible officer (title)
	documentation is accessible from this area and includes forms such as an SBAR transfer document that aims to facilitate and expedite the transfer in a safe and efficient manner. A Welsh PAS transfer to discharge guide also simplifies the process for updating the patient location in a timely approach. Using this data will be conducive to our ongoing monitoring of discharge lounges and the amount of time that patients remain there. This is already embedded as a requirement for the transferring ward however closer monitoring and review will ensure compliance.		(Community and Integrated Medicine Clinical Care Group)

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

3.3

10:20, 0 Mins

3.3 - Review of the Management of Outpatients

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

DEFERRED to 9 December 2025 meeting

For assurance

4

10:20, 0 Mins

4 - Clinical Audit

4.1 **10:20, 20 Mins**

4.1 - Clinical Audit Update

Mark Henwood (Hywel Dda UHB - Executive Medical Director), Ian Bebb (Hywel Dda UHB - Clinical Audit Manager)

For assurance

Attachments

4.1 Clinical Audit Update ARAC October 2025.pdf

4.1 Appendix 1 - National Clinical Audit and Outcome Review Programme 2025-~.pdf

4.1 Appendix 2 - Clinical Audit Programme 2025-2026 (April-September).pdf

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

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	14 October 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Clinical Audit Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mark Henwood, 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)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide the Audit and Risk Assurance Committee with an update on the Health Board's Clinical Audit Function and Programmes.

Cefndir / Background

The Health Board develops an annual Clinical Audit Programme (CAP) which is carried out by the Operational Services. This programme consists of a list of key clinical audit projects which have been prioritised in line with Health Board (service specific or otherwise) aims and objectives. The programme also includes all projects mandated by Welsh Government (NCAORP) and other national bodies. National benchmarking is possible through this mechanism, as well as access to advanced analysis and reporting.

National Clinical Audit

The National Clinical Audit and Outcome Review Plan (NCAORP) is a mandatory audit programme in Wales.

The risk associated with non-participation is the inability to benchmark our practice with other sites and health boards. This does not directly indicate that there are issues with clinical care; only that we do not have sufficient data to assess Health Board compliance with key guidelines and professional standards. There are other ways to demonstrate the "health" or quality within a service through other Quality Improvement (QI) work, Safety Dashboard, performance targets, clinical effectiveness process e.g. National Institute for Health and Care Excellence (NICE), service evaluation, etc.

The programme of audits is mandatory; therefore, there is always the potential for reputational damage with non-participation or clinical standards not being met. Potentially, Welsh Government may write to health boards for a response. National audit reports are also in the public domain, so there is the potential for negative feedback from patients and other service users, etc. As national clinical audits are used as a benchmarking tool, they could impact on recruitment and retention, where higher performing trusts/health boards could attract the interest of new staff.

Full participation with each mandatory audit is considered by some specialties as not possible without further investment. In these cases, we would expect the risk to be addressed by the appropriate services where they can factor compliance with an audit into their other risks, business cases and key objectives.

Local Clinical Audit Programmes
The Clinical Audit Department (CAD) liaise with a number of services to establish a local programme each financial year. The 2025-26 programme has been split into 6 monthly sections to allow services more opportunities to contribute and create more accurate time frames for audit commencement and completion.

The April-September 2025-26 programme included 30 audits from 12 different committees/ groups. The 45 National audits are automatically included as standard. A number of the groups are no longer running and have now been superseded by the Clinical Care Group structure.

The October-March 2025-26 programme is currently being compiled and the Clinical Audit Department have written out to a number of groups including the Clinical Care Groups. All Clinical Care Groups have clinical audit on their quality agendas and include clinical audit representation.

Audit Management and Tracking (AMAT) Software
The CAD are implementing the AMAT software within the Health Board. All clinical audit projects are now registered via the system. Outputs are also monitored through this system. The system is being used as a data collection platform. The transparency and ease of access of the system is proving very beneficial, as it can be widely accessed by all users. The roll-out of the system requires the training of various staff, and ad hoc training is also provided.

Asesiad / Assessment

Clinical Audit Department
As of April 2025, the Clinical Audit Department have been moved to sit within the Medical Directorate. This has been welcomed as a positive move, to allow further integration with the Medical Directorate teams (e.g. Medical Education and Clinical Effectiveness) and the Clinical Audit Manager meets regularly with the other Directorate teams.

Audit Management and Tracking (AMAT) Software
The Ward & Area module is now up and running, with a total of 11 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 fall primarily under the nursing remit. Outputs are monitored through various groups and actions are embedded within AMAT and are carried out regularly. An additional 10 audits are currently being planned.

Funding for the AMAT system is secured from the Medical Directorate until 2026. Funding beyond this has also been secured and AMAT is being considered as part of the Digital Programme.

A total of 223 audits have been completed on the system since it was implemented. All of this information is available for all users to view and learn from, as the system offers high levels of transparency.

National Clinical Audit
The Health Board is contributing to all of the mandatory national projects. 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)
- 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 and provide an improvement plan. Services also have the option of applying to the Quality Impact Assessment Panel for further support.

More detailed information about the status of each registered audit is available on request.

Clinical Audit Programme 2025/26
Letters were sent to owning groups regarding the October-March 2025/26 CAP, with a deadline for submission of 30 September 2025. The new programme will largely feature the continued audits from the previous programme, with a small number having already been completed. A total of 45 National audits will be included.

The current programme is attached for information (Appendix 2).

Shared Learning
The CAD are continuing to hold Whole Hospital and Whole Health Board Audit meetings. An additional two events have been held since last reporting.

The CAD continue to support the Enabling Quality Improvement in Practice (EQIiP) programme by attending event days and giving presentations on the links between QI and Clinical Audit and how they can complement each other. The most recent event was held on 9 July 2025, where a presentation on the links between Quality Improvement and Clinical Audit was given, as well as a clinical audit "market stall". A number of groups from the day have come forward and made links with the CAD.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to:

- **TAKE ASSURANCE** from the increased use of Audit Management and Tracking (AMAT) software within the Health Board, as well as the secured funding for the system
- **TAKE ASSURANCE** from the continuation of the majority of mandatory national audits and the processes followed for escalation
- **TAKE ASSURANCE** from the integration of clinical audit within all Clinical Care Groups
- **NOTE** the development of the 2025/26 programme
- **TAKE ASSURANCE** from the continued shared learning through Whole Hospital and Whole Health Board Audit Meetings

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: Datix Risk Register Reference and Score:	Audit specific risks are included and owned by the Services and will feature on other risk registers.
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 Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Clinical Audit Manager Medical Director

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 2025-26

National Audit Title	Expected Participation 2025-26
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) National Diabetes Core Audit (PC)	Yes
NDA: National Diabetes Footcare	Yes
NDA: National Diabetes Inpatient Safety Audit (NDISA)	Yes
NDA: National Pregnancy in Diabetes Audit (NPID)	Yes
NDA: National Integrated Specialist Survey	Yes
NDA: Transition and Young Type 2 Audit	Yes
National Respiratory Audit Programme (NRAP) COPD Secondary Care	Yes
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) Myocardial Ischaemia National Audit Project (MINAP)	Yes
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

IJB, March 2025

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

Clinical Audit Programme (CAP) 2025-2026 (Apr-Sept)					
AUDIT CODE	**AUDIT STATUS**	**ORIGINATING COMMITTEE**	**SPECIALITY**	**AUDIT TITLE**	**REASON FOR INCLUSION**
Mat/CA/2024-25/01	In Progress	HDUHB W&CH'S QSE	Women & Child Health	Maternity Record Keeping Audit: January 2025 - January 2026	
Respiratory/CA/2024-25/01	In Progress	Respiratory Annual Forum	Respiratory	Acute NIV Re-audit	Deemed a critical priority by BTS. It forms part of the prioritised NRAP which the Health Board has committed to. On an even more urgent basis, concerns have been raised by frontline staff in at last ¼ of our hospitals that their NIV service is not safe. We must therefore compare all the data for HDUHB. Welsh and UK standards are calling for the establishment of RSSUs (Respiratory Support Units) in all hospitals admitting general medical /respiratory patients (post COVID). This would require very significant investment and new staff. I feel we do not need these RSSUs in HDUHB and satisfactory performance in this NIV unit would reassure me a lot.
Rost/WA/2025-26/01	In Progress	SNMT	Professional Standards Team	Rostering Audit	High Priority for Service
AWC/WA/2025-26/04	In Progress	SNMT	Professional Standards Team	Medicines Management Patient Audit - All Wales Core	All Wales agreed core audit
AWC/WA/2025-26/05	In Progress	SNMT	Professional Standards Team	Medicines Management Ward Audit - All Wales Core	All Wales agreed core audit
AWC/WA/2025-26/01	In Progress	SNMT	Professional Standards Team	Bare Below the Elbows - All Wales Core	All Wales agreed core audit
AWC/WA/2025-26/02	In Progress	SNMT	Professional Standards Team	Hand Hygiene - All Wales Core Audit	All Wales agreed core audit
AWC/WA/2025-26/03	In Progress	SNMT	Professional Standards Team	Personal Protective Equipment (PPE) - All Wales Core	All Wales agreed core audit
Falls/WA/2025-26/01	In Progress	SNMT	Professional Standards Team	Falls Management Audit	High Priority for Health Board
Cont/WA/2025-26/01	In Progress	SNMT	Professional Standards Team	Continence Care Audit	Ombudsmen Case
RADAR/WA/2025-26/02	In Progress	HDUHB RADAR	Cross Speciality Improvement	NEWS 2 and the Burden of Acute Illness	High priority audit – To ensure that all observations are being undertaken on the NEWS chart, that they are accurate and there is the appropriate response and escalation to patients who are deteriorating.
TBC	In Progress	Thrombosis	Thrombosis	RE-AUDIT '25 - Venous Thromboembolism Inpatients Audit NICE QS 201 S1 - Cycle 4	Improve compliance with the VTE risk assessment. Provide assurance of NICE Quality standards 201. Welsh risk pool have recently indicated that they may not support claims for hospital acquired thrombosis unless there is evidence of staff being trained and risk assessments being completed.
TBC	In Progress	Thrombosis	Thrombosis	RE-AUDIT '25 - Venous Thromboembolism Lower Limb Immobilisation Audit NICE QS 201 S2 - Cycle 4	Improve compliance with the VTE risk assessment. Provide assurance of NICE Quality standards 201. Welsh risk pool have recently indicated that they may not support claims for hospital acquired thrombosis unless there is evidence of staff being trained and risk assessments being completed.
TBC	In Progress	Thrombosis	Thrombosis	RE-AUDIT '25 - Venous Thromboembolism Outpatient Follow Up Audit NICE QS 201 S4 & S5 - Cycle 4	Improve compliance with the VTE risk assessment. Provide assurance of NICE Quality standards 201. Welsh risk pool have recently indicated that they may not support claims for hospital acquired thrombosis unless there is evidence of staff being trained and risk assessments being completed.

TBC	In Progress	Thrombosis	Thrombosis	RE-AUDIT '25 Venous Thromboembolism Radiology Referral USS Audit NICE QS 201 S3 (H61) - Cycle 2	Improve compliance with the VTE risk assessment. Provide assurance of NICE Quality standards 201. Welsh risk pool have recently indicated that they may not support claims for hospital acquired thrombosis unless there is evidence of staff being trained and risk assessments being completed.
Crit/CA/2023-24/01	Awaiting Action Plan	QSE	Critical Care	Central Line Care Bundle - A Clinical audit to Assess Compliance with the Completion of Care Bundles within Critical Care, HDUHB.	Critical care is undergoing Peer Review from the NHS executive in April 2024. We are required to supply evidence of audits completed re: care bundles used within our critical care units. This information will be relayed to the Welsh Government. There is currently no evidence of these audits being undertaken in the last 3 years, it is an expectation that these audits are undertaken and will therefore come under scrutiny from the NHS executive.
Crit/CA/2023-24/02	Awaiting Action Plan	QSE	Critical Care	Ventilator Care Bundle - A Clinical audit to Assess Compliance with the Completion of Care Bundles within Critical Care, HDUHB.	Critical care is undergoing Peer Review from the NHS executive in April 2024. We are required to supply evidence of audits completed re: care bundles used within our critical care units. This information will be relayed to the Welsh Government. There is currently no evidence of these audits being undertaken in the last 3 years, it is an expectation that these audits are undertaken and will therefore come under scrutiny from the NHS executive.
Path/CA/2023-24/04	Awaiting Action Plan	Blood Transfusion Committee	Haematology	Path/CA/2023-24/04: Audit of NICE Quality Standards QS138	Welsh Blood Service requires us on each site in Wales to run this every quarter to ensure standards are being met and are improving
Nutrition & Dietetics/CA/2025	Awaiting Action Plan	Nutrition and Hydration Group	Nutrition & Dietetics	Nasogastric Tube Insertion and Care Audit	To provide the Health Board with an understanding of current nasogastric tube insertion and care practice with doctors and nurses.
Crit/CA/2024-25/01	Awaiting Action Plan	QSE	Critical Care	Rehabilitation after critical illness in adults	The audit is to assess our compliance to the NICE CG83 guidelines in the provision of rehabilitation after critical illness. The data is intended to support the peer review process (Critical care network – welsh government) and provide an evidence base to outline areas of service deficit and as such areas for service development. Whilst currently we have anecdotal evidence of adherence to the guidelines, we have no measureable data. This audit will be essential to establish baseline for future service delivery targets. Provision of AHP staffing in Critical care and its subsequent impact on rehabilitation after critical illness is currently being drafted for inclusion on the risk register
Multiple/CA/2023-24/01	Complete (being implemented)	Mental Capacity and Consent Group	Mental Capacity and Consent	Welsh Risk Pool All Wales Peer Review Consent Audit	Required by Welsh Risk Pool as part of a national consent audit.
Multiple/CA/2024-25/02 (Form 4) Multiple/CA/2023-24/02 (Form 5)	Complete (being implemented)	Mental Capacity and Consent Group	Mental Capacity and Consent	Audit of Form 4: Treatment in Best Interests, Consent Form 5: Refusal of blood and blood products	To ensure compliance with the Mental Capacity Act and to protect the rights of patients who lack capacity to consent to their surgical procedure.

Smoke/CA/2024-25/02	Complete (being implemented)	Public Health & Wellbeing QSE	Smoking Cessation & Wellbeing	Smoke/CA/2024-25/02: Hywel Dda Inpatient Smoking Re-Audit -	Royal College of Physicians – Hiding in plain sight document - If smokers aren't identified routinely then they are not offered access to nicotine replacement to prevent withdrawal often leading to discomfort or aggression. Hospitalisation provides a teachable moment that prompts a long term quit in large numbers of smokers. Access to support prevents relapse on discharge but also prevents withdrawal during a hospital stay. Without this support 50% of those who have remained abstinent whilst in hospital will relapse within 2 days of discharge. Identification of smokers is vital to allow them to access medication to treat their withdrawal, to offer them support to remain smoke free but also as smoking has an impact on the metabolism of medication. The health board has to show report on its compliance with identification of smokers to NICE, Welsh Gov and central PHW. The Welsh Nursing Care Records provide the opportunity to electronically record smoking status and offers of help. This re-audit is to assess if there is any difference in the reliability of the reporting via this package and whether offers of support (both pharmacotherapy & behavioural support) are accepted by patients. Smoking prevalence has historically been higher in the inpatient population than in the general population yet the recent audit found this not to be the case according to WNCR (10% verses 12.5% in the general population)
TBC	Planning	Nutrition and Hydration Group	Nutrition & Dietetics	Meal Time Audit	
TBC	Planning	Nutrition and Hydration Group	Nutrition & Dietetics	Fluid Balance	
TBC	Planning	Hywel Dda Palliative and End of Life Care Group	Care of the Elderly	All Wales Care Decisions for the Last Days of Life (April 2024 - March 2025)	This is a national audit looking at the evidence the quality of care provided at the end of life in Wales
TBC	Planning	HDUHB Cardiology Quality, Safety & Assurance	Cardiology	TOE Audit	High Priority for Service
RADAR/WA/2025-26/03	Planning	HDUHB RADAR	Cross Speciality Improvement	Medical Emergency Trolley - Daily Audit	High priority audit
RADAR/WA/2025-26/04	Planning	HDUHB RADAR	Cross Speciality Improvement	Medical Emergency Trolley - Weekly Audit	High priority audit
RADAR/WA/2025-26/01	Discontinued	HDUHB RADAR	Cross Speciality Improvement	NEWS and the Burden of Acute Illness	High priority audit – To ensure that all observations are being undertaken on the NEWS chart, that they are accurate and there is the appropriate response and escalation to patients who are deteriorating.

5

10:50, 0 Mins

5 - NWSSP – Audit and Assurance Services - Internal Audit

5.1

10:50, 10 Mins

5.1 - Internal Audit Plan Progress Report

James Johns (NWSSP - Internal Audit)

For assurance

Attachments

5.1 SBAR IA Plan Progress Report October 2025.pdf

5.1 IA Plan Progress Report October 2025.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	14 October 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit & Assurance Services Progress Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Head of Internal Audit
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Internal Audit

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

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

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

Asesiad / Assessment

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

Argymhelliad / Recommendation

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

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

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

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

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

Enw Da: **Reputational:**	n/a
Gyfrinachedd: **Privacy:**	n/a
Cydraddoldeb: **Equality:**	n/a

Hywel Dda University Health Board

Audit & Risk Assurance Committee

October 2025

Audit & Assurance Services
Internal Audit Progress Report

CONTENTS

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

Appendix A - Assignment Status Schedule
Appendix B - Audit Approach - Sampling

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
Emergency Department Data Validation	**Limited**
Human Tissue Authority Compliance	**Limited**
Commissioning Long Term Agreements	**Reasonable**
Control of Contractors Policy (Advisory)	n/a
Capital Governance (Advisory)	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 to ensure effective management of the available resources.

3.2 Audit work at the start of 2025/26 has progressed well with eight audits finalised, as well as several others at the fieldwork and planning stages.

3.3 The current position of the audits that have not made the Committee deadline are summarised in the table below.

Audit	Status	Current Position/ comments	ARAC
Vaccination and Immunisation	Field work complete	Aligning work with that at another UHB to aid comparison of current practice and arrangements in place.	Dec

3.4 As a result of ongoing planning discussions, the Health Board has asked to defer the Fragility in Primary Care Corporate Risk audit as a reassessment of risks in this area have taken place. In addition, we recently have had discussions around deferring the Complaints audit due to pending changes to the Putting Things Right regulations which will require implementation. Additional follow-up audit work will also be required later in this audit year looking at the implementation of agreed actions from the limited assurance reviews.

3.5 Regular meetings with the Director of Corporate Governance have continued, along with meetings taking place with Executive Directors and senior managers in relation to audits currently being planned and delivered. The UHB Board meetings have been observed, with ongoing liaison meetings with Counter Fraud, Audit Wales and Health Inspectorate Wales continuing.

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

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

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

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

APPENDIX B - Note on Sampling as part of our audit approach.

The internal Audit assignment planning process will determine the approach and scope for the audit, and the approach can vary from audit to audit. This could be for example a high-level review of strategy and action plans, a newly implemented system, compliance with regulations or procedures, or a transactional based system.

As part of the assignment planning process, we will consider a number of factors associated with the control environment in place to manage the associated risks for that area, including the design of controls, the alignment between the controls and the risks identified, the nature of the control, frequency of the control and period covered by the control. Internal audit testing can look at the control design and the operation of the controls.

Where the audit approach contains sample testing, there are a range of approaches that can be taken with the sample selection guided by several factors including sample population, control frequency, and risk level. Our approach is in line with established good practice sampling methodology.

The table below sets out example traditional sample sizes based on population and frequency of control. It is important to recognise that other factors are considered when selecting the sample including audit objectives, data trend analysis, high risk areas, outcomes of other audit work, organisational configuration and structure.

Frequency of Control	**Population**	**Sample size Guide**
Annual	1	1
Quarterly	4	2
Monthly	12	2 (min) – 5 (max)
Weekly	52	5-15
Daily	25	20-40
Multiple times a day	Over 250	25-60 (30-45 mid range)

Office details: Audit & Assurance Services West Team

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

5.2

11:00, 20 Mins

5.2 - Validation of Emergency Department Waiting Time Data (Limited Assurance)

James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Gareth Cottrell (Hywel Dda UHB - Deputy Chief Operating Officer), Keith Jones (Hywel Dda UHB - Director of Operational Planning & Performance), Peter Skitt (Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine), Anna Chiffi (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality)

For assurance

Attachments

5.2 Validation of ED Waiting Time Data Final IA Report.pdf

Validation of Emergency Department Waiting Time Data

Final Internal Audit Report

2025/26

Hywel Dda University Health Board

Limited Assurance

Contents

Executive Summary 1

Findings & Agreed Action Plan 4

Appendix A 8

Review Reference	HDU-2425-07
Fieldwork	August 25
Executive Sign Off	30 September 25
Audit Committee	October 25
Executive Lead	Andrew Carruthers, Chief Operating Officer
Audit Team	James Johns, Head of Internal Audit Sophie Corbett, Deputy Head of Internal Audit

Executive Summary

Purpose

The NHS Wales Performance Framework 2025-26 sets out performance measures mapped to the 'A Healthier Wales' quadruple aims, with aim 2 focusing on the measures for urgent and emergency care. This audit has focused on measure 23 and implementation of the Emergency Department (ED) 4-hour Breach Validation Standard Operating Procedure.

23. Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission transfer or discharge [target = 95%]

Overview

Time spent in the ED is captured and accurately calculated within the WPAS system although data quality issues were identified with the completion of casualty cards, with some missing the information required to determine whether or not a breach is exempt from reporting.

We were provided with a copy of a Standard Operating Procedure for breach validation although issues were identified which require addressing for it to adequately meet operational requirements. Additional guidance is available to support staff in the correct application of breach reasons.

Arrangements are in place for validation of breaches at each site reviewed and the approach to validation is consistent although the level of clinical involvement varied. Our testing found the validation to be effective at GGH, WGH and PPH. Validation at BGH only commenced in April 2025 and we identified that nearly 40% of breaches[1] had not been validated due to an unresolved system access issue, so there is a risk of under/over-reporting of breaches both internally and externally to Welsh Government.

A record of breaches validated is not maintained so there is no source of assurance that all breaches are validated. An audit trail of validation amendments is maintained by the system but this information is not fed back to EDs to facilitate learning and improve data quality.

Performance monitoring arrangements are inconsistent, with no evidence of service-level monitoring at two sites. However, good arrangements were observed within the Carmarthenshire System which is also demonstrating an improving trend in 4-hour breaches (see page 3). There is evidence of ED waiting time data reported within both the operational governance and Health Board assurance committee structures.

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

- Completion of casualty cards with requisite information to facilitate breach validation *[Medium]*
- The SOP requires updating and formal dissemination to relevant staff *[Medium]*
- No source of assurance that all breaches are validated *[Medium]*
- Inconsistency in clinical involvement in the validation process *[Medium]*
- Significant proportion of breaches at BGH are not subject to validation *[High]*
- Inconsistent performance monitoring arrangements *[High]*

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

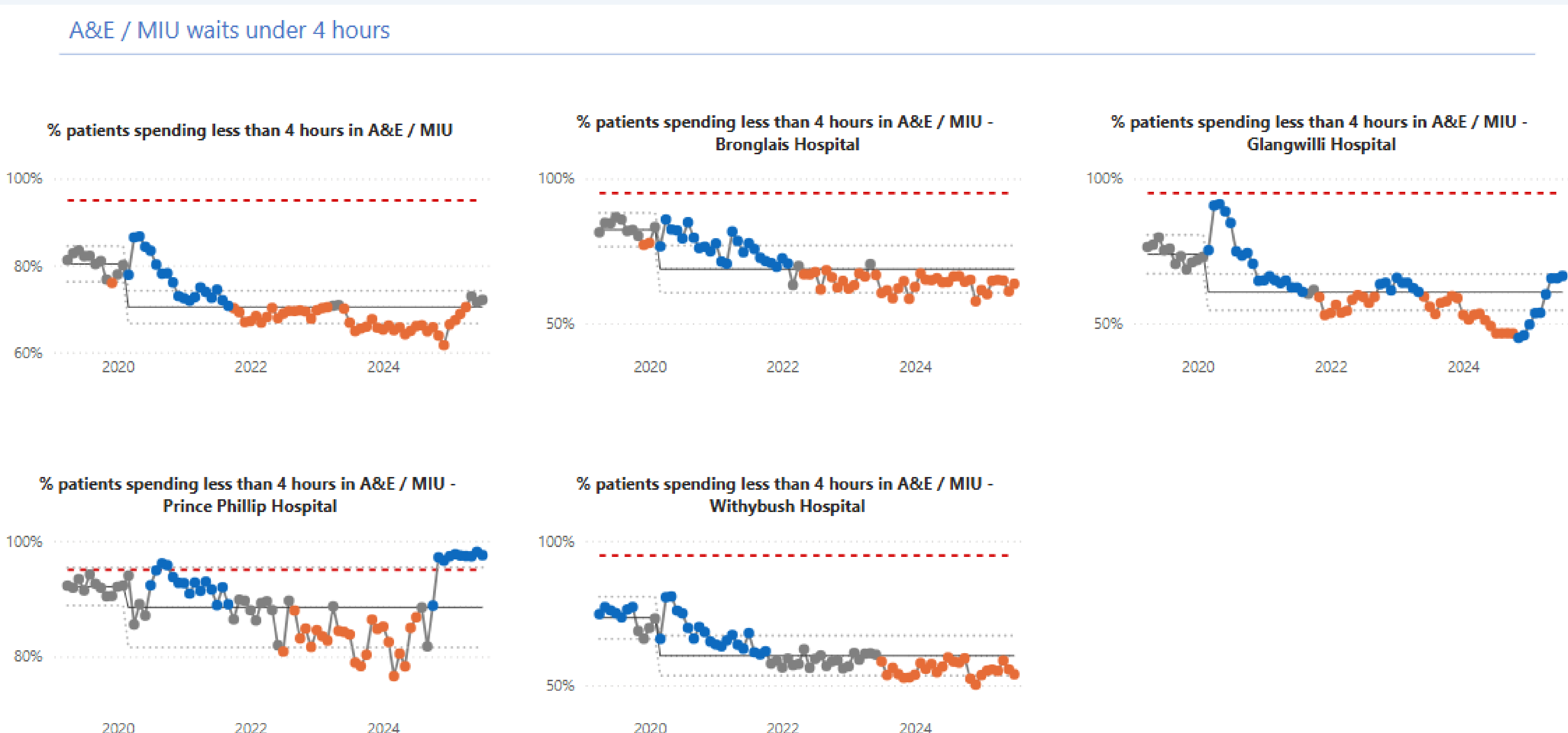
[1] During the period 1 May – 7 August 2025

Scope & Assurance Summary

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

	Objectives	Related Findings	Assurance
1	Waiting time data is accurately captured and calculated.	1	**Reasonable**
2	Data validation processes ensure that reported data is complete, accurate and timely with appropriate and consistent application of the SOP and breach exemption rules.	2 - 5	**Limited**
3	Timely monitoring and review of performance takes place at appropriate forums within the Health Board.	6	**Reasonable**

ED Waiting Time Data



Source: HDUHB IPAR as at 31st July 2025

Findings & Agreed Action Plan

Objective 1: Waiting time data is accurately captured and calculated — Reasonable

Overview

Waiting time data is captured and calculated within the Welsh Patient Administration System (WPAS) based on the time the patient presents at ED reception and when the attendance is closed on return of the casualty card to reception. Review of WPAS data for ED attendances during the period 1st May – 7 August 2025 confirmed that the requisite fields had been populated, and consequently the time in department calculated, in all cases. Re-performance of a small sample confirmed accuracy of this system calculation.

Time in department of 4 hours or more is considered a breach, unless one of the Welsh Government breach exemptions applies. Additional information about the patient journey is required from the casualty card to determine whether a breach is exempt. Sample testing of ED visits identified that 52% of casualty cards reviewed had time stamps missing. In all cases reviewed the information was available elsewhere within WPAS, but this relies on the validator investigating and searching for it which hinders the efficiency and effectiveness of the validation process. **[Finding 1]**

	Key Findings	Risk & Impact	Agreed Management Action
1	**Completion of Casualty Cards** Sample testing of 40 ED visits during the period May – August 2025 identified 21 instances where the casualty card was incomplete, with information such as the time of referral for diagnostics or request for a bed not recorded. Gaps in completion were more evident in WGH and BGH where there is greater reliance on locum medical staff, and some individuals we spoke with cited limited clinician engagement with the 4-hour target.	Breaches are not validated or are validated incorrectly, resulting in under/over-reporting of performance against the 4-hour target.	**Agreed Action:** Escalation to the Medical Director to reinforce with clinical teams the significance of the 4-hour target and importance of fully documenting the patient journey on the casualty cards. **Expected Evidence of Implementation:** Correspondence to clinical teams
		Medium Priority	**Officer:** Peter Skitt, Community & Integrated Medicine Clinical Care Group Service Director
	Theme: Information, Data Quality & Data Accuracy	Control Design	**Target Implementation Date:** 31st October 2025

Objective 2: Data validation processes ensure that reported data is complete, accurate and timely, with appropriate and consistent application of the SOP and breach exemption rules	Limited

The standard operating procedure (SOP) outlines the high-level process and requirements for validating breaches of the 4-hour target. We identified issues with the SOP which require addressing – these are detailed at **[Finding 2]**. Information Services have developed a WPAS ED Breach Reason Guide to support in the correct application of breach reasons.

Visits to the EDs in Glangwili (GGH), Withybush (WGH) and Bronglais (BGH) General Hospitals, and the Minor Injury Unity (MIU) at Prince Philip Hospital (PPH) confirmed that arrangements are in place at each site to undertake breach validation. Validation has only been undertaken at BGH since April 2025 when there was a change in General Manager. We were advised that validation is undertaken at all sites every weekday however validation is not documented so there is no evidence to confirm this. **[Finding 3]**

The SOP states that "all relevant ED clinical notes and information will be reviewed by an ED Unit Manager" (a band 7 clinical role). This is case in GGH and PPH, but in WGH and BGH validation is undertaken by administrative (non-clinical) staff. **[Finding 4]**

Validation was reperformed for a sample of 40 breaches across the four sites. Instances were identified where the breach flag and/or reason stipulated by the clinician at the time of ED attendance was incorrect but there was evidence that this had been corrected as part of the validation process, confirm that validation is taking place. No issues were identified for GGH, PPH or WGH. However, our testing revealed a wider issue at BGH where due to a system access issue nearly 40% of records cannot be amended by the validator and are therefore not subject to validation, so there is a risk of under/over-reporting of breaches. **[Finding 5]**

	Key Findings	Risk & Impact	Agreed Management Action
2	**Standard Operating Procedure** • the SOP does not identify the author, implementation or review dates and we have been unable to identify the source of the SOP. • it is not clear if or when the SOP has been communicated to or how it is accessible to staff. During our site visits some staff were of unaware of the document. • the SOP requires "validated non-breaches" (i.e. where an exemption applies) to be changed to 3:59 wait time but this is not done in practice and not necessary because breach reporting is based on the selected breach flag rather than the time in department.	Breaches are not validated or are validated incorrectly, resulting in under/over-reporting of performance against the 4-hour target.	**Agreed Action:** The SOP will be updated to address the issues identified, and approved by an appropriate forum. The revised SOP will be formally communicated with relevant staff and accessible on the intranet. **Expected Evidence of Implementation:** Updated SOP. Evidence of dissemination to relevant staff.
		Medium Priority	**Officer:** Peter Skitt, Community & Integrated Medicine Clinical Care Group Service Director
	Theme: Policies & Procedures	Control Design	**Target Implementation Date:** 28th November 2025
3	**Audit Trail** WPAS does not have the functionality to evidence or record where an ED attendance/breach has been validated, although	Poor data quality Inefficient use of resources	**Agreed Action:** The ED attendance reports used for validation will be annotated to identify the records subject to validation.

No.	Finding	Risk	Recommendation / Agreed Action
	the system does maintain an audit trail of amendments made as part of the validation process. Reports of amendments were requested for the sample of 40 ED attendances we reviewed, but we were advised that this could not be provided. This information could support the identification of common errors or areas with frequent errors (both in terms of documenting the ED attendance, and the subsequent validation process) to support learning, enhance data quality and improve the efficiency of breach validation.		Information Services to provide routine reports of amendments to records as part of the validation process, to facilitate learning and improve data quality.
			Expected Evidence of Implementation: Record of breaches that have been validated. WPAS audit trail reports shared with EDs, and evidence that these are reviewed/analysed to identify learning.
		Medium Priority	**Officer:** Peter Skitt, Community & Integrated Medicine Clinical Care Group Service Director
	Theme: Reporting	Control Design	**Target Implementation Date:** 31st December 2025
4	**Requirement for Validation by Clinical Role** The SOP states that "all relevant ED clinical notes and information will be reviewed by an ED Unit Manager" (a band 7 clinical role). This is case in GGH and PPH, but in WGH and BGH validation is undertaken by administrative (non-clinical) staff.	Incorrect application of breach exemptions, resulting in under/over-reporting of performance against the 4-hour target.	**Agreed Action:** The validation process and associated roles and responsibilities as per the SOP will be reassessed to determine the extent of clinical involvement required and ensure appropriate use of clinical time. Training needs of any non-clinical roles involved will be assessed and fulfilled.
			Expected Evidence of Implementation: Validation undertaken by clinical roles as per the current SOP, or requirements updated in the SOP where appropriate. Evidence of training needs assessed/training provided, where applicable.
		Medium Priority	**Officer: Anna Chiffi**, Assistant Director of Nursing Patient Safety & Quality
	Theme: Governance	Control Operation	**Target Implementation Date:** 31st December 2025
5	**Breach Validation at BGH** Validation was reperformed for a sample of 40 breaches across the four sites. Our sample was selected from a WPAS report of ED attendances (pre-validation) during the period 1 May – 7 August 2025. Three instances were identified for BGH where a breach was incorrectly flagged as exempt by the clinician and this had not been corrected as part of validation. It transpired that in these instances the breach reason had not been stipulated by the clinician and where this is the case, the validator is unable to amend the breach flag/reason due to a system access restriction.	Incorrect application of breach exemptions, resulting in under/over-reporting of performance against the 4-hour target.	**Agreed Action:** The system access issue will be escalated to IT to resolve as a matter of urgency, to ensure that 100% breach validation can resume for BGH at the earliest opportunity. The outcome of finding/action 4 may impact on the longer-term validation arrangements.
			Expected Evidence of Implementation:

	Analysis of WPAS data for ED attendances (pre-validation) during the period 1st May – 7 August 2025 identified 1225 instances (out of 3244 ED attendances where time in department exceeded 4 hours) where the breach reason for BGH had not been populated by the clinician and therefore the record would not be editable by the validator. We were advised that these records (37.8%) are not validated for this reason. There is a risk that these breaches have been under/over reported to WG.		Email correspondence with IT to confirm system access issue resolved. Record of breaches that have been validated (links to finding/action 3) confirming that all breaches are being validated for BGH.
		High Priority	**Officer:** Peter Skitt, Community & Integrated Medicine Clinical Care Group Service Director
	Theme: Information, Data Quality & Data Accuracy	Control Design	**Target Implementation Date:** 31st December 2025

Objective 3: Timely monitoring and review of performance takes place at appropriate forums within the Health Board — Reasonable

The 4-hour performance data is discussed at the Weekly Performance Escalation meeting for the Carmarthenshire System, with a recent action to investigate what can be done to address the cause of the breach reasons and improve performance. The graphs on page 3 demonstrate an improving trend for GGH and PPH. There are no such monitoring arrangements for the Pembrokeshire and Ceredigion Systems. **[Finding 6]**

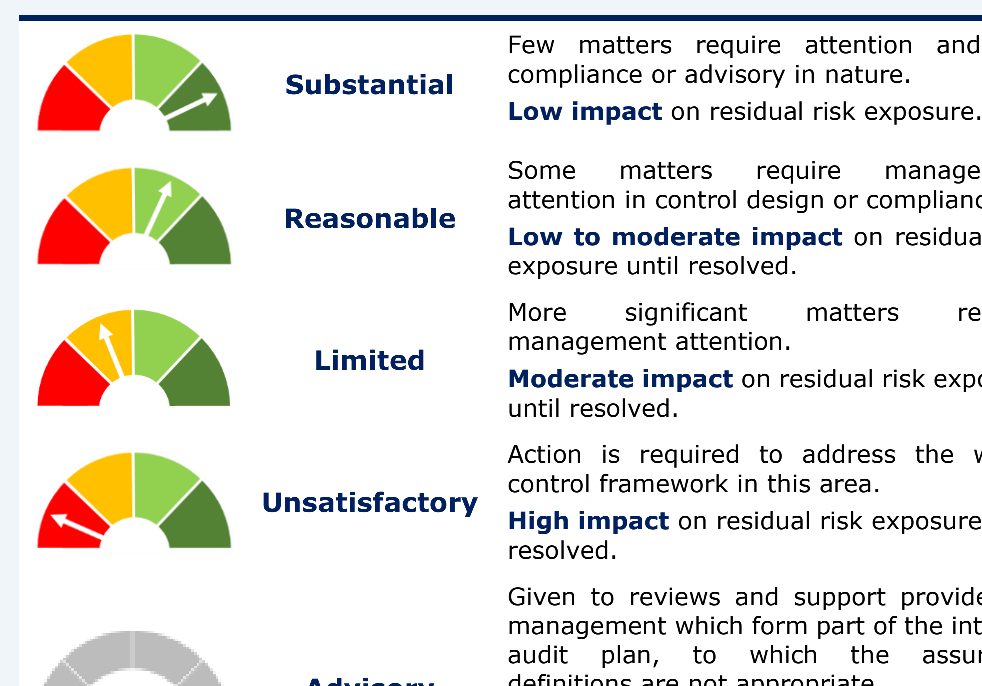
ED waiting time data features in the Performance Exception Report and UEC Six Goals Programme Update to IQFPD, although these have focused on the number of patients spending over 12 hours in ED/MIU (for which there is no target) rather than the 4-hour target.

The percentage of patients spending less than 4 hours in the ED / MIU is a key metric reported within the Integrated Performance Assurance Report (IPAR) presented at each meeting of the Finance & Performance Committee and Health Board. Performance as at 31st July 2025 was reported as 72.1% against the 95% target and highlighted as an 'alert' under the 3As reporting.

Key Findings		Risk & Impact	Agreed Management Action
6	**Inconsistent Monitoring Arrangements** There is no evidence that 4-hour breach data for WGH and BGH is monitored or reported to appropriate forum(s) to aid learning and to improve performance.	Learning is not identified and used to improve performance. Inconsistency across ED / MIU sites.	**Agreed Action:** The performance monitoring arrangements for GGH and PPH will be implemented for BGH and WGH.
			Expected Evidence of Implementation: Minutes/actions evidencing monitoring and reporting of 4-hour performance at appropriate service level forum(s)
		High Priority	**Officer:** Peter Skitt, Community & Integrated Medicine Clinical Care Group Service Director
	Theme: Performance Monitoring	Control Design	**Target Implementation Date:** 28th November 2025

Appendix A

Assurance Opinion



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

Prioritisation of Findings

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

Disclaimer

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

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

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

5.3

11:20, 20 Mins

5.3 - Human Tissue Authority (Limited Assurance)

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)

For assurance

Attachments

5.3 HTA Final IA Report.pdf

Human Tissue Authority

Final Internal Audit Report

2025/26

Hywel Dda University Health Board

Limited Assurance

Contents

Executive Summary 1

Findings & Agreed Action Plan 3

Appendix A 9

Review Reference	HDU-2526-21
Fieldwork	August – September 2025
Executive Sign Off	2 October 2025
Audit Committee	October 2025
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

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

Executive Summary

Purpose

To provide assurance over the systems and controls in place for the management and monitoring of activities under the scope of the *Human Tissue Act 2004*.

The Human Tissue Authority (HTA) is a UK government regulatory body established under the *Human Tissue Act 2004* ('the Act') to oversee the legal and ethical framework governing the removal, storage, use, and disposal of human tissue and organs in England, Wales and Northern Ireland. NHS organisations are required to obtain a licence from the HTA to undertake post-mortem examinations and to store human tissue. Organisations must maintain comprehensive and accurate records of consent, storage conditions and the use and disposal of tissue. Compliance with the Act is essential to ensure ethical and lawful handling of human tissue and to maintain HTA licences required for mortuary services.

Overview

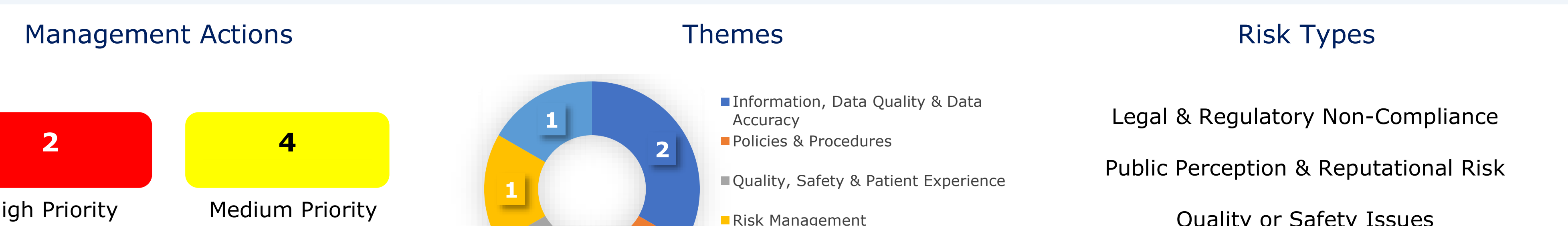
Our review confirmed compliance with key HTA standards in relation to the secure storage of tissue and adherence to family wishes regarding disposal. Tissue samples for all active cases reviewed could be physically located and verified, although we identified instances of missing and incomplete forms and records for both active and closed (disposed) cases, compromising full traceability. We also identified instances of delayed disposals resulting in tissue being held without consent, these had not been reported to the HTA as 'reportable incidents' (HTARIs). The mortuary service undertakes a programme of compliance audits although there is no evidence that action is taken to address areas of non-compliance. We confirmed that HTA regulations compliance matters are regularly reviewed via the internal reporting structure with significant matters escalated through the governance groups and committees. We have concluded **Limited** assurance on this area. Matters requiring management attention include:

- Procedures and associated documentation require review and updating to reflect existing working arrangements under one site (GGH) and remove duplication
- Low compliance with competency requirements and discrepancies in competency records
- Central record of tissue samples requires enhancement to provide oversight of tissue location and case progress tracking
- Missing and incomplete traceability documentation
- Delays in tissue disposal and inappropriate retention of tissue without consent
- Risks in the risk register are overdue for review

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

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	Comprehensive and accurate records of consent, storage conditions and the use and disposal of human tissue are maintained, ensuring full traceability from donor to final use or disposal	1, 2, 3, 4, 5	**Limited**
2	There is oversight and monitoring of compliance with the Act, with regular assurance reporting via Health Board governance structures	4, 5, 6	**Reasonable**


Management Actions
2
High Priority
4
Medium Priority
Themes
2
1
1
1
1
Information, Data Quality & Data Accuracy
Policies & Procedures
Quality, Safety & Patient Experience
Risk Management
Training & Development
Risk Types
Legal & Regulatory Non-Compliance
Public Perception & Reputational Risk
Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: Comprehensive and accurate records of consent, storage conditions and the use and disposal of human tissue are maintained, ensuring full traceability from donor to final use or disposal	**Limited**

Overview / Summary of Observations

Glangwili General Hospital (GGH) is the sole licensed facility for the Health Board for undertaking postmortems (PMs), following the removal of Withybush General Hospital as a back-up facility. The Health Board's HTA licence authorises the removal and storage of human tissue for a range of scheduled purposes including determining cause of death. The licence is displayed within the mortuary at GGH.

Historically each hospital site has operated with its own set of Standard Operating Procedures (SOPs) for licensed activities, resulting in multiple versions and site-specific forms, and we observed examples of information duplicated across multiple forms. The intention is that SOPs will be updated as part of the standardisation for the regional mortuary with Swansea Bay UHB. This will be a significant undertaking and there is no plan in place setting out how and when it will be achieved. **[Finding 1]**

Review of staff training records revealed gaps in competency training for a number of staff. **[Finding 2]** Training compliance is discussed at the HTA Operational Group and the HTA Assurance Group, which reports to the Quality, Safety & Experience Sub-Committee (QSESC). The Regional HTA Assurance Group Update Report (September 2025) reported that the overall compliance position for mortuary staff training was 52% as of 22 August 2025, an improvement on the 34% in July 2025.

Tissue samples removed during PMs and retained as blocks and slides were found to be securely stored under appropriate conditions with access restricted. A central record of PMs and related tissue samples is maintained in the form of a spreadsheet. However, it 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. **[Finding 3]**

Sample review of active and closed PM cases to assess tissue traceability from donor to use and disposal identified several instances of missing or incomplete forms, although we were able to trace and physically verify the tissue samples for active cases. **[Finding 4]**

The tissue retention period as per the HTA standards is 14 weeks after the Closure of Investigation (COI) date notified by the Coroner. Sample testing identified errors in calculating the retention expiry date, delayed disposals and instances where tissue was being inappropriately retained. We were advised that in some cases these may be due to delayed notification of COI from the Coroner although there was no means of verifying this. HTA standards state that discovery of retained tissue blocks or slides that should have been disposed of and instances of unnecessary delays in disposal are 'HTA reportable incidents' (HTARIs) – the instances identified had not been reported. **[Finding 5]**

	Key Findings	Risk & Impact	Agreed Management Action
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	Outdated and inefficient SOPs and forms that don't reflect the current arrangements and/or best practice.	**Agreed Action:** Hywel Dda SOPS and forms will be reviewed and consolidated to ensure all Hywel Dda mortuaries work to the same standardisation of practice and consistency of information. An action plan will be developed to achieve this.

No.	Finding	Risk	Action
	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.		**Expected Evidence of Implementation:** Document review identifying duplication/discrepancies. Documented action plan with timescales for achievement.
		Medium Priority	**Officer:** Hannah Albery, Pathology Quality Manager
	Theme: Policies & Procedures	Control Design	**Target Implementation Date:** 31/12/2025 (for the action plan to be put in place)
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+ • 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.	Staff are not competent to perform their role which could impact on service capacity and quality and compliance with the Act	**Agreed Action:** Gap analysis to be undertaken to identify where records have not been uploaded to the QMS and where records have not been fully completed. Review recent audit undertaken (September 2025) of compliance with training and competences and assign target dates for completion – target dates to be updated in the QMS so ongoing compliance can be monitored. Ensure renewal period is defined in the QMS so that automatic reminders are sent to staff when training/competences are due for renewal. A competency compliance target will be determined and monitored at the HTA Operational Group.
			Expected Evidence of Implementation: Output from gap analysis. Agreed competency compliance target. Improving trend in the competency compliance rate.
	The overall compliance position for mortuary staff training was 51% as at 22 August 2025.	**Medium Priority**	**Officer:** Cathy Cenayko, Mortuary Manager **Target Implementation Date:** 31/12/2025
	Theme: Training & Development	Control Operation	
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	Tissue samples are not traceable from donor to disposal. Non-compliance with the Human Tissue Act, potentially resulting in sanction	**Agreed Action:** The central tracker will be further enhanced to ensure full traceability of tissue samples. Flowchart of the tissue traceability process to be created. Robust process to be implemented to proactively chase outstanding paperwork from external stakeholders.

	PM date, incorrect number of slides recorded as disposed, items recorded as disposed but still retained.	imposed by the HTA (e.g. loss of licence) causing service disruption and reputational damage.	The existing programme of audits will be further enhanced to include reconciliation of case records to the central tracker to identify and correct any discrepancies. **Expected Evidence of Implementation:** Updated central tracker spreadsheet. Flowchart of Traceability Process Audits evidence reconciliation of case records to central tracker.
		Medium Priority	**Officer:** Yasmin Brown, Regional Mortuary Manager **Target Implementation Date:** 31/12/2025
	Theme: Information, Data Quality & Data Accuracy	Control Design	
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.	Tissue samples are not traceable from donor to disposal. Non-compliance with the Human Tissue Act, potentially resulting in sanction imposed by the HTA (e.g. loss of licence) causing service disruption and reputational damage.	**Agreed Action:** Compliance with SOPs and completion of required documentation to ensure full traceability of tissue samples will be monitored via the existing audit programme. Standards of record keeping document to be recirculated to staff. Audit template and frequency of audit to be reviewed. Monthly Quality meetings to be established to enable more in-depth discussion of audits and audit findings. **Expected Evidence of Implementation:** Minutes of monthly quality meetings demonstrating discussion of completed audits and non-compliances discussed Standards of record keeping disseminated to staff Updated audit template (where applicable)
		High Priority	**Officer:** Hannah Albery, Pathology Quality Manager **Target Implementation Date:** 31/12/2025
	Theme: Information, Data Quality & Data Accuracy	Control Operation	
5	**Delayed Disposals / Prolonged Retention of Tissue** Sample testing of 15 active and 15 closed cases identified:	Unlawful retention of tissue samples without consent, in	**Agreed Action:** The tissue being held without consent has been disposed of immediately and in accordance with SOPs.

	• 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.	breach of the Human Tissue Act, potentially resulting in sanction imposed by the HTA (e.g. loss of licence) causing service disruption and reputational damage.	The individual cases identified will be reviewed and reported to HTA as a HTARI if appropriate. The central tracker spreadsheet will be enhanced to auto-calculate the retention expiry date based on the Coroner's investigation closed date. Paper correspondence from the Coroner will be date stamped on receipt and the central tracker spreadsheet will be enhanced to record the date that the confirmation of investigation closure is received by the mortuary. Follow-up correspondence with the Coroner's Office will be documented on the case file. If this demonstrates recurring issues with the timeliness of correspondence from the Coroner the issue will be formally escalated to the Coroner's Office by the Mortuary and then via the HTA governance structure if the issue isn't resolved. Meeting was held with HM Coroner on the 26/09/25 and a review of whole tissue traceability system is to be scheduled for October 2025.
			Expected Evidence of Implementation: Disposal forms for the tissue held without consent. Updated central tracker spreadsheet. For the individual cases identified - evidence of HTARI reporting, or justification as to why it is not applicable. Output of review of tissue traceability system. If applicable, evidence of correspondence with the Coroner's Officer re delayed communication.
		High Priority	**Officer:** Craig Baker, Cellular Pathology Service Delivery Manager
	Theme: Quality, Safety & Patient Experience	Control Design	**Target Implementation Date:** 31/12/2025

Objective 2: There is oversight and monitoring of compliance with the Act, with regular assurance reporting via Health Board governance structures	Reasonable

Overview / Summary of Observations

We reviewed mortuary related incidents recorded in Datix over the past 12 months to establish whether incidents are recorded, reviewed and corrective actions taken. There were 14 incidents recorded in Datix, although none relate to tissue samples. All but three incidents are closed. We confirmed that incidents are a standing agenda item for the HTA Operational Group and HTA Assurance Group, which evidence discussion and action taken. Datix incidents and HTARIs have also been considered at the Clinical Care Group Integrated Governance Group and escalated to the IQFPD via the Alert, Advise, Assure templates. As highlighted under objective one, our sample testing identified instances of delayed disposal and retained tissue which had not been reported as incidents either internally via Datix or externally to the HTA. **[Finding 5]**

Mortuary Services undertake a programme of audits to monitor HTA compliance of tissue blocks and slides held by the Health Board. A schedule of monthly audits is maintained in the QMS. Review of a sample of completed Tissue Traceability, Blocks and Slides and Tissue/Organs audits noted that a number of non-compliances had been identified in the audits, however there is no evidence that audit findings were followed up or addressed. An action to address this has been raised at **Finding 4**.

Risks associated with the mortuary service and compliance with Human Tissue Authority (HTA) standards are documented within the organisational risk register. Mitigating actions have been identified and are subject to ongoing monitoring through the HTA Assurance Group. Evidence was observed of risk escalation through the Clinical Care Group (CCG) governance structure, with reporting to the Quality, Safety and Experience Sub-Committee (QSESC). Risk 1552 is also scheduled for presentation to the Formal Executive Team in September for approval to escalate to the Corporate Risk Register. The current review dates for risk actions are June/July 2025, therefore, a review of progress and updates to risks and associated actions are now required. **[Finding 6]**

We confirmed that HTA compliance matters are regularly reported internally via the HD HTA Operational Group and HD HTA Assurance Group. The HTA Assurance Group provides oversight and assurance to the QSESC regarding the Health Board's responsibilities under the HTA licence and we saw evidence that QSESC receives updates from the HTA Assurance Group.

Pathology is part of the Allied Health and Health Sciences Clinical Care Group (CCG) and its IGG meets fortnightly to discuss planning, performance and people, and quality and safety maters. We observed HTA compliance updates being provided to these meetings, including assurance that findings from the 2024 HTA inspection have been addressed. However, our sample testing contradicts this and indicates that some of the issues identified in the HTA inspection have not been addressed – findings have been raised under objective 1 to address these.

Key Findings		Risk & Impact	Agreed Management Action
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.	Risks in relation to HTA compliance are not identified and mitigated	**Agreed Action:** The risk register will be reviewed and updated and reported to the HTA Assurance Group. Mortuary manager to receive risk register training to increase the number of staff able to provide updates on risks.
			Expected Evidence of Implementation:

			Updated risk register. Evidence of reporting to/discussion at HTA Assurance Group
		Medium Priority	**Officer:** Craig Baker, Cellular Pathology Service Delivery Manager
	Theme: Risk Management	Control Operation	**Target Implementation Date:** 31/12/2025

Appendix A

Assurance Opinion

Opinion	Description
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

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

5.4

11:40, 10 Mins

5.4 - Control of Contractors (Advisory Report)

James Johns (NWSSP - Internal Audit), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)

For assurance

Attachments

5.4 Control of Contractors Final IA Advisory Report.pdf

Control Of Contractors – Policy Review

1. Introduction

This advisory note has been prepared following our review of the Health Board's Control of Contractors policy, with specific reference to how it addresses Right to Work (RTW) requirements in the UK. The purpose of the review was to consider whether the policy reflects current good practice in ensuring that individuals engaged through contracting arrangements are subject to appropriate RTW checks. This note recognises the update provided to the Audit and Risk Assurance Committee meeting held on the 24th of June 2025 and associated risk assessments. The note also recognises the recent positive actions in respect of the contractual arrangements applied at Health Board capital schemed. In this context this advisory note seeks to highlight management considerations intended to support the ongoing development and strengthening of the policy in line with legal and regulatory expectations.

2. Scope

The Estates Control of Contractors policy No 541 dated March 2025 and wider UHB Control of Contractors procedures were reviewed by NWSSP – Audit and Assurance Services to ensure that appropriate arrangements for the Right to Work in the UK are appropriately addressed.

3. Observations and Considerations

Management Consideration 1

Under the Immigration, Asylum and Nationality Act 2006, employers must ensure that anyone working on their premises has the legal right to work in the UK—even if they are employed through a third party (e.g. contractors or subcontractors).

Amendments to the current policy under the key legislation section could include the following: we have provided a summary version or an expanded version as an example for consideration.

Summarised version

Right to Work Verification:

All contractors and sub-contractors working on HDUHB premises must provide evidence of their legal right to work in the UK. It is the responsibility of the Principal Contractor or

Supplier to carry out and document appropriate RTW checks in line with Home Office guidance. The Trust reserves the right to audit this documentation at any time.

Or an Expanded version may be -

All contractors and sub-contractors engaged to work on HDUHB premises must have the legal Right to Work (RTW) in the United Kingdom, in accordance with the Immigration, Asylum and Nationality Act 2006.

It is the responsibility of the Principal Contractor or Supplier to ensure that:

- A compliant RTW check has been conducted for all personnel prior to deployment to site.
- Evidence of the check (including copies of acceptable documentation or a share code for online verification) is retained in accordance with current Home Office guidance.
- No personnel are deployed to site without passing the RTW check.

HDUHB reserves the right to:

- Request and audit RTW check records at any time.
- Refuse or remove access to site for any individual where RTW compliance cannot be demonstrated.

Failure to comply with these requirements may result in removal from the Health Boards approved contractor list, termination of contract, and reporting to the relevant authorities.

Management Consideration 2

The policy includes an 'Operational Control – Procedure' section containing a Pre-Qualification Questionnaire (PQQ) used to gather information on regulatory and Health Board-specific health and safety requirements. Management may wish to consider incorporating a Right to Work declaration within this questionnaire to strengthen assurance prior to the issue of a permit-to-work.

Suggested declaration for inclusion:
"We confirm that Right to Work checks have been completed for all our personnel attending this site, and valid documentation is held on record.

Management Consideration 3

While the policy makes several references to the issue of contractor badges, it does not specify the process for obtaining them or identify where they are sourced from. Management may wish to consider updating the policy — or developing a supporting standard operating procedure — to outline the operational steps involved.

This would help ensure consistency in implementation, support staff understanding, and enable effective monitoring of compliance.

Management Consideration 4

Given the large geographical area covered by the Health Board and the operational challenges associated with multiple rural sites, management may wish to consider including more detailed guidance within the policy regarding contractor identification. This could include a requirement for contractors to always wear identification badges visibly while on Health Board premises, and a provision for contractors not issued with Health Board ID to display a company ID badge or other clear identification (e.g. high-visibility clothing with company branding), in line with practice adopted by other Health Boards. This may already be considered as part of the Security Management Group's (ID Management Subgroup) review of current arrangements and associated risks.

Management Consideration 5

The policy recognises that the '*Responsible Person (RP) is the manager or senior staff member responsible for the area where the contractors work is to be carried out. The RP has an important role in the monitoring and supervision of contractors at work in their area.'* This is an important role while recognising the large geographical area covered by the Health Board. There may be benefit in detailing any RP training requirement (recognising that the individual may change depending on the locality of the works and also confirming the named RP and declare/confirm understanding the requirements of the role.

Management Consideration 6

The Health Board may wish to consider updating the legislation references within the policy to specifically include the *Immigration, Asylum and Nationality Act 2006*, to clearly reflect the key statutory basis for Right to Work checks and reinforce legal compliance.

4. Conclusion

This advisory note is intended to support the Health Board in ensuring that its *Control of Contractors* policy appropriately reflects good practice in relation to Right to Work requirements. While no formal findings have been raised, the observations outlined are provided for management consideration as part of ongoing policy development and governance. We encourage the Health Board to review these points and determine whether any enhancements to the policy or supporting procedures may be beneficial in strengthening assurance and ensuring continued compliance with legal obligations.

Date: July 2025

5.5

11:50, 10 Mins

5.5 - Commissioning – Long Term Agreements (Reasonable Assurance)

James Johns (NWSSP - Internal Audit), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Shaun Ayres (Hywel Dda UHB - Director of Delivery), Anne Simpson (Hywel Dda UHB - Head of Strategic Commissioning)

For assurance

Attachments

5.5 Commissioning - LTAs Final IA Report.pdf

Commissioning – Long Term Agreements

Final Internal Audit Report

2025/26

Hywel Dda University Health Board

Reasonable Assurance

Contents

Executive Summary 1

Findings & Agreed Action Plan 3

Appendix A 6

Review Reference	HDU-2526-09
Fieldwork	August – September 2025
Executive Sign Off	23 September 2025
Audit Committee	October 2025
Executive Lead	Lee Davies, Director of Strategy & Planning
Audit Team	James Johns, Head of Internal Audit
	Sophie Corbett, Deputy Head of Internal Audit

Executive Summary

Purpose

The overall objective of this review was to assess and provide independent assurance on the management and monitoring arrangements of commissioned long-term agreements (LTAs) for services provided by other NHS bodies to the Health Board.

Overview

The Health Board has approved LTAs for commissioned services with several NHS Wales bodies for 2025-26 that outline roles and responsibilities, quality and performance monitoring arrangements, and financial and service planning details including activity volumes, unit and total costs. Financial and performance monitoring arrangements are established with providers submitting regular monthly statement including supplementary minimum dataset information. Meetings take place between Hywel Dda and the larger LTA providers throughout the year with staff communicating with all other providers when issues or queries arise.

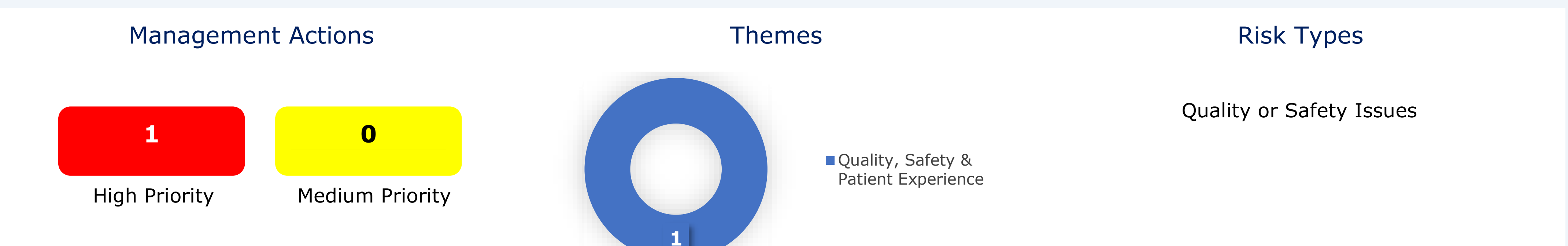
An established governance structure is in place with the Finance and Performance Committee and the Strategy and Planning Committee providing assurance on LTA commission, whilst a new operational group – Commissioning & Contracting Oversight Group – has recently been created to oversee regional agreements and specialised services. Health Board representation was also evident at other All Wales groups and meetings.

We identified one key matter requiring management attention regarding Hywel Dda not receiving regular quality and safety reports from any LTA provider organisations, with the exception of one provider, whose reports also lack some key detailed narrative on the subsequent actions taken and no reporting of patient experience [*High Priority*].

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

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	Agreements are in place that establish the basis of the commissioning arrangements, including processes in place for the development of agreements with NHS bodies and with roles and responsibilities clearly defined	-	**Substantial**
2	Appropriate financial management, performance and quality measure arrangements are in place between the Health Board and other NHS bodies to ensure services provided meet the required standards	1	**Reasonable**
3	There are sufficient levels of monitoring, challenge and scrutiny to ensure the services provided meet the standards required, with an escalation process in place where services fall short of performance and quality requirements	-	**Substantial**


Management Actions
1
High Priority
0
Medium Priority
Themes
1
Quality, Safety & Patient Experience
Risk Types
Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: Agreements are in place that establish the basis of the commissioning arrangements, including processes in place for the development of agreements with NHS bodies and with roles and responsibilities clearly defined	**Substantial**

Overview / Summary of Observations

Hywel Dda have approved commissioning and provider long term agreements (LTAs) with NHS organisations across Wales for 2025-26. LTAs are developed through the rolling forward of the previous year's agreement with confirmed accurate adjustments made for inflationary costs and services changes. The commissioned and provider values of each agreement are also accurately reflected in the Health Board's Annual Plan 2025-26.

The commissioning process for LTAs is due to change in 2026-27 from the 'roll forward' process that has historically been utilised when developing LTAs with the communicated intention across Wales for a 'rebasing' of LTAs within the financial funding available to organisations. A review of the potential savings and opportunities available around schemes in place across the organisation, including a review of LTAs, is currently ongoing.

The agreements in place for commissioned services followed a set template with key details such as roles and responsibilities, quality and performance monitoring arrangements evident, whilst financial and service planning details were outlined by activity volumes, unit and total costs. The agreements also have dedicated sections detailing the escalation process of any disputes and a force majeure for non-performance.

Objective 2: Appropriate financial management, performance and quality measure arrangements are in place between the Health Board and other NHS bodies to ensure services provided meet the required standards	**Reasonable**

Overview / Summary of Observations

The commissioning of services is managed through a framework of LTAs that outline the volume of activity, associated funding and the financial monitoring arrangements for both parties. Service providers are required to submit monthly statements of activity volumes delivered to allow Hywel Dda to scrutinise monitor variations in performance. Agreed marginal rates are used where activity volumes overperforms and/or underperforms against the agreed base figure, whilst invoices are raised at year end where there is any under or overperformance.

Testing at Month 3 confirmed:

- the Health Board had promptly received monthly performance statements from all providers
- supplementary minimum datasets (MDS) were received
- the monitoring and scrutiny of monthly statements for over and under performance by the Healthcare Commissioning Team
- a 1/12th payment (of the agreed LTA contract total) was evident for all providers in the schedule submitted to the Creditors Team

LTAs have a dedicated 'Duty of Quality' section that explicitly outlines the structures and procedures that providers and commissioners should have in place to support the delivery of services that meet the duty of quality outlined in the *Health and Social Care (Quality and Engagement) Wales Act 2020*. Historically, quality and safety reports from service providers have not been produced due to agreed reciprocal arrangements between NHS Wales organisations. Hywel Dda only receive a regular quality and safety report from one provider, whilst work is ongoing to establish these reports with another Health Board provider. The only quality and safety report received by Hywel Dda provides high-level

summary of incidents, complaints, claims and inquests for the period noted, no detailed narrative is given nor of the actions taken. In addition, there is no reporting of patient experience.

Key Findings		Risk & Impact	Agreed Management Action
1	**Quality and Safety Reports** Hywel Dda do not receive regular quality and safety reports from any LTA provider organisations with the exception of one provider. Whilst the report provides high-level summary of incidents, complaints, claims and inquests for the period noted, no detailed narrative is given nor of the actions taken. In addition, there is no reporting of patient experience.	Lack of quality and safety reporting could result in the Health Board being unaware of incidents or hazard that are leading to patient harm.	**Agreed Action:** Commissioning with the support of quality colleagues to work with providers to develop a quality and safety report which meets the requirement of the reporting criteria within the LTA. To be part of the commissioning and contracting intentions. To submit a development request to the OfWCMS[1] for LHB of residence to be extractable from the OfWCMS. **Expected Evidence of Implementation:** Provision of quality and safety reports from Hywel Dda main providers
		High Priority	**Officer:** Shaun Ayres (Director of Delivery) **Target Implementation Date:** 30 April 2026
	Theme: Quality, Safety & Patient Experience	Control Operation	

Objective 3: There are sufficient levels of monitoring, challenge and scrutiny to ensure the services provided meet the standards required, with an escalation process in place where services fall short of performance and quality requirements — **Substantial**

Overview / Summary of Observations

The Health Board obtains assurance on LTA commissioning through two statutory committees – Finance and Performance Committee (FPC) and the Strategy and Planning Committee (SPC). The FPC provides assurance on the financial performance and governance of LTAs. Whilst the SPC provides assurance on strategic and planning element of LTA commissioning.

A new Commissioning & Contracting Oversight Group was formed in July 2025 to oversee regional agreements and specialised services. This operational group provides strategic oversight of agreements with neighbouring Health Boards, specialised services provided by the NHS Wales Joint Commissioning Committee (NWJCC) and other regional programmes of work, such as South-West Wales Cancer Centre.

[1] Once for Wales Concerns Management System

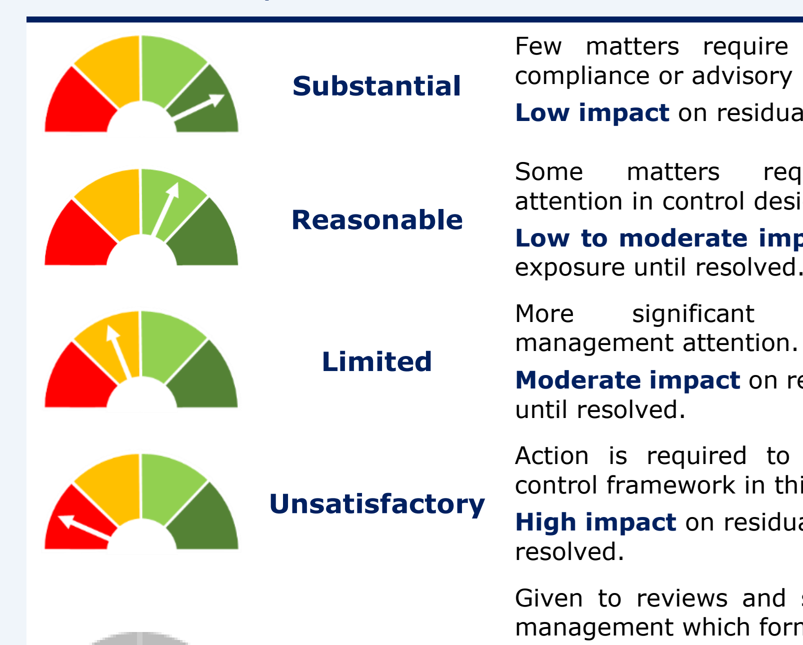
Health Board representatives also participate in the All-Wales Finance Working Group and the Specialised Services Collaborative Commissioning Group to review LTAs and national commissioning arrangements, whilst the Assistant Director of Finance would meet with the Director of Delivery on a bi-monthly basis to discuss the financial position and performance to identify potential risks and opportunities.

The provider and commissioner organisations should agree to meet at least four times a year at LTA Monitoring Meetings as per the agreements in place. Testing identified only four (CAV, SBU, Powys and Velindre) regularly meet in line with the requirements of the LTA. The agreement also sets out the key representatives that are required to attend the meetings. Testing of LTA Monitoring Meetings for 2025 confirmed a good level of attendance of Hywel Dda representatives.

Where LTA Monitoring Meetings do not take place, the Healthcare Contracting Team would contact their opposite number to question the performance data queries identified in the monthly monitoring returns (MMRs).

Appendix A

Assurance Opinion



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

Prioritisation of Findings

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

Disclaimer

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

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

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

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

Public Sector Internal Audit Standards

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

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

5.6

12:00, 10 Mins

5.6 - Capital Governance Arrangements (Advisory Report)

Huw Richards (NWSSP - Audit and Assurance Services), Eifion Jones (NWSSP - Audit and Assurance Services), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Eldeg Rosser (Head of Capital Planning)

For assurance

Attachments

5.6 Capital Governance Final IA Advisory Report.pdf

Capital Governance Arrangements

Internal Advisory Report

2024/25

Hywel Dda University Health Board

An assurance rating has not been provided as this review is advisory in nature and provided to management.

Contents

Executive Summary 1
Findings..2
Appendix A 6
Appendix B 7

Review Reference	HDU-SSU-2425-XX
Fieldwork	February – March 2025
Executive Sign Off	26th August 2025
Executive Lead	Lee Davies, Executive Director of Strategy and Planning
Audit Team	Huw Richards, Head of Internal Audit Eifion Jones, Deputy Head of Internal Audit

Advisory

Executive Summary

Purpose

This advisory review was commissioned as an additional review for 2024/25.Management requested a pro-active review and appraisal of the existing capital management reporting and accountability requirements to ensure compliance with expectations and to identify any opportunities to enhance arrangements.

The focus of the review included the following key committees/ groups identified with responsibility for capital:

- **Strategic Development & Operational Delivery Committee (SDODC)** oversees strategic objectives and planning, ensuring alignment with performance outcomes and targeted intervention frameworks.
- **A Healthier Mid and West Wales (AHMWW) Group** addresses broader strategic implementation, such as clinical services, digital plans, and population health.
- **Integrated Quality Finance and Performance Delivery (IQFPD) Group** focuses on achievement of Annual Plan and overseeing performance to address Targeted Intervention.
- **Infrastructure & Estates Plan Sub-Group** is responsible for ensuring the delivery of major capital plans and schemes that support the Health Board's strategy, including the development of business cases, land acquisition, infrastructure planning, and alignment with clinical service requirements to facilitate the implementation of "A Healthier Mid and West Wales" strategy.
- **Capital Sub-Committee (CSC)** oversees the delivery of the Health Board's capital programmes and projects, ensuring alignment with strategic priorities, managing capital resources, and providing assurance on financial and risk management to support infrastructure and estate development.
- **Strategic Property & Environment Task Force Group (SPETFG)** is responsible for environmental, accommodation and estates related matters.

Overview

The review did not identify any gaps in reporting between the various groups and that each operated in line with their terms of reference. Several observations have been made to stimulate discussion and are there for management consideration - an action plan has been provided at **Appendix A** for completion by management.

Scope & Summary

	Objectives	Related Findings
1	**Control Framework:** To ensure that the expected requirements in respect of capital were adequately defined within the existing control framework, including the operational and assurance governance structures including terms of reference and ensuring minimal duplication and mitigating any gaps in controls.	1,2.3
2	**Compliance:** To determine whether the existing arrangements were fit for purpose in respect of accountability, monitoring and reporting.	2
3	**Effectiveness:** To consider the effectiveness of the existing arrangements, identifying any duplication, inefficiency and/ or opportunities to enhance the existing arrangements.	2

Findings

Finding 1: Potential Overlap/ Duplication of Responsibilities:

Overview / Summary of Observations

The following elements were observed within the respective terms of reference:

Capital Sub-Committee	AHMWW Group (Infrastructure & Estates Plan Sub-Group)
5.6 Scrutinise and quality assure major capital business cases prior to submission to SDODC including those developed in partnership with other organisations such as, Local Authorities, GP partners and Third Sector organisations.	The Infrastructure & Estates Plan Sub-Group will, in respect of producing an approvable SOC and other Business Cases to the Board:
5.7 Ensure a robust disposal policy for redundant estate is in place. 5.8 Consider options for the acquisition or disposal of estate and agree recommendations for the Board, via the SDODC.	3.2 The Infrastructure & Estates Plan Sub-Group will also oversee the development of the interim infrastructure and estate plans and ensure alignment of short and medium term schemes with the strategy. These will include schemes such as fire, business continuity, major infrastructure and those emanating from the Clinical Services Plan (CSP).
5.2 Develop prioritised recommendations for discretionary capital sums and All Wales Capital Schemes and receive investment proposals, in response to an assessment of the organisation's risks, and to support the Health Board's A Healthier Mid and West Wales Strategy (including delivery plans) and vision for healthcare and its strategic objectives, including performance and financial improvement.	3.5 The Infrastructure & Estates Plan Sub-Group will also be responsible for the coordination of the other major capital plans and schemes that support delivery of the Health Board's Strategy 'A Healthier Mid and West Wales', including: 3.5.1 Fire 3.5.2 Business Continuity 3.5.3 Other major capital plans and schemes e.g. those emanating from the Clinical Services Plan.
5.3 Provide a co-ordinated approach to overseeing delivery of the Health Board's capital programmes and projects included in the planning cycle (in year and longer term) enabling the Health Board to understand the overall delivery commitments and risks and proposing changes as appropriate.	4.1 The Infrastructure & Estates Plan Sub-Group will, in respect of producing an approvable SOC and other Business Cases to the Board: 4.1.1 Identify risks, issues and mitigations for the successful completion of an approvable Business Case 4.1.2 Ensure the Business Cases deliver within its agreed boundaries (e.g. cost, organisational impact and adoption, expected actual benefits realisation).

There were no observed gaps in proposed coverage, however there would be benefit in reviewing terms of reference to reduce potential duplication and/or overlap. Key observations were:

a) That a significant amount of capital/ estates focus now falls within the remit of AHMWW Group, but that legacy terms of reference have not been updated to reflect this – thus creating potential duplication.

b) There is potential to reconsider the roles of the CSC and AHMWW Group (Infrastructure & Estates Plan Sub-Group), for example:

- CSC could focus on capital project delivery post approval of e.g. business cases, Targeted Estates Funds, approved within discretionary programmes etc.
- AHMWW Group (Infrastructure & Estates Plan Sub-Group) could ensure strategic alignment and enabling infrastructure - pre-approval of business cases and post completion to ensure achievement of approved project objectives/benefits etc.
- The above should be reflected in revised terms of reference and membership.
- Key interrelationships and dependencies should be documented within a single organogram.

The above would require reconsideration of CSC role in recommending business cases to SDODC.

c) CSC currently has responsibility for acquisition/ disposal of estate and is updated on backlog and issues of utilisation/ rationalisation. Consideration should be given to whether utilisation, rationalisation, acquisition and disposal sits appropriately within the AHMWW Group responsibilities?

Finding 2: Potential Overlap/ Duplication of Responsibilities:

Overview / Summary of Observations

Potential Overlap/ Duplication of Responsibilities:

<table>
<tr><th>Capital Sub-Committee</th><th>AHMWW Group (Infrastructure & Estates Plan Sub-Group)</th><th>Strategic Development and Operational Delivery Committee (SDODC)</th></tr>
<tr><td>Highlight Reporting was produced for each Capital Sub-Committee, the latest reporting for January 2025 included:
Fire Schemes:
WGH
GGH
Major Infrastructure – Phase 1
North Pembrokeshire Health and Wellbeing Centre in Fishguard
RAAC – Withybush
Cross Hands Health and Wellbeing Centre
Carmarthen Hwb
Pentre Awel
Cylch Caron
Aberystwyth Integrated Care Centre
Additionally:
Aseptics
Aberystwyth Sexual Assault & Referral Centre
Chemotherapy Day Unit BGH
Radiology
Corporate HQ
Regional Pathology</td><td>Separate dashboard reports were produced for Infrastructure & Estates Plan Sub-Group, the December 2024 meeting received an update on the following:
Fire Schemes:
WGH
GGH
BGH
PPH
Major Infrastructure – Phase 1
North Pembrokeshire Health and Wellbeing Centre in Fishguard
RAAC – Withybush
Cross Hands Health and Wellbeing Centre
Carmarthen Hwb
Pentre Awel
Cylch Caron
Aberystwyth Integrated Care Centre
Additionally:
AHMWW
Llandovery</td><td>SDODC received a financial update on all of the projects, but narrative updates were limited to projects of concern and/or significance. For December 2024 included:
Aseptics
Cross Hands Health and Wellbeing Centre
Regional Pathology
Carmarthen Hwb
Pentre Awel
Cylch Caron
RAAC – Withybush
Additionally:
A separate update on AHMWW for information covering:
Cross Hands Health and Wellbeing Centre
Carmarthen Hwb
Pentre Awel
North Pembrokeshire Health and Wellbeing Centre in Fishguard
Cylch Caron
Aberystwyth Integrated Care Centre</td></tr>
<tr><td>Corporate Risk Reporting</td><td>AHMWW Risk Register</td><td>Corporate Risk Reporting</td></tr>
</table>

The reporting observed was comprehensive and current, but there is scope for reduced reporting:

a) There was evidence that reporting was repetitive rather than complimentary between each group – does this have the potential to confuse responsibilities of the various groups and risk error in transposition?

b) There were project additions/ omissions across the various group reporting (e.g. Regional Pathology).

c) Potential duplication in risk and performance monitoring arrangements as SDODC receives updates from CSC and monitors AHMWW's delivery within broader organisational strategies. For example, AHMWW has its own risk register that does not currently link to any existing risks at the Corporate Risk Register but covers wide ranging issues such as workforce capacity, clinical strategies, existing estates infrastructure and future investment strategies.

d) It may be beneficial to review Executive lead ownership of areas that would include capital and revenue funded projects.

Finding 3: Meeting Membership

Overview / Summary of Observations

Several of the groups share membership, which may be viewed as posing a potential for duplication/ repetition, however this does provide assurance that issues are raised consistently across the various forums. For example, it is noted that the Director of Planning either chairs and/or attends the CSC, AHMWW Group and SDODC.

a) Whilst the CSC had an independent member within its membership, the AHMWW did not – this may need to be reviewed, recognising any revisions to terms of reference that may arise from this review.

Appendix A

Finding	Proposed Management Action	Responsibility	Timescale
1.	**Potential Overlap/ Duplication of Responsibilities: - Review Terms of Reference** We have reviewed the Terms of Reference and are content that nothing is falling between the gaps. We recognise that there is an element of overlap and that we will streamline our reporting to minimise duplication.	Lee Davies	Completed
2.	**Potential Overlap/ Duplication of Responsibilities: - Look at scope for reduced reporting:** We have reviewed the Terms of Reference. The Capital Sub Committee is the key operational control function and is working effectively. We are therefore not proposing any change in it's remit. We are however in a holding position around the AHMWW capital Programme, whilst we still liaise with WG on the programme of work to support the strategy. At that point we will look to review the Terms of Reference between CSC and the AHMWW Infrastructure and Estates Sub Group to ensure our programme management arrangements are effective. We will also take further advice from Audit on the governance for the new programme of work. In the interim we will review the elements of operational reporting into the Infrastructure and Estates Sub Group to ensure reporting is appropriate and where necessary reporting is into the operational management structure.	Lee Davies/ Paul Williams	Completed
3.	**Meeting Membership:** Meeting membership has been reviewed for AHMWW and CSC and will be reviewed again when the terms of reference are reviewed as noted above.	Lee Davies/ Paul Williams	Completed

Appendix B

Assurance Opinion

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

Prioritisation of Findings

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

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

5.7 **12:10, 0 Mins**

5.7 - Vaccination and Immunisation

James Johns (NWSSP - Internal Audit), Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health)

DEFERRED to 9 December 2025 meeting

For assurance

6

12:10, 0 Mins

6 - Financial Focus

6.1

12:10, 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 October 2025.pdf

6.1 Financial Assurance Report ARAC October 2025.pdf

6.1 Appendices 1-4 - Financial Assurance Report ARAC October 2025.pdf

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

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	14 October 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Financial Assurance Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Tim John, Head of Accounting and Statutory Reporting

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

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

Asesiad / Assessment

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

Alert: No issues to report

Advise:

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

b) While the level of staff overpayments increased, the average recovery period continues to be reasonably consistent circa 5 to 6 months. The target is to have no overpayments; however, the total overpaid during July and August 2025 represents 0.24% of the average monthly net pay costs (May and June 2025 – 0.16%)

c) There were no individual losses exceeding £5,000 in July and August 2025. However, there were losses and write offs in the period totalling £46,131, a small increase on the previous two month period.

Assure:

a) Activity ongoing to reduce non-compliance with No PO, No Pay. The Health Board actively enforces the No PO, No Pay policy and, whilst there have been zero invoices paid without a purchase order, preventative control checks are in place to ensure that proactive management minimises the potential for non-compliance in the future and any delays for vendor payment. This preventative control is called invoices on hold (IOH). The Core Accounting Team within Finance monitors directorates who do not comply with the policy and Service Delivery Mangers are being advised that they are failing to follow policy and assistance with any training that is required is offered. The local Procurement team are assisting with this process and are preparing an in depth review and action plan.

b) Public Sector Payment Policy (PSPP) compliance remains on target for delivery for the year - the target is to pay 95% of all non-NHS invoices within 30 days. The Core Accounting Team is continually pursuing budget holders to authorise invoices promptly as e-mail requests from NWSSP Accounts Payable are often ignored. The team has also been providing training to areas where there are frequently high numbers of failures. This is in addition to contacting suppliers with invoices on hold without a PO, to help find the relevant PO or contacting the service users to raise a PO if required.

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

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

e) Compliance with reporting requirements – as part of the Audit of Accounts, Audit Wales make certain observations. These were formally shared with the Health Board on 17 September 2025 via the Audit of Accounts – Report Addendum. Where actions have been agreed, compliance will be monitored via the audit tracker.

Argymhelliad / Recommendation

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

- **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
- **TAKE ASSURANCE** from the actions taken to reduce the instances of non-compliance with the No PO, No Pay policy; to ensure Public Sector Payment Policy (PSPP) compliance; to manage Single Tender Actions (STAs) and ensure National Minimum Wage (NMW) compliance.
- **SCRUTINISE** the award of contracts listed in Appendix 1a.

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

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

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

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

Financial Assurance Report for the period 1 July to 31 August 2025
Audit and Risk Assurance Committee

14 October 2025

Compliance requirements for ARAC - Overview

Requirement	Reporting	Frequency	Status	Reference
Scheme of delegation changes	• Exception reporting for approval	As and when	Compliant	N/a – no changes
Compliance with Purchase to Pay requirements	• Breaches of the No PO, No Pay policy/Instructions for noting	Bi-monthly	Assure Committee	Schedule 2a
	• Public Sector Payment Policy (PSPP) compliance	Bi-monthly	Assure Committee	Schedule 2a
	• Tenders awarded for noting	Bi-monthly	Assure Committee	Schedule 2b
	• Single tender action	Bi-monthly	Assure Committee	Schedule 2b
	• Breaches of Standing Financial Instructions (SFIs)	Bi-monthly	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	Following approval of annual capital plan	Compliant	N/a – no changes
Compliance with Tax requirements	• Compliance with VAT requirements	Bi-monthly	Compliant	N/a – no changes
	• Compliance with employment taxes	Bi-monthly	Assure Committee	Schedule 5
Compliance with Reporting requirements	• Changes in accounting practices and policies • Agree final accounts timetable and plans • Review of annual accounts progress • Review of audited annual accounts and financial statements	Annually	Compliant	Schedule 5

2a. Compliance with Purchase to Pay requirements

IOH

July and August 2025
No. 150 ; Value £654k

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

Cumulative to end August 2025
No. 99; Value £498k

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

PSPP

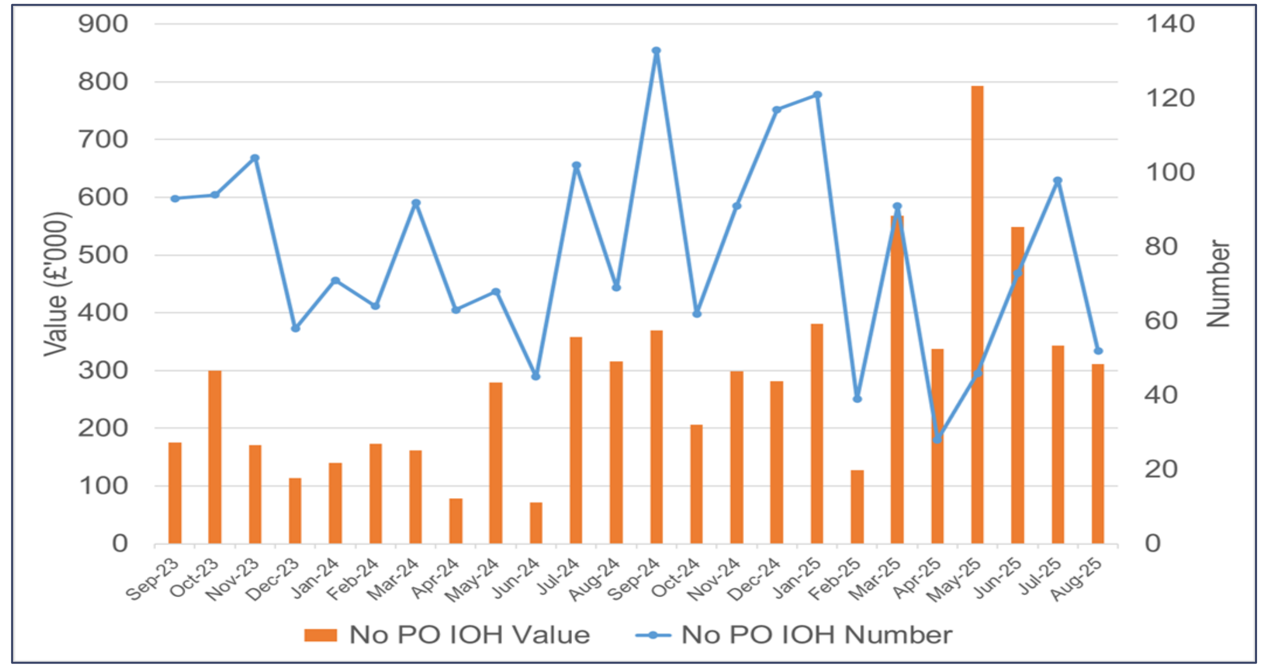
Non – NHS (target > 95%)
July 2025 – 96.3%
August 2025 – 97.0%

Cumulative to 31 August 2025
96.8%

NHS (no target)
July 2025 – 91.1%
August 2025 – 83.2%

Cumulative to 31 August 2025
80.2%

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



Reducing invoices on hold

Supplier and Health Board Non-Compliance exceeding £20,000	No. of invoices	Value £
Suppliers *		
Carmarthenshire County Council	3	115,265
Royal Mail Group PLC	13	100,980
Parkway Clinic	2	41,542
Cardiff Council	4	26,239
St John Cymru – Wales	2	25,744
Consultant Connect Limited	2	20,897
* In addition, 5 suppliers with 1 invoice > £20k (total value - £211k)		
Clinical Care Groups/Executive function		
Pembrokeshire Integrated System	6	77,128
Transport	2	59,335
Hospital Sterilisation and Decontamination Unit	1	49,083
Primary Care	11	43,461
Cancer and Scheduled Care	14	40,666
Digital	1	22,091

2b. Compliance with Purchase to Pay requirements

STA

July and August 2025
No. 0; Value £0

May and June 2025
No. 0; Value £0

Tenders Awarded (>£25k)

July and August 2025
No. 8; Value £1,349,630

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

Consultancy

July and August 2025
Number = 0; Value = £0

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

Top 5 Tenders Awarded (>£25k)

Supplier	Description	Value £	Department
Olympus Keymed	Surgical urology product placement	512,685	Planned Care
Healthcare Business Solutions	Insourcing of a theatre scrub team	500,000	Planned Care
T J Smith & Nephew Ltd	Coblation (ENT) consumable deal	74,969	Planned Care
Smart Occupational Health	Contract consultant in Occupational Medicine	57,200	Workforce
Curtins Consulting Ltd	Professional Services - structural survey and related works (precast cladding panels at WGH)	52,788	Estates
Total		**1,197,642**	

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

Contracts Awarded	Number	Value £	Details
Post competitive tender	3	158,138	**Appendix 1a**
Direct awards via Framework agreement	5	1,191,492	**Appendix 1a**
VEAT	-	-	**Appendix 1a**
Total	**8**	**1,349,630**	
Consultancy Contracts	**-**	**-**	**-**
Breaches of SFIs	**5**	**90,984**	**Appendix 1b**
Contract Awards reported retrospectively	**-**	**-**	**-**

3. Compliance with Income to Cash

Salary Overpayments

July and August 2025 No. 36; Value £100,039 (Appendix 2)

May and June 2025 No. 44; Value £61,827

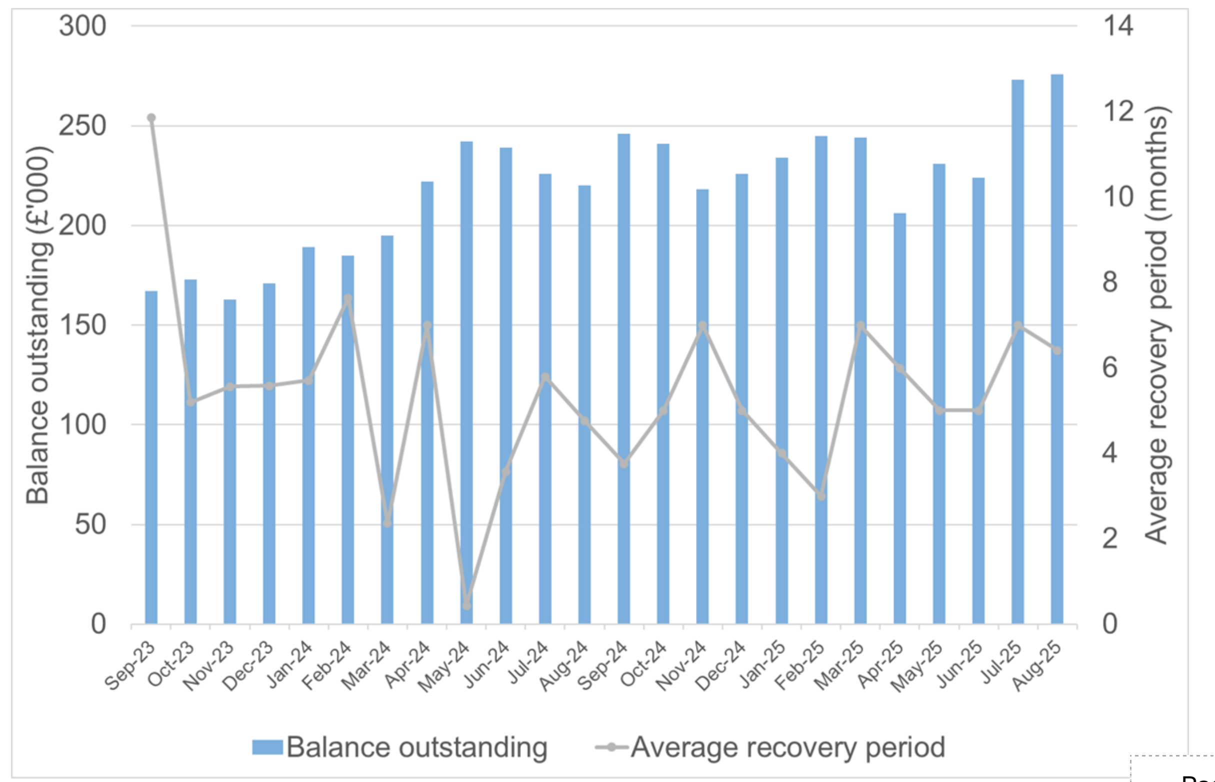
Debt balance as at 30 August 2025: £276k with average recovery period of 6 months

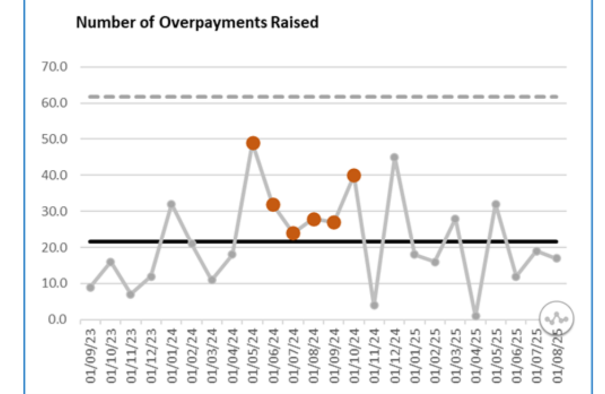
30 June: £224k; average recovery period of 5 months

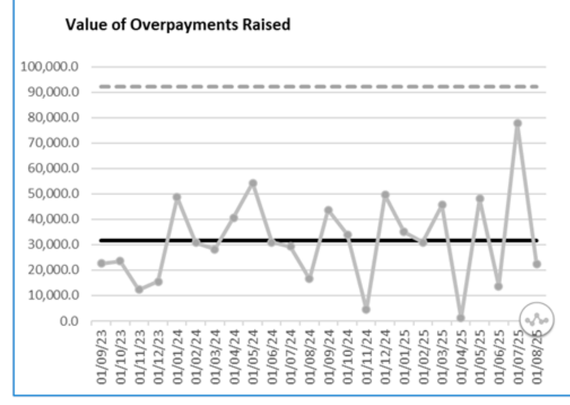
	August	June
Avge no of invoices raised	22	21
Avge value	£32k	£29k
Avge no paid	18	16
Avge value	£29k	£27k

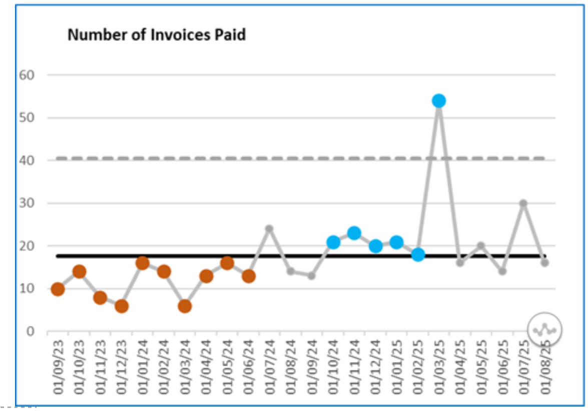
Underpayments in July and August 2025 - £24,467

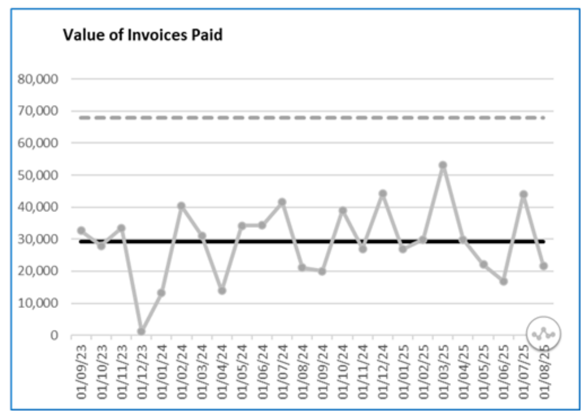
May and June 2025 - £14,792











4. Losses and Special Payments

Losses £5k and over requiring ARAC Approval

July and August 2025
£Nil

May and June 2025
£Nil

Losses under £5k approved by DoF and CEO

July and August 2025
£46,131
(Appendix 3)
May and June 2025
£44,657

Losses – Requiring Approval from ARAC	£
N/a as no losses £5k and over in period	Nil
All Other Losses	
Ex gratia	66
Overpayments of salaries, salary sacrifice, accommodation, Wagestream etc	4,520
4b Other causes* - expired stock, wastage, breakages	41,545
Total Losses	**46,131**

*** 4b Other causes**

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

5. Other Areas

Compliance with Capital Requirements

No updates or issues to report - there are currently no live capital projects requiring a Project Bank Account (PBA).

Compliance with Tax Requirements

Compliance with VAT Requirements

- Completion of all **VAT recovery** activities in respect of expenditure incurred in the 2024/25 financial year - **£11.1m recovered (Appendix 4).**
- **BT PSBA network – VAT recovery non-statutory clearance request.** In September 2025, HMRC confirmed the VAT charged on this service is recoverable, thereby concluding this matter. As HMRC's confirmation had been anticipated by the Health Board, there is no immediate financial impact for the Health Board but removes future uncertainty regarding the VAT treatment of this supply.

Compliance with Employment Tax Requirements

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

Compliance with reporting requirements

2024/25 Audit of Accounts – Report Addendum

Items identified by Audit Wales during the 2024/25 audit, that did not merit inclusion in the ISA 260, have subsequently been notified to the Health Board by way of the Audit of Accounts – Report Addendum. The observations made and the management responses have been shared with ARAC Members and are included for transparency in **Appendix 5.**

Appendices

Appendix 1a: Contracts awarded

Contracts Awarded Post Competitive Tender:

P Reference & Title	P0078 – Active Monitoring for Adults – Tywi Taf Cluster Area
Supplier	Carmarthenshire & Pembrokeshire Mind
Contract Period	01/11/2025 to 31/10/2026
Value	£50,937.98
Department	Primary Care
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	No
Compliant	Y
Comment	An extension to a competitive tender has been awarded to Carmarthenshire & Pembrokeshire Mind for 12 months. The contract is for Active Monitoring for Adults - Tywi Taf Cluster Area. This contract award does not allow for a further extension period.

P Reference & Title	P0065 – Consultant in Occupational Medicine
Supplier	Smart Occupational Health
Contract Period	01/10/2025 to 30/09/2026
Value	£57,200.00
Department	Workforce
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	No
Compliant	Y
Comment	An extension to a competitive tender has been awarded to Smart Occupational Health for 12 months. The contract is for a consultant in Occupational Medicine. This contract award does not allow for a further extension period.

P Reference & Title	P0312 – Ad-Hoc Recruitment Campaigns
Supplier	Four Communications Limited
Contract Period	01/09/2025 to 01/08/2026
Value	£50,000.00
Department	Workforce
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	No
Compliant	Y
Comment	Following a competitive tender, Four Communications Limited were awarded a 12-month contract for Ad-Hoc Recruitment Campaigns. An option to extend the contract for a further 12 months is included within the award.

Direct awards via Framework Agreements:

P Reference & Title	P0368 – Insourcing of Theatre Scrub Teams
Supplier	Healthcare Business Solutions
Framework Utilised	NHS Shared Business Services Insourcing of Clinical Services Framework Agreement (SBS102023)
Contract Period	04/08/2025 to 31/03/2027
Value	£500,000.00
Department	Planned Care
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	No
Compliant	Y
Comment	A direct award via the Shared Business Services Insourcing of Clinical Services (SBS102023) framework has been awarded to Healthcare Business Solutions for the Insourcing of a Theatre Scrub Team for 20 months. This contract award does not allow for an extension.

P Reference & Title	P0371 – Healthy IO Wound Care App
Supplier	Healthy io UK Ltd
Framework Utilised	NHS Shared Business Services Advanced Wound Care and Lymphoedema Products and Services Framework Agreement (SBS10142)
Contract Period	01/09/2025 to 01/09/2026
Value	£51,051.00
Department	Tissue Viability and Community Nursing
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	No
Compliant	Y
Comment	A direct award via the Shared Business Services Advanced Wound Care and Lymphoedema Products and Services Framework Agreement (SBS10142) has been awarded to Healthy io UK Ltd for a Wound Care App for 12 months. This contract award does not allow for an extension.

P Reference & Title	P0348 – Coblation (ENT) Consumable Deal
Supplier	T J Smith & Nephew Ltd
Framework Utilised	NHS Wales's Surgical Instruments Agreement
Contract Period	01/08/2025 to 01/08/2030
Value	£74,969.00
Department	Planned Care
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	No
Compliant	Y
Comment	A direct award via NHS Wales's Surgical Instruments Agreement has been awarded to T J Smith & Nephew Ltd for a Coblation (ENT) Consumable Deal for 60 months. This contract award does not allow for an extension.

P Reference & Title	P0393 – Professional Services for a Structural Survey and Related Works for Precast Cladding Panels at Withybush General Hospital (WGH)
Supplier	Curtins Consulting Ltd
Framework Utilised	WPA Construction Consultancy (WS1)
Contract Period	11/08/2025 to 10/02/2027
Value	£52,787.50
Department	Estates
Professional Services (Yes/No)	Yes
Date of Board Approval (If Applicable)	No
Compliant	Y
Comment	A direct award via the WPA Construction Consultancy (WS1) framework has been awarded to Curtins Consulting Ltd for Professional Services for a Structural Survey and Related Works for Precast Cladding Panels at WGH for 19 months. This contract award does not allow for an extension.

P Reference & Title	P0296 – Surgical Urology Product Placement (Olympus)
Supplier	Olympus Keymed
Framework Utilised	NHS Wales's Cardiology, Radiology, Endoscopy & Surgical Urology (CRESU) Framework Agreement (CLI-OJEU-46286)
Contract Period	01/07/2025 to 30/06/2028
Value	£512,685.00
Department	Planned Care
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	No
Compliant	Y
Comment	A direct award via NHS Wales's Cardiology, Radiology, Endoscopy & Surgical Urology (CRESU) Framework (CLI-OJEU-46286) has been awarded to Olympus Keymed for a Surgical Urology Product Placement for 36 months. This contract award does not allow for an extension.

Appendix 1b: Breaches of SFIs

Title	Extension to Rental of 15BSS at GGH Mortuary (Unit 2) - 03.03.25 to 26.06.25
Supplier	Nutwell Logistics Ltd
Month/Year	July 2025
Value	£7,300.00
Department	Operational Allied Health and Health Sciences
Comment	In the month of July 2025, a retrospective purchase order was raised to Nutwell Logistics Ltd for the payment of an Extension to a Rental of 15BSS at GGH Mortuary (Unit 2) - 03.03.25 to 26.06.25. The total value of the purchase order was £7,300.00. This breach of Standing Financial Instructions sits within the Operational Allied Health and Health Sciences Directorate.
Action Taken	End User Educated

Title	Embroidered Doctors Uniform
Supplier	AW Bent Ltd
Month/Year	July 2025
Value	£37,131.50
Department	Medical
Comment	In the month of July 2025, a retrospective purchase order was raised to AW Bent Ltd for the payment of Embroidered Doctors Uniform. The total value of the purchase order was £37,131.50. 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	PPH Block 3 Flooring
Supplier	Commercial Flooring Contractors Ltd
Month/Year	July 2025
Value	£24,430.00
Department	Medical
Comment	In the month of July 2025, a retrospective purchase order was raised to Commercial Flooring Contractors Ltd for the payment of PPH Block 3 Flooring. The total value of the purchase order was £24,430.00. 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	Alerts Workflow - 1st August 2025 to 31st July 2026
Supplier	ECRI European Office
Month/Year	August 2025
Value	£9,845.00
Department	Chief Operating Officer Management
Comment	In the month of August 2025, a retrospective purchase order was raised to ECRI European Office for the payment of an Alerts Workflow - 1st August 2025 to 31st July 2026. The total value of the purchase order was £9,845.00. This breach of Standing Financial Instructions sits within the Chief Operating Officer Management Directorate.
Action Taken	Breach Added to Procurement Workplan

Title	Wall Bed Supply and Install
Supplier	Croyde Medical Ltd
Month/Year	August 2025
Value	£12,277.16
Department	Charitable Funds
Comment	In the month of August 2025, a retrospective purchase order was raised to Croyde Medical Ltd for the payment of the Supply and Installation of a Wall Bed. The total value of the purchase order was £12,277.16. This breach of Standing Financial Instructions sits within the Charitable Funds Directorate.
Action Taken	End User Educated. Procurement being involved within the Charitable Funds allocation approval process would support the elimination of such awards.

Appendix 2: Overpayment of Salaries

	Period covered by this report: 1 July 25 – 31 August 25		
Ref	**Reason for Overpayment**	**Value (£)**	**Number of invoices**
1	Processing Error	17,879.42	5
2	Late Notification of Changes	39,916.36	10
3	Late Notification of Termination	20,430.43	11
4	Late Notification of Absence	18,514.72	8
5	Incorrect Information Supplied to Payroll	3,298.63	2
		100,039.56	**36**

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

	Period covered by this report:		1 July 2025 to 31 August 2025
Ref	**Losses and Special Payments Category**	**Value (£)**	**Explanation**
	N/a – no losses over £5k		
	Total Losses (for approval)		

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

2025/26	WRITE OFF LIST		
	Period covered by this report:	1st July to 31 August 2025	
	Losses and Special Payments Category	**Value (£)**	**Explanation**
	SALARY SACRIFICE	1,712.94	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
	Total Write Off	**1,712.94**	
	4b Other	1,028.40	P05-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	1,050.03	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1,056.00	P05-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	1,274.40	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	1,362.54	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1,701.00	P05-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	1,800.00	P05-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	2,826.00	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	3,615.60	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	4,267.37	P04-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	Total Other/Ex Gratia	**19,981.34**	
	Total	**21,694.28**	

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

2025/2	WRITE OFF LIST		
	Period covered by this report:	1st July to 31 August 2025	
	Losses and Special Payments Category	**Value (£)**	**Explanation**
	SALARY SACRIFICE	0.03	UNDERPAID OF INVOICE
	PRIVATE PATIENT	0.07	UNDERPAID OF INVOICE
	RELOCATION EXPENSE	0.41	UNDERPAID OF INVOICE
	PRIVATE PATIENT	123.00	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
	OVERPAYMENT OF SALARIES	212.37	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
	OVERSEAS PATIENT	326.00	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
	OVERPAYMENT OF SALARIES	330.20	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
	OVERPAYMENT OF SALARIES	822.50	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
	SALARY SACRIFICE	992.31	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
	Total Write Off	**2,806.89**	
	4b Other	- 0.84	P04-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	0.01	P05-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.02	P04-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.03	P04-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.03	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.03	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.03	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.04	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.04	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.05	P04-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.05	P05-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.09	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.09	P05-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	0.13	P04-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	0.13	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.15	P04-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.15	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.19	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.21	P04-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.21	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.23	P05-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	0.26	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.29	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.32	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.35	P05-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	0.35	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.36	P04-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	0.36	P05-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	0.38	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.39	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.43	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.45	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.54	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.54	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.60	P05-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	0.64	P04-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	0.64	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.65	P04-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	0.70	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	1.02	P05-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	1.07	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.20	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.30	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.32	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.40	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.42	P04-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	1.44	P04-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	1.44	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	1.46	P04-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	1.64	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	1.64	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.66	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	1.76	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH

	4b Other	1.81	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	1.90	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.10	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	2.13	P05-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	2.16	P04-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	2.16	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	2.17	P05-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	2.18	P05-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	2.31	P05-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	2.40	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.40	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.40	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	2.40	P05-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	2.44	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.51	P04-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	2.52	P05-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	2.52	P05-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	2.70	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.88	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	3.18	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	3.23	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	3.33	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	3.45	P04-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	3.47	P04-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	3.50	Travel costs for cancelled appointment - KMT
	4b Other	3.55	P04-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	3.60	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	4.07	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	4.20	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	4.21	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	4.30	P04-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	4.32	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	4.43	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	4.68	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	5.00	Travel costs for cancelled appointment - MAR
	11 EX-GRATIA	5.03	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	5.05	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	5.21	P05-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	5.62	P04-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	5.64	P04-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	5.64	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	5.81	P05-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	6.00	Travel costs for cancelled appointment - AP
	4b Other	6.00	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	6.00	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	6.36	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	6.48	P04-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	6.50	Travel costs for cancelled appointment - JML
	4b Other	6.67	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	6.69	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	6.70	P05-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	6.72	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	7.08	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	7.08	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	7.21	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	7.39	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	7.41	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	11 EX-GRATIA	7.43	P04-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	7.43	P04-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	7.53	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	7.60	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	7.90	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	8.26	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	8.34	P04-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	8.39	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	8.47	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	8.54	P05-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	8.64	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	9.00	P04-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	9.75	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH

	4b Other	9.79	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	11 EX-GRATIA	10.11	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	10.24	P05-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	10.74	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	10.78	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	10.78	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	10.96	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	11.04	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	11.14	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	11.28	P05-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	11.34	P04-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	11.47	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	11.76	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	11.76	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	11.76	P05-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	11.77	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	12.00	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	12.25	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	12.26	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	12.28	P04-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	12.35	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	12.59	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	12.60	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	12.60	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	12.62	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	12.73	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	12.87	P04-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	13.14	P04-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	14.38	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	14.69	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	14.76	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	14.88	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	15.00	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	15.09	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	15.41	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	15.52	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	15.95	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	15.97	P04-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	16.45	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	16.56	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	16.93	P04-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	17.33	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	11 EX-GRATIA	17.47	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	17.73	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	17.82	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	18.00	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	18.00	P04-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	18.47	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	18.77	P04-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	19.12	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	19.20	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	20.24	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	20.33	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	20.65	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	20.83	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	20.94	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	21.83	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	21.84	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	21.86	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	22.07	P04-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	22.20	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	22.36	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	22.90	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	23.96	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	23.99	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	24.00	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	24.13	P04-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	24.13	P04-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	25.18	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	25.20	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH

	4b Other	25.20	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	25.60	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	25.68	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	25.80	P05-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	11 EX-GRATIA	25.92	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	26.00	Travel costs for cancelled appointment - CW
	4b Other	26.33	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	27.00	Travel costs for cancelled appointment - KAB
	4b Other	27.20	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	27.46	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	28.34	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	28.80	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	28.85	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	29.10	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	29.34	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	29.65	P04-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	29.93	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	30.00	P04-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	30.00	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	30.21	P04-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	30.78	P04-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	31.15	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	31.51	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	31.84	P05-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	32.24	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	32.31	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	33.64	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	35.35	P04-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	35.47	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	35.87	P05-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	35.97	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	36.61	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	36.74	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	36.78	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	37.20	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	37.30	P05-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	38.40	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	38.92	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	39.20	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	41.92	P05-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	42.07	P05-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	42.68	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	43.92	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	44.70	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	45.96	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	47.27	P05-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	47.95	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	48.05	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	49.46	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	50.40	P04-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	50.40	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	50.46	P05-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	51.26	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	53.69	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	54.91	P05-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	54.97	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	57.39	P05-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	57.65	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	57.98	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	59.14	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	59.14	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	60.21	P05-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	62.40	P04-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	62.81	P04-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	63.00	P04-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	64.08	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	64.80	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	65.52	P04-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	66.00	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	66.00	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH

	4b Other	67.30	P05-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	73.69	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	73.80	P04-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	78.61	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	81.00	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	85.56	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	89.21	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	89.28	P05-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	90.22	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	90.24	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	91.78	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	93.84	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	94.55	P04-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	95.51	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	95.81	P05-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	96.84	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	97.47	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	98.40	P05-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	104.24	P04-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	108.00	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	109.80	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	110.40	P04-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	114.41	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	115.20	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	117.37	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	119.93	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	120.00	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	124.80	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	128.08	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	133.20	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	134.28	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	149.23	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	156.00	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	161.54	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	162.61	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	169.48	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	171.29	P04-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	174.55	P05-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	182.88	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	189.36	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	191.61	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	193.01	P04-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	194.89	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	196.08	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	202.92	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	205.92	P04-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	207.74	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	207.74	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	217.49	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	220.80	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	232.80	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	240.00	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	245.94	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	251.50	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	264.00	P04-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	270.65	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	306.77	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	309.24	P04-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	316.80	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	331.80	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	344.47	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	354.24	P05-26 WDA - HDUHB~~E EXPIRED STOCK WDA
	4b Other	360.00	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	386.02	P04-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	396.00	P04-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	441.11	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	450.00	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	479.98	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	489.60	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	504.00	P05-26 Glangwili Hospital~~G EXPIRED STOCK GGH

	4b Other	528.00	P05-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	579.03	P04-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	675.82	P05-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	864.00	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	900.00	P04-26 Withybush Hospital~~W EXPIRED STOCK WGH
	Sub total	**21,630.03**	
	Total	**24,436.92**	

Appendix 4: Compliance with VAT Requirements

Further to the completion of all VAT recovery activities in respect of expenditure incurred in the 2024/25 financial year, Figure 1 below summarises the Health Board's performance for the year in respect of the identification of recoverable VAT and compares this with its performance for the previous three financial years.

Total VAT recovered in 2024/25 decreased slightly to £11.1m from £11.5m in 2023/24. This decrease was in similar proportion to the decrease in the total amount of VAT incurred over two years, falling from £33.1m in 2023/24 to £32.1m in 2024/25. VAT recovered as a percentage of VAT incurred remained consistent with recent financial years at just under 35%.

The proportion of VAT recovered automatically "at source", via the Procure to Pay process (rather than by manual accounting journal), decreased significantly from 2023/24 to 2024/25 from 61% to 47%. This was driven by a £1.4m (37%) reduction in the amount of VAT incurred on supplies of agency nurses, in respect of which the VAT is recovered wholly at source due to the relatively straightforward VAT recovery criteria which applies to this type of supply. This reduction in VAT incurred reflected the significant decrease in agency nursing activity over the same period. In addition, 2024/25 saw a significant £0.9m (130%) increase in the amount of VAT recovered on the procurement of IT/digital systems and infrastructure, an area of particular complexity where recovery of VAT at source is not often practical. The Health Board continues its joint effort with the Procurement department to increase the proportion of VAT recovered at source over the longer term.

Figure 1: VAT recovery summary 2021/22 to 2024/25

VAT recovery summary - 2021/22 to 2024/25
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
% VAT recovered
£14,000,000
£12,000,000
£10,000,000
£8,000,000
£6,000,000
£4,000,000
£2,000,000
£0
Total VAT recovered
48.7%
51.3%
39.7%
60.3%
39.2%
60.8%
53.1%
46.9%
2021/22
2022/23
2023/24
2024/25
VAT recovered at source
VAT recovered manually
% VAT recovered

6.2

12:15, 5 Mins

6.2 - Counter Fraud Update

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

For information

Attachments

6.2 SBAR Counter Fraud Update ARAC October 2025.pdf

6.2 Counter Fraud Update ARAC October 2025.pdf

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

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	14 October 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Counter Fraud Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Ben Rees, Head of Counter Fraud

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

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

Cefndir / Background

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

Asesiad / Assessment

Main Report:
The Health Board is compliant with the Welsh Government Directives.

Argymhelliad / Recommendation

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

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

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

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

HYWEL DDA UNIVERSITY HEALTH BOARD

COUNTER FRAUD UPDATE

For Presentation 14 October 2025

The NHS Protect Standards are set in four generic areas:

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

AREA OF ACTIVITY	2025/26 Resource (days)	Resource Used as at 30/09/2025	Resource Used (%) as at 30/09/2025)
STRATEGIC GOVERNANCE	40	15	38
INFORM AND INVOLVE	85	42	49
PREVENT AND DETER	130	56	43
HOLD TO ACCOUNT	185	75	41
TOTAL	**440**	**188**	**43**

Work Area	*Summary of work areas completed*
Inform and involve	• All new inductees are required to complete the Health Board's induction programme and the Counter Fraud mandatory training e-learning package. • Counter Fraud content was delivered to Nurses by way of presentations on the Medicines Management programme. In addition, this last quarter has seen presentations delivered to optometrists covering the Ceredigion and Pembrokeshire areas, engaging with all clusters, raising awareness of fraud in the NHS and the need for greater collaborative working to reduce instances to an absolute minimum. • Counter Fraud have issued 5 Viva Engage posts, covering various fraud and scam related alerts and news articles covering recent publicised criminal case outcomes. • In response to the National Fraud Initiative and the need to declare secondary interests, a publication was shared via the Health Board's SharePoint system around the need to declare conflicts of interest, including those linked to secondary employment and associations. A link to the article can be found here: Declarations of Interests - Family members and partners. • A second publication was shared raising awareness of expenses-related fraud, linked to claiming of mileage expenses incurred in connection with employment. A copy of the article can be found here: "Claiming Trouble": When mileage takes a wrong turn • Counter Fraud representatives currently sit on the quarterly HDdUHB Local Intelligence Network (LIN), at which advice is provided on current fraud trends associated with Controlled Drugs. Where applicable, relevant advice, including raising awareness of Fraud in the NHS, is provided.

Prevent and deter	
	• In August 2025, Counter Fraud highlighted the reporting of a risk linked to the impersonation of Agency employed Registered Nurses and Healthcare Support Workers. In response, a local proactive exercise was undertaken, which confirmed that existing processes to mitigate the risk were in operation and were effective in reducing the likelihood of an adverse incident. A copy of the report from this exercise has been appended to the In-Committee report. In response to the findings, further risks were identified, relating to identification cards provided to Agency Workers linked to one supplier. Relevant actions were undertaken to address and resolve the issues raised and have been noted within the same report. • Following a concern raised in connection with the creation of HDdUHB staff identification cards by someone other than the appointed person, a Counter Fraud System Weakness / Risk Identification Report was created and issued to the Assistant Director of People Management and the Executive Director of Allied Health Professions and Health Science. A copy of the report has been appended to the In-Committee report. Recommendations have been made and the risk posed is deemed low. • Following a concern raised in connection with a stolen prescription from a GP practice in the HDdUHB area, a review was conducted into existing controls governing the storage, control, and destruction of NHS prescriptions. This report has been shared with Primary Care, and a copy of the report has been appended to the In-Committee report. No concerns of fraud were identified. • Following an investigation into an overpayment of salary, a review into existing controls governing the administration and management of rosters on Allocate was undertaken by way of a local proactive exercise. A copy of the report has been appended to the In-Committee report. No concerns of fraud were identified. • Following a concern raised in connection with the checking and verification of identification documents produced during the recruitment process, a Counter Fraud System Weakness / Risk Identification Report was created and

issued to the Head of Recruitment and Workforce Equality, Diversity & Inclusion. A copy of the report has been appended to the In-Committee report. Recommendations have been made and the risk posed is deemed low.

- During the reporting period, Counter Fraud have assisted in the review of the Health Board's Standards of Behaviour Policy and a financial procedure governing Patient Property and Money.
- The Public Sector Fraud Authority (PSFA) – part of the UK Government's Cabinet Office and HM Treasury – oversees the National Fraud Initiative (NFI) across the UK. Audit Wales leads the exercise in Wales under the Auditor General's powers in the Public Audit (Wales) Act 2004. The Auditor General's Code of Data Matching Practice summarises the key legislation, and controls governing the exercise in Wales. The Auditor General has mandated that unitary local authorities, NHS bodies, police forces, and fire and rescue authorities participate in the NFI. NFI helps prevent and detect fraud by sharing and matching sets of data electronically. Further information on the initiative can be found here, National Fraud Initiative | Audit Wales.

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

  To date, the exercise has assisted in the recovery of approximately £33,000. Further activity around risk identification and the testing of controls associated with the match groups listed below will continue into Quarter 3, with the intention of a final report being presented in Quarter 3.

  A breakdown of each exercise and a summary of activity undertaken has been provided below:

Match Type	Purpose of the match	Total Matches	Opened	Reviewed and closed	Remaining	Remarks
Payroll to Payroll	To identify individuals who may be committing employment fraud by failing to work their contracted hours because they are employed elsewhere or are taking long-term sickness absence from one employer and working for another employer at the same time. The criteria for a match are a person having one full-time post plus at least one other post elsewhere.	86	86	84	2	2 enquiries remain open, one of which is linked to an ongoing investigation linked ot an offence of Fraud by False Representation. The Health Board is awaiting a response from a third party reference the second open case. and the other is pending finalisation.
Payroll to Pension	To identify cases where employees who have gone back into employment after drawing a pension that could result in an abatement of pension.	110	110	110	0	Enquiries undertaken include working with NWSSP Pensions to ensure each entry is valid and compliant. No issues have been identified, and all matches are now closed.
Payroll to Creditors	The match identifies instances where an employee and creditor are linked by the same bank account or the same address to identify employees with interests in companies with which your organisation is trading. This may indicate potential undeclared interests and possible procurement corruption or where a member of staff has set up a creditor with their own bank details in order to receive payments they are not entitled to.	24	24	24	0	All matches are now complete, resulting in no concerns being identified.

	Payroll to companies' house	To identify potential undeclared interests that have given a pecuniary advantage. To do this NFI have matched payroll data to companies' house information and then to your creditors data. The reports are split between those highlighting employees who appear to be registered directors of companies that the employing body has traded with and those where the employees address appears to have links to the company directors or the company.	49	49	49	0	All matches are now complete, resulting in no concerns being identified.
Hold to Account	• New referrals have been received into the department over the last two months, with significant work being undertaken. A detailed report of all new, existing, and closed investigations has been provided to the Committee via an In-Committee report.						
Strategic Governance	• Quarterly statistics have been submitted to Counter Fraud Service (CFS) Wales and in compliance with WG directions.						

Report Provided by:
Ben Rees - Lead Local Counter Fraud Specialist
For presentation; 14 October 2025

Report agreed by:
Huw Thomas
Director of Finance

12:20, 0 Mins

7 - Assurance and Risk

7.1

12:20, 10 Mins

7.1 - Internal and External Recommendations and WHC Tracking Assurance Report

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

For assurance

Attachments

7.1 Audit Tracker and WHC Report October 2025.pdf

Audit and Risk Assurance Committee

Internal & External Recommendations and Welsh Health Circulars Assurance Report

14 October 2025

Situation and Background

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

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

The Health Board remains in Targeted Intervention (TI) (Level 4) status with Welsh Government (WG) as a result of challenges relating to financial sustainability, strategy and planning, service delivery and organisational performance. Whilst the Health Board has been de-escalated for 'Governance' from TI (Level 4) to Enhanced Monitoring (Level 3), the Health Board is required to meet the following revised set criteria:

- Evidence that all recommendations from the Royal Colleges / Health Inspectorate Wales (HIW) and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the Health Board's longer-term improvement plan;
- Demonstrate a prompt response to any HIW inspections, concerns, incidents, never-events, coroners requests and regulation 28s; and
- The Board acts on, and addresses appropriately, concerns raised through NHS regulators such as HIW.

This report now includes detail to provide ARAC with assurance on the effectiveness of processes in place across the Health Board in relation to the implementation of the requirements of Welsh Health Circulars (WHCs) as issued by Welsh Government.

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 tracker report provided to ARAC in June 2025:

Next Steps	Progress Made
Where system improvements have been identified in relation to the recording, reporting and monitoring of implementation of recommendations on AMaT, to follow up requests with the national systems team to address these gaps.	The Head of Assurance and Risk partakes in fortnightly meetings with AMAT super-users in Hywel Dda, where any identified system improvements are discussed and sent to AMAT development team. Requests are prioritised by the national system teams, with system development plans reviewed on a quarterly basis. This is an ongoing control process, supplemented by regular meetings between the Assurance and Risk Team and QAST to further identify system improvements, recognising that requests are not always actioned by the national AMAT team in a timely manner due their national prioritisation processes.
To work with the Performance team and explore and confirm timescales, when capacity allows, to develop audit performance dashboards via 'Power BI', replicating the detail as utilised for the monitoring of risks via the internal escalation framework, so that this information is readily available to users across the Health Board.	The Head of Assurance and Risk and Head of Performance are in the process of developing a specification document to inform the development of an audit performance dashboard, based on relevant metrics and criteria which will be accessible to staff across the Health Board, and support the provision of data for future Committee reporting along with required analysis as part of the Governance domain for the internal escalation framework. Once the specification document has been finalised this will inform implementation timescales, pending resource availability.
Further development of the Assurance and Risk SharePoint site to provide guidance and support, including the development of material detailing the purpose and benefits of tracking recommendations and supporting processes within the Health Board to ensure transparency and accountability:	The Assurance and Risk SharePoint site has been further enhanced to strengthen accessibility and clarity of information. The site has been restructured to provide a more user-friendly and visually engaging layout, enabling staff to easily navigate and locate the relevant guidance. Updates include the incorporation of the internal escalation process and the addition of information reflecting recent structural changes made within the Health Board. Staff can now enrol for training on the AMaT system via the Assurance and Risk SharePoint site.
Reiterating the importance of developing SMART action plans to ensure Clinical Care Groups (CCG) develop management responses which are credible and deliverable. Information on developing SMART responses is available from the Assurance and Risk SharePoint site and shared at CCG and CSG meetings. This will also be included in the Corporate Governance training which will be provided to CCGs in July 2025.	Supporting information is available via the Assurance and Risk SharePoint site in the development of management responses, and the significance of providing SMART management responses has also been embedded within CCG and CSG Assurance and Risk presentation materials. This approach continues to promote consistency and strengthen accountability across governance processes. Corporate Governance training sessions have been delivered with the CCGs to reinforce the importance of developing SMART action plans, ensuring that management responses are both credible and deliverable.

Audits and Inspections

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

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

Progress is monitored via the utilisation of a traffic light system based on performance against **original completion dates** based on the following criteria:

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

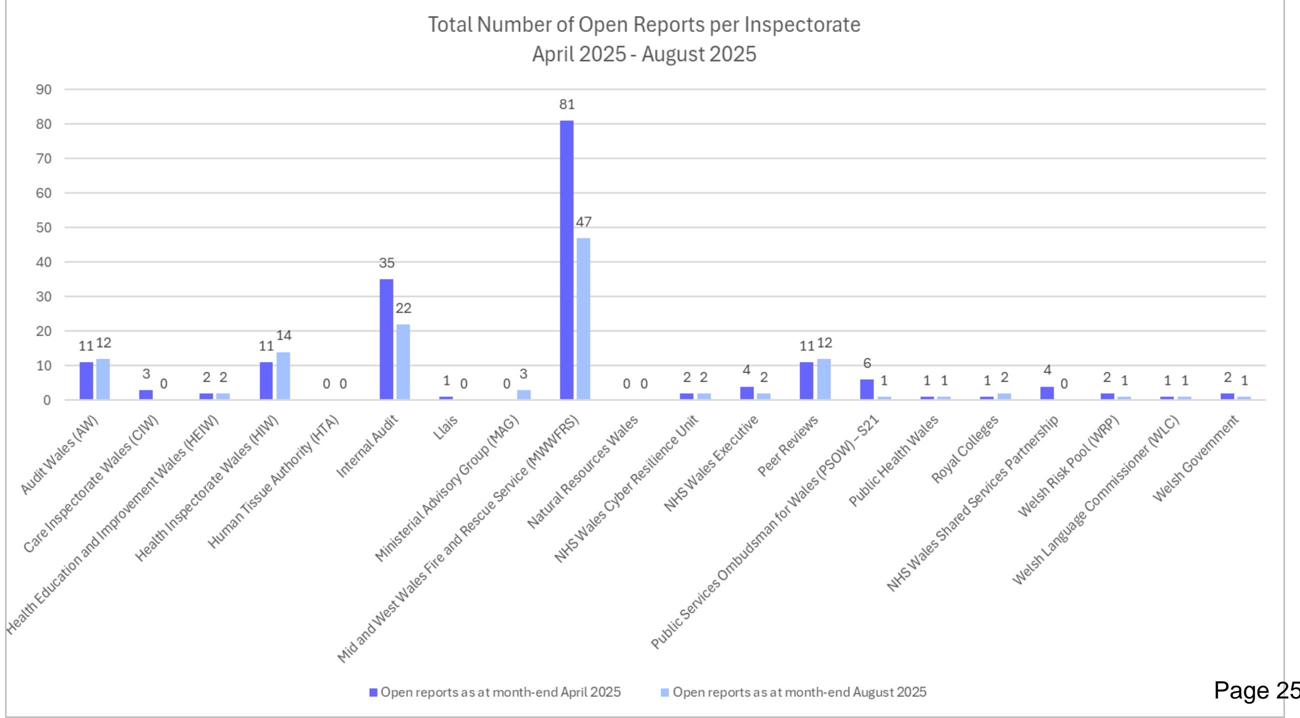
The Assurance and Risk team and Quality, Assurance and Safety team (QAST) liaise directly with services and review the status of the monitored reports to support the provision of progress updates and revised completion dates where applicable, and to provide technical support as required. Training is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

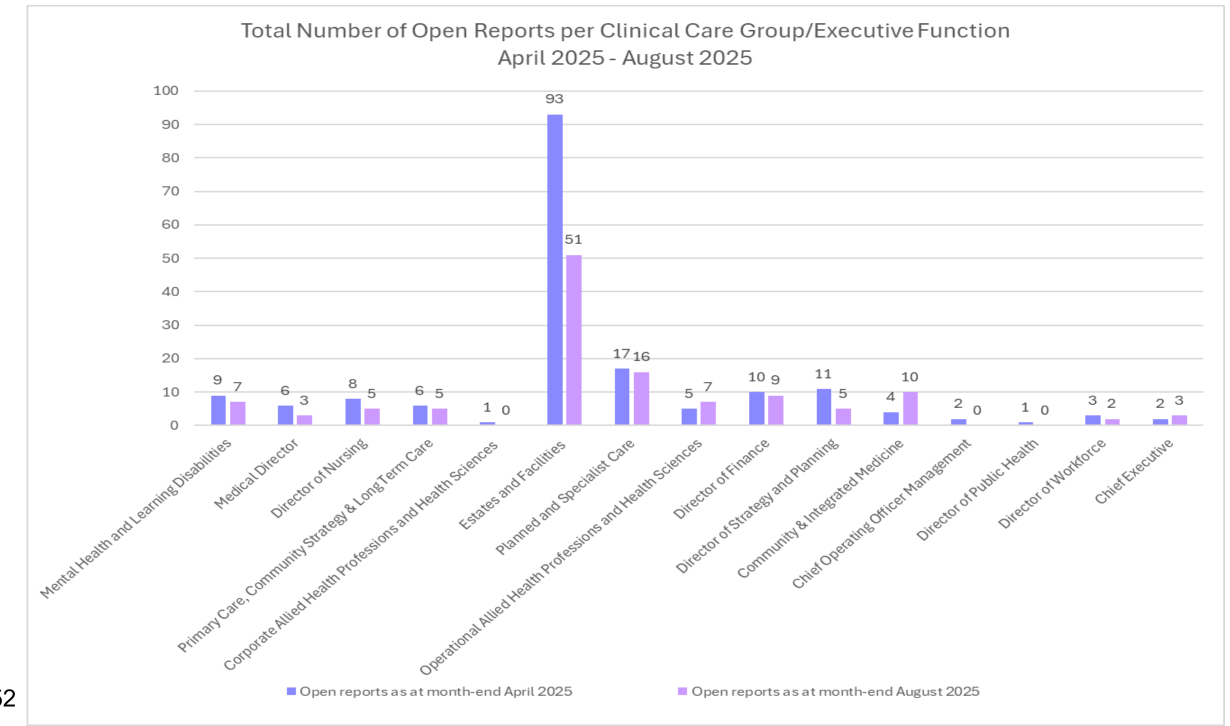
Overview of the Audit Tracker

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

Since the previous report presented to the Committee in June 2025, (based on data as extracted on 30 April 2025), there has been a significant reduction in the total number of open reports, decreasing from 178 to 123 in August 2025. The number of overdue reports has also reduced from 81 to 56. The graph below illustrates the number of open reports per auditor/inspectorate/regulator as at April and August 2025, representing a 31% reduction in open reports.

Since the previous report presented to ARAC,13 Internal Audit reports have been formally approved for closure by the Internal Audit Team, with relevant evidence appropriately uploaded to the AMaT system. Additionally, a revised administrative process for managing the Letters of Fire Safety Management (LOFSMs) was presented and agreed at the Estates & Facilities Integrated Governance Group (Quality Health & Safety) in May 2025, reinforcing the requirement to provide 'evidence' for completed actions on AMaT. Following the implementation of this new process, evidence was uploaded to those reports which had been 'pending closure' which enabled 34 of LOFSMs (some historical) to be formally signed off via the Head of Fire Safety in July 2025.

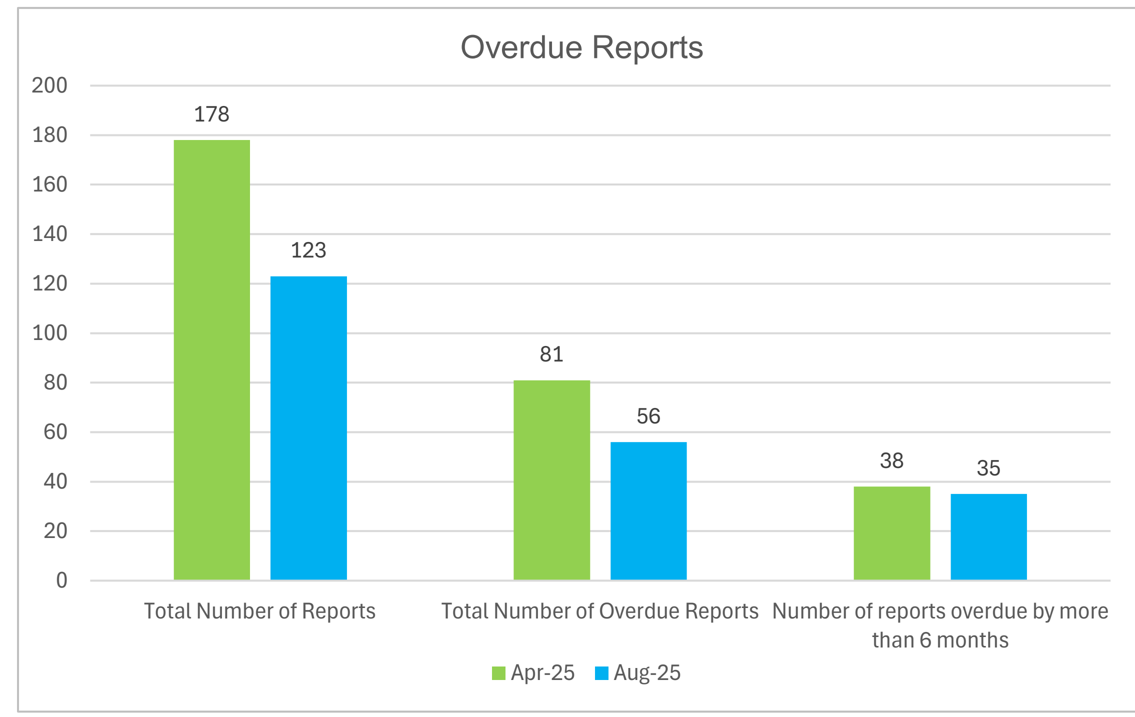


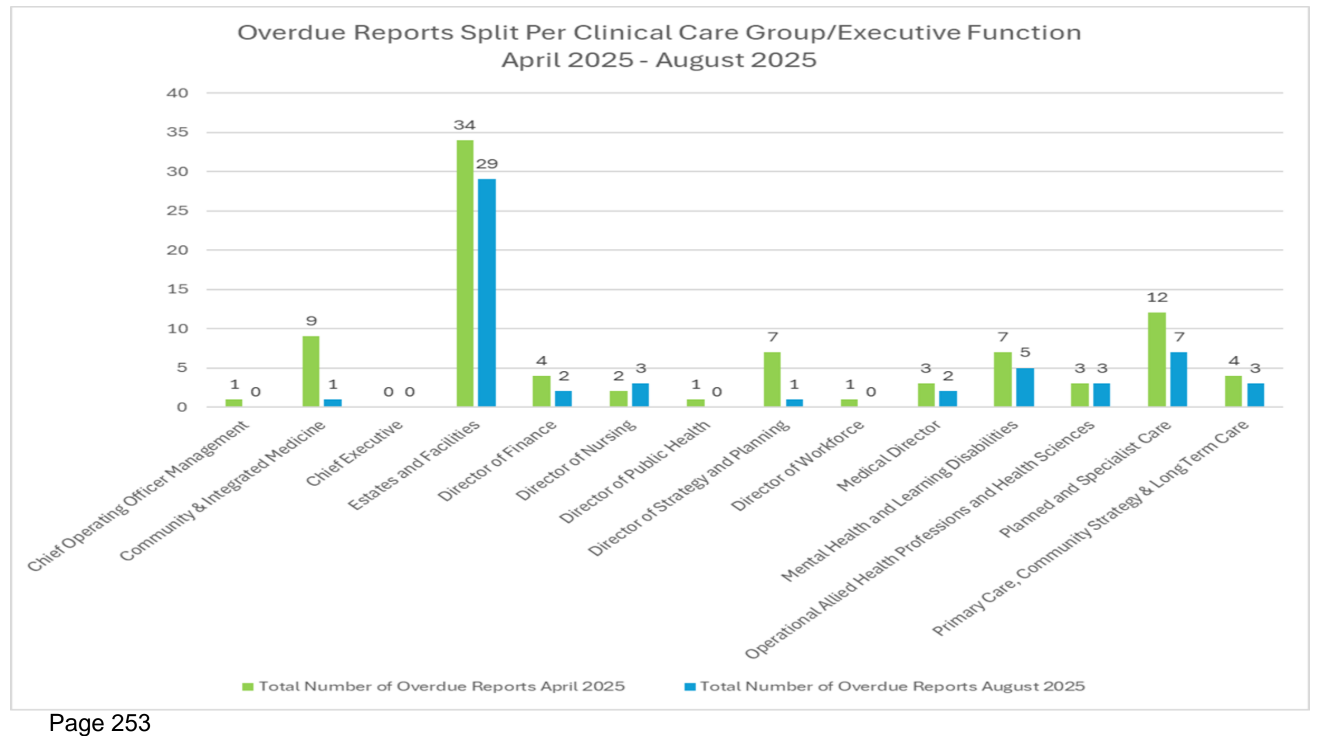


Audit Tracker Analysis – Overdue Reports

Since the last report presented to ARAC in June 2025, the number of overdue reports has decreased by 31% (from 81 to 56). Of the current open reports, 35 are overdue by more than six months, compared to the 38 reports noted in April 2025, showing a marginal improvement These reductions reflect continued progress made in clearing the backlog of historical reports, and the graph below illustrates a sustained downward trend in both the volume and ageing of the overdue reports.

The graph below illustrates a comparative analysis of overdue reports across organisational functions between April and August 2025. The data reflects an improving trend with several functions fully completing reports. The Director of Allied Health Professions and Health Sciences, while still holding the highest volume of overdue reports, achieved a reduction from 34 to 29. Community and Integrated Medicine saw a decrease in overdue reports from 2 to 1, while the Director of Strategy and Planning reduced theirs from 7 to 1. A number of functions maintained zero overdue reports throughout the period, indicating sustained compliance. Currently, the Director of Public Health and Chief Operating Officer Management do not have any reports assigned to them, therefore are not noted on the graph below

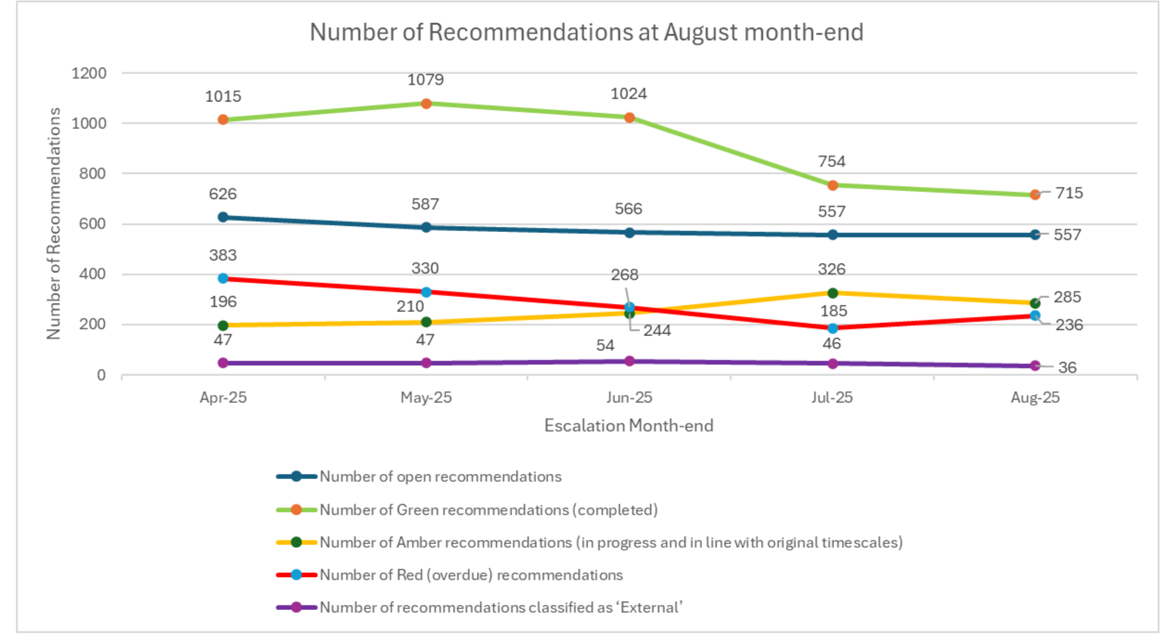


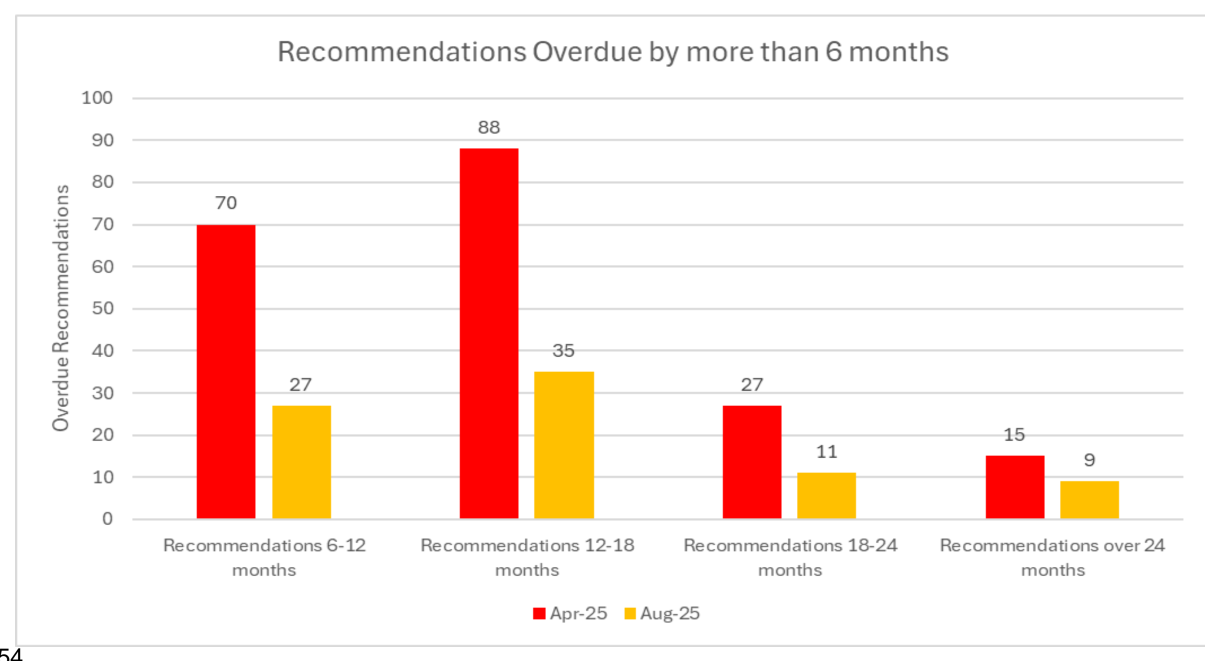


Audit Tracker Analysis – Overdue recommendations

The August data demonstrates the progress made in the management of the Audit and Inspections recommendations. The total number of recommendations has reduced from 1,641 in April 2025 to 1,272, with the number of open recommendations decreasing from 626 to 557.

It is noted that there has been an increase in the number of “in progress” (Amber) recommendations primarily attributable to the number of new reports received since the previous report presented to ARAC. The number of “overdue” (Red) recommendations has fallen significantly from 383 to 236, with 82 overdue by more than 6 months. The number of recommendations without revised timescales has also reduced from 286 to 162. These reductions have been primarily seen within Estates and Facilities, Planned and Specialist Care and Mental Health and Learning Disabilities. The improvements noted in addressing long-standing overdue recommendations is primarily due to the completion of recommendations raised with reports issued by Mid and West Wales Fire and Rescue Service reports, NHS Wales Shared Services Partnership report and Peer Review reports.



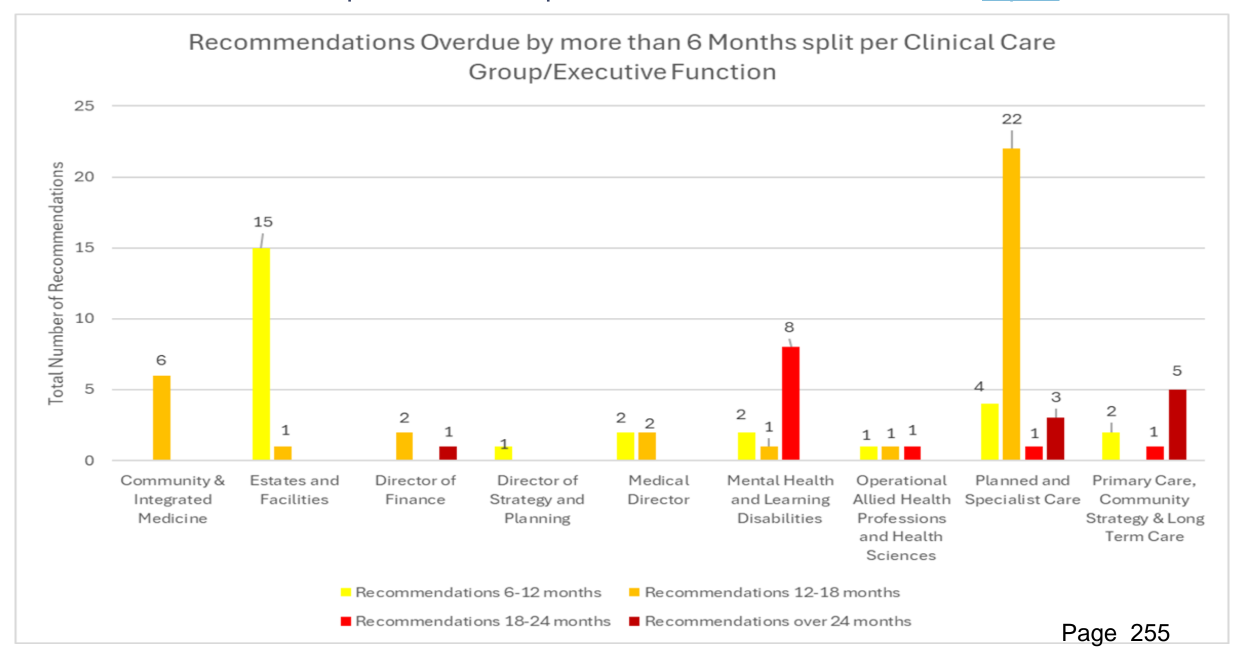


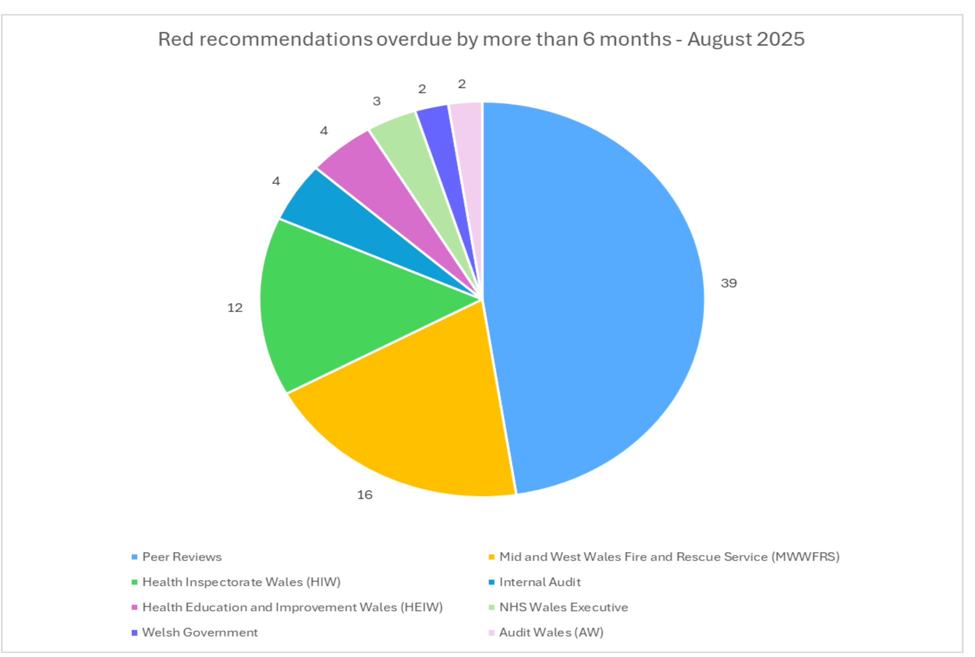
Audit Tracker Analysis – Overdue recommendations (continued)

Of the 82 recommendations overdue by greater than 6 month, 37% are attributable to Planned and Specialist Care, 19% to Estates and Facilities, and 13% to Mental Health and Learning Disabilities.

Analysis of the recommendations overdue by greater than 6 months per audit/inspectorate/regulator highlight that 39 (48%) are from Peer Review reports, 19 of which are from the Peer Review – 'Cervical Screening Wales Quality Assurance Visit Report' whereby the service has noted as them as "unable to complete" on AMaT due to barriers such as funding and the restrictions on recruitment of administrative staff. These 19 recommendations represent the majority of the 22 recommendations aged between 12–18 months assigned to Planned and Specialist Care. Since the data for this report was extracted, these recommendations have been escalated via the CCG IGG QSH meeting whereby it agreed that the Clinical Service Group review the recommendations further. In light of this, 4 of these recommendations previously marked as "unable to complete" have now been noted as complete on AMaT. 16 (20%) are attributable to the Mid and West Wales Fire and Rescue Service reports, 12 (15%) Health Inspectorate Wales, 4 (5%) Internal Audit, 4 (5%) Health Education and Improvement Wales, 3 (4%) NHS Wales Executive, 2 (2%) Welsh Government and 2 (2%) Audit Wales.

The Assurance and Risk Team have strengthened the escalation criteria within the Governance domain per the internal escalation framework to include more detail on those services with long-standing overdue recommendations. Key improvement metrics for progress against audits and inspection (as well as risk management) are now relayed via the Clinical Care Group (CCG) / Executive Function structures, with a level between 1 and 4 assigned for each metric based on the level of assurance around the targets in each area. The key measures to assess against the Governance domain for audits and inspections are explained in more detail later in this report.





Audit Tracker Analysis - Recommendations without revised timescales

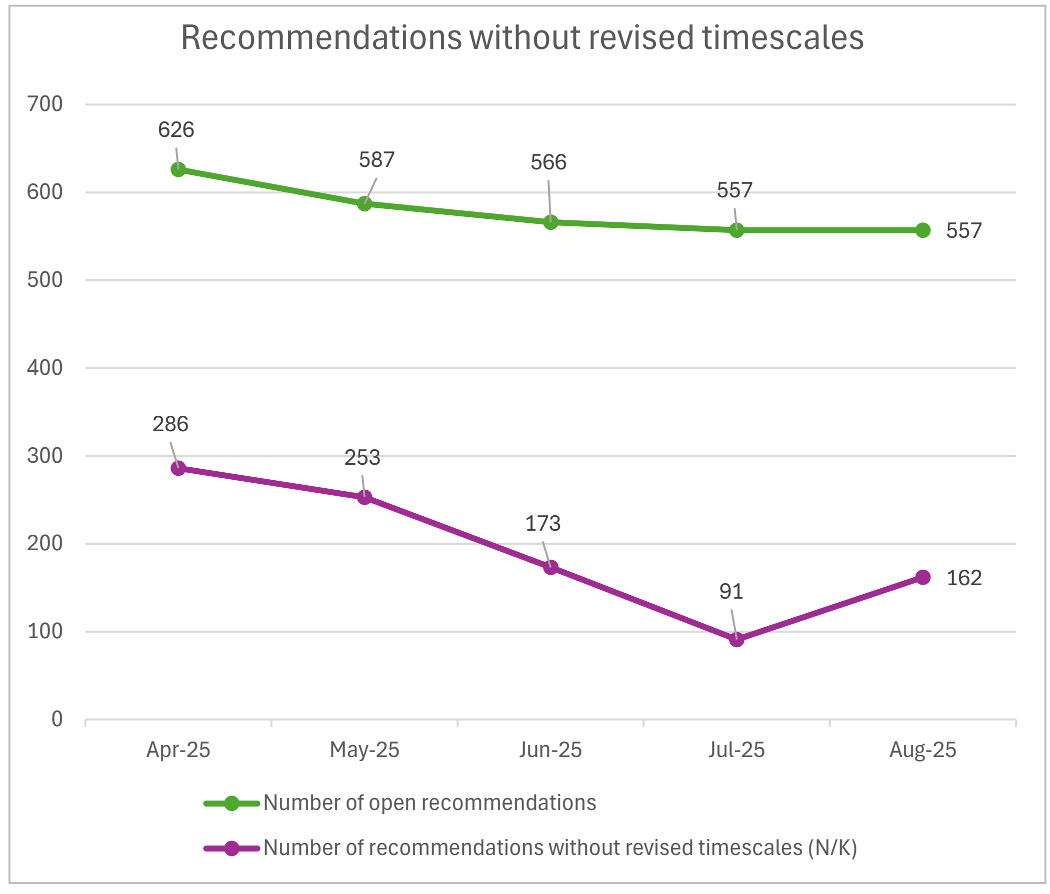
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

There were 162 (29%) recommendations without revised timescales as at August 2025. Recommendations without revised timescales are mainly attributed to the following:

- Reliance on external factors such as further guidance or clarification from relevant inspectorates, regulators or Welsh Government / implementation of national systems to inform revised completion dates;
- Recommendations previously noted as 'complete' being re-opened due to lack of appropriate supporting evidence on review by relevant system approvers;
- 79 recommendations lapsed since July 2025 which have yet to be updated with a revised completion date. In the absence of a specific 'revised date' field on AMaT, the Assurance and Risk team continue to remind services to provide revised dates on the AMaT system through their progress updates. A delay in the provision of revised completion dates may be attributable to operational pressures and capacity within the Health Board over the summer months;
- CCGs / Executive Functions have provided progress updates on AMAT but not included a revised completion date.

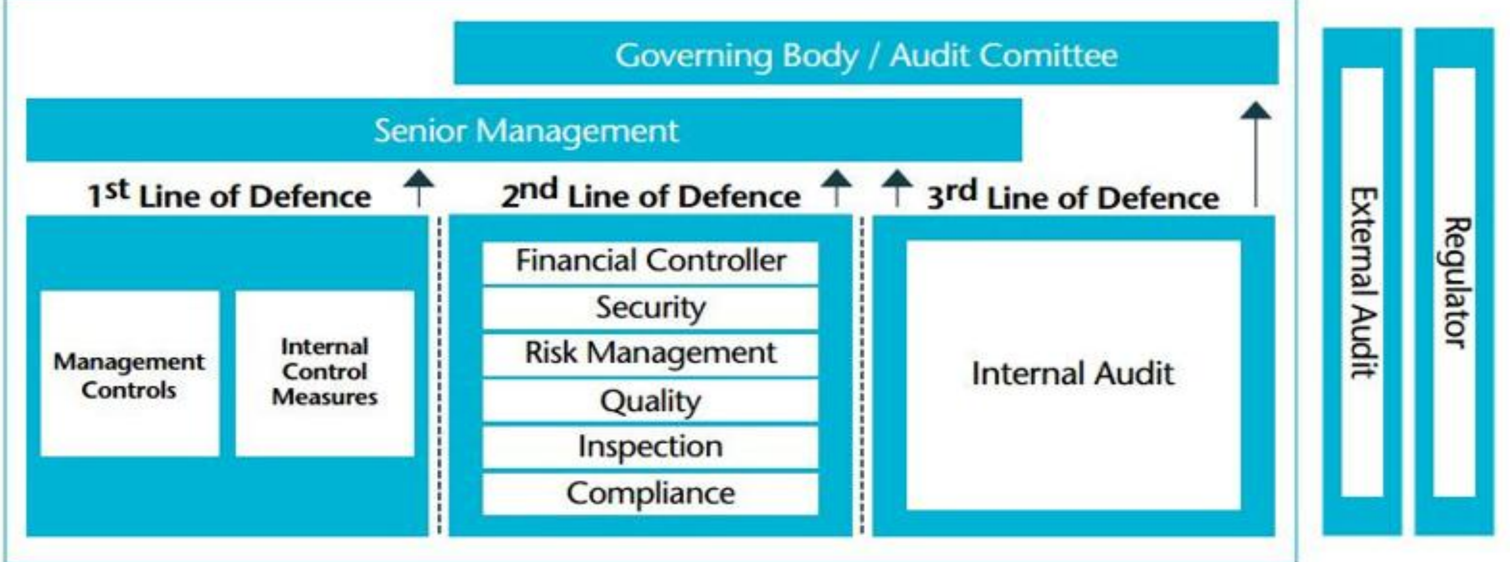
Service leads are able to note on AMaT the specific barriers to the full implementation of recommendations. Training materials and sessions highlight the requirement for recommendation owners to include revised completion dates where appropriate when providing progress updates. Guidance is also available on the team's Sharepoint site. The Assurance and Risk team continue to remind services of the need to include revised completion dates within the Assurance and Risk overview reports presented to CCG / CSG and Executive Function governance meetings, and continue to review recommendations where progress updates have not been obtained, with the relevant business partner for those services prioritising the support offered.

Scoping work has commenced to explore the opportunity to develop performance dashboards on the data captured on AMaT via 'Power BI' with colleagues in QAST and the Performance Team. This would provide services with improved oversight of their performance, including the number of recommendations without a revised timescale, and would support the internal escalation framework.



Three Lines of Defence

The Health Board operates within the widely accepted "Three Lines of Defence" model, which provides a simple and effective way to delegate and coordinate roles and responsibilities within an organisation to ensure the appropriate responsibility is allocated for the management, reporting and escalation of the implementation of recommendations.



Operational Management (1st line)

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

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

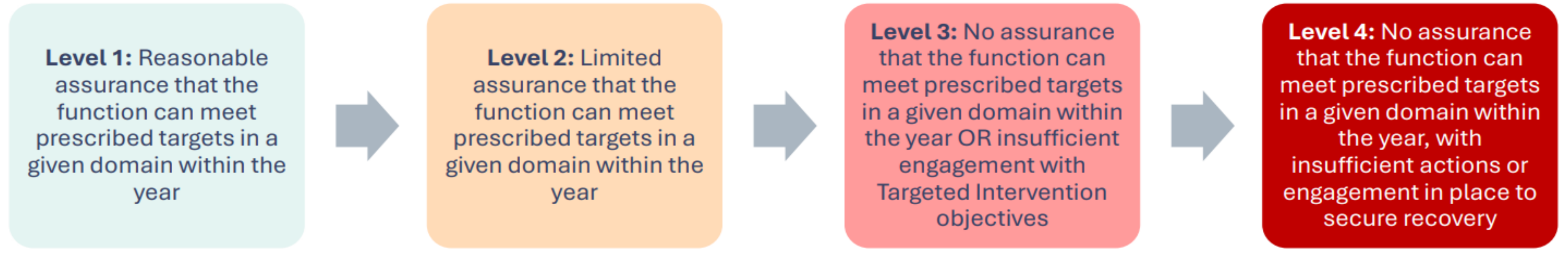
Where meetings are stood down, or in the absence of formal governance arrangements, assurance and risk reports are provided to management and service leads via e-mail to enable them to address any areas of concern.

Three Lines of Defence

Internal Escalation (2nd Line)

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

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



Independent Assurance (3rd line)

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

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

The graph below provides a summary of open reports as at August 2025, and the status of the recommendations split per CCG/ Executive Function as per the revised internal escalation framework structure, further detail of which can be found on the next slide. The graph below details how many recommendations are overdue, and of those overdue recommendations how many are overdue by more than 6 months as well as the recommendations without revised completion dates.

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

Y-axis: Total Number of Recommendations (0–400)

	Total Number of Recommendations	Number of Overdue Recommendations	Total number of Recommendations overdue by more than 6 months	Total number of N/K recommednations
Chief Operating Officer Management	0			
Community & Integrated Medicine	214	104	6	92
Director of Allied Health Professions and Health Sciences	0			
Estates & Facilities	336	46	16	15
Director of Finance	49	5	3	3
Director of Nursing	45	8	0	3
Director of Public Health	0			
Director of Strategy and Planning	13	1	1	1
Director of Workforce	8			
Medical Director	27	4	4	3
Mental Health and Learning Disabilities	139	12	11	2
Operational Allied Health Professions and Health Sciences	84	12	3	10
Planned and Specialist Care	284	31	30	28
Primary Care, Community Strategy & Long Term Care	59	11	8	5
Chief Executive	14			

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

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

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

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

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

Service	April 2025	May 2025	June 2025	July 2025	August 2025
Chief Operating Officer Management	2	2	1	1	1
Community & Integrated Medicine	2	2	2	2	3*
Estates & Facilities	3	3	2	2	2
Executive Director of Allied Health Professions and Health Sciences	1	2	1	1	1
Executive Director of Finance	2	2	2	1	1
Executive Director of Nursing, Quality and Patient Experience	2	2	2	2	2
Executive Director of Public Health	2	1	1	1	1
Executive Director of Strategy and Planning	2	2	2	1	1
Executive Director of Workforce and Organisational Development	1	1	2	1	1
Executive Medical Director	2	2	1	1	1
Governance and Communication	1	1	1	1	1
Mental Health and Learning Disabilities	3	3	2	2	2
Operational Allied Health Professions and Health Sciences	2	2	2	2	2
Planned and Specialist Care	3	3	3	3	3
Primary Care, Community Strategy & Long Term Care	2	2	2	2	2

A summary of each CCG / Executive Function's performance for the Governance domain can be found in the table to the left.

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

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

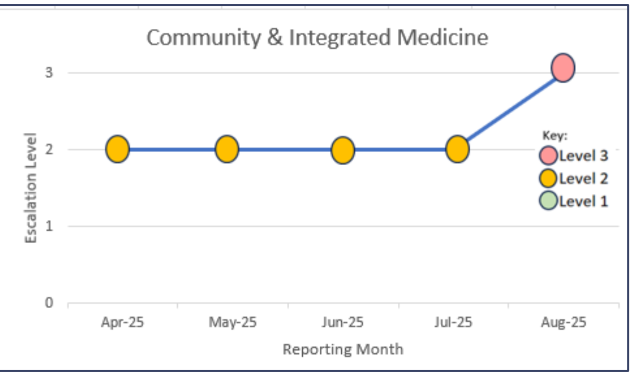
*Detailed analysis of those CCGs / Executive Functions who have been awarded either a Level 3 status as at August 2025 is provided on the next slide, based on performance in the management of recommendations (to note, 0 functions were awarded Level 4 in August 2025).

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

Community & Integrated Medicine

As at 31 August 2025,104 of 214 recommendations are overdue (49%). 6 are overdue between 12-18 months, all others are less than 6 months overdue. Of the 104:

- 73 are aligned to Carmarthenshire Integrated System, none of which are overdue by more than 6 months. 62 of the 73 became overdue during August 2025. None of the overdue recommendations have revised completion dates);
- 12 are aligned to Ceredigion Integrated System, 5 of which are overdue by 12-18 months. 8 recommendations do not have revised dates (N/K);
- 7 are aligned to Pembrokeshire Integrated System, one of which is overdue by 12-18 months. 1 recommendation does not have a revised completion date; and
- 12 aligned to the overarching Clinical Care Group, none of which are overdue by more than 6 months. 10 recommendations do not have revised dates completion dates.



Of the 104 overdue recommendations, 57 are from the *NHS Wales Executive Report on Urgent and Emergency Care Opportunities: GGH site report*. Of these, 19 did not have original completion dates noted, therefore the status of these recommendations will be amended as appropriate once completion dates are including on AMaT. An additional 32 of the 57 recommendations were noted as complete in the initial management response, however evidence has yet to be uploaded to AMaT to support this response. These recommendations are noted as overdue until such time relevant evidence has been uploaded. NHS Wales Performance and Improvement have revisited the Health Board in August 2025, and the report is awaited.

18 overdue recommendations are from the *Getting It Right First Time (GIRFT) Emergency Department* report, of which 5 have revised completion dates. GIRFT are revisiting the Health Board during September 2025. 5 overdue recommendations sit with the *Ministerial Advisory Group (MAG) Urgent and Emergency care report*. A MAG progress update is scheduled to be reported to the Public Board in September 2025.

Internal Escalation - Governance Domain : Level 2 – Limited Assurance

The following services were awarded a Level 2 in terms of their audit and inspection reports as at August 2025:

Service	Reason for award of L2	De-escalation Criteria
Medicines Management	17% of recommendations overdue.	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Estates & Facilities	46 (14%) of recommendations overdue	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Executive Director of Nursing	8 (18%) of recommendations overdue	To achieve L1, Executive Function required to implement over 90% of recommendations and provide revised completion dates for those where completion dates have lapsed
Mental Health and Learning Disabilities	9 (8%) of recommendations overdue, however, 3 (60%) of reports overdue and trajectory target was breached with 1 action outstanding from July 2025.	To achieve Level 1, CCG required to implement over 90% of recommendations
Operational Allied Health Professions & Health Sciences	11 (20%) recommendations overdue	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Planned and Specialist Care	31 (11%) of recommendations overdue.	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales
Primary Care, Community Strategy & Long Term Care	11 (19%) recommendations overdue	To achieve de-escalation to Level 1, 90% of recommendations to be implemented within agreed timescales

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

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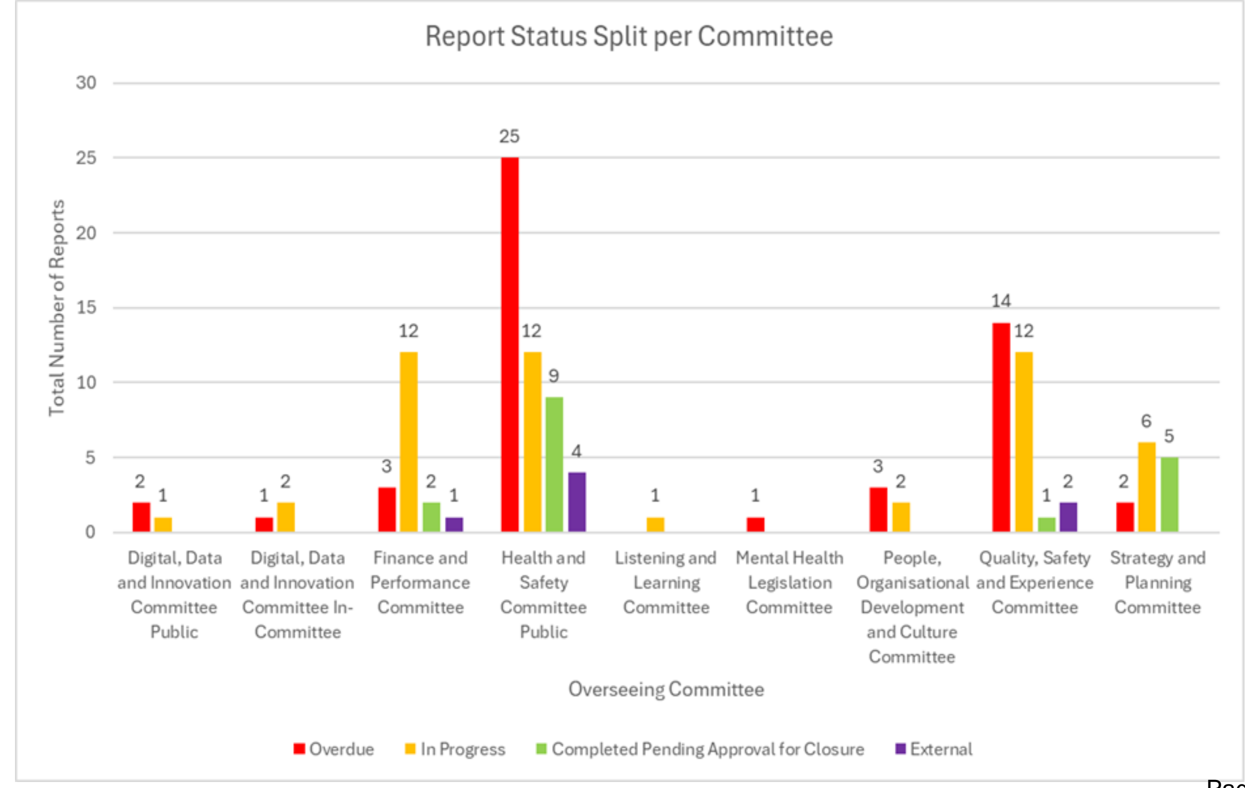
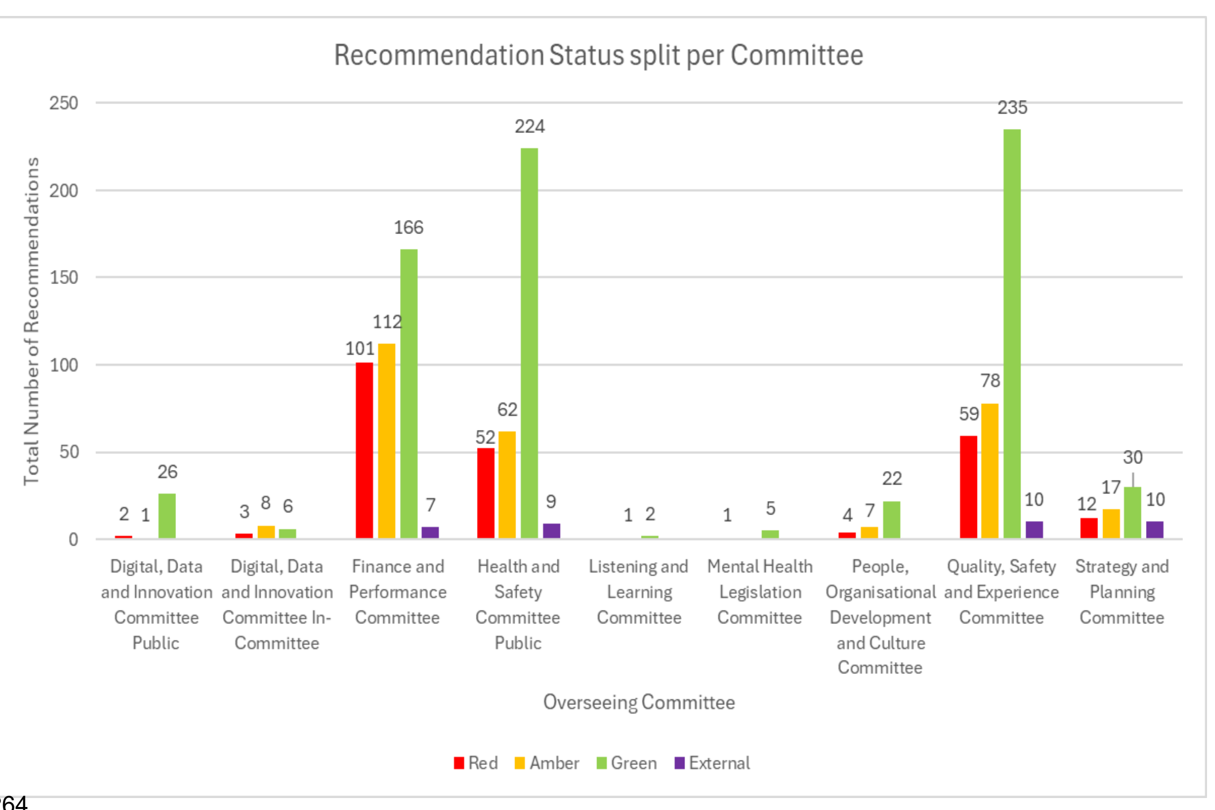
Board level Committees are to receive assurance of the timely implementation of external recommendations. On initial receipt of reports from inspectorates and regulators, these should be presented to the relevant committee for awareness of their findings, highlighting recommendations which have been raised. This process is followed for reports issued by Internal Audit, External Audit, Peer Reviews, HIW and CIW. Assurance on the overall process of tracking recommendations is undertaken by ARAC.

Since the previous report to ARAC, the Assurance and Risk team have produced a new report for presentation to all Board Committees which includes on the progress made in implementing recommendations which are aligned to them in order to provide assurance and outlining any barriers to implementation. Below is a breakdown of the number of reports and recommendations assigned to each Board level committee.





Three Lines of Defence: 2nd Line - Thematic Analysis

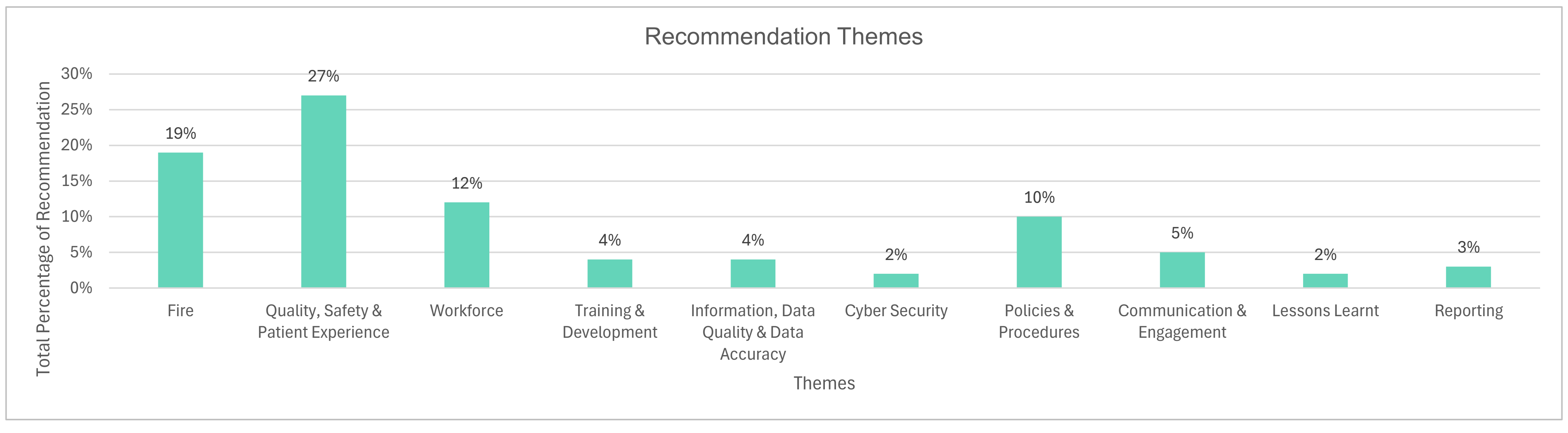
As part of the second line of defence, themes are assigned to each recommendation, which allows the Health Board to analyse groups of similar recommendations. The Assurance and Risk team commenced sharing recommendations with themed subject matter experts (replicating the process undertaken of sharing of thematic risk registers) on a bi-monthly basis, with ongoing review to ensure alignment between both Datix and AMaT.

The graph below provides a thematic analysis for all open recommendations per theme as at August 2025. 27% of the open recommendations were assigned the Quality, safety & Patient Experience theme. (In June 2025, the Assurance and Risk Team amalgamated the 'Patient Safety' and 'Safe' themes with the Quality, Safety & Patient Experience theme).

The following themes had less than 1% of Recommendations assigned to them:

Health and Safety, Governance, Finance, Performance Monitoring, Medical Devices, Infection Control, Information Governance, Partnerships, Safeguarding, Estates, Medication, Business Disruption, Approvals, Financial Management & Control, Planning Delivery & Deadline Management, Resourcing, Strategy, Capital Equipment, ICT (Information and Communication Technology), Risk Management.

The Assurance and Risk Team share the themed recommendations with themed subject matter experts (replicating the process undertaken of sharing of thematic risk registers) on a bi-monthly basis, with ongoing review to ensure alignment between both Datix and AMAT.



Welsh Health Circulars

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

Each WHC is assigned a RAG status, the table below provides the definition for each category:

RAG Status	Definition
Red	Behind schedule to the timescale provided by the Lead officer or as stipulated in the WHC, or a plan (with date for implementation) is not yet in place.
Amber	A plan is in place and on schedule to be completed by the timescale provided by the Lead Officer (if a timescale is not provided within the WHC)
Green	Completed
External	Considered to be outside the gift of the Health Board to currently implement, for example reliant on an external organisation to implement.

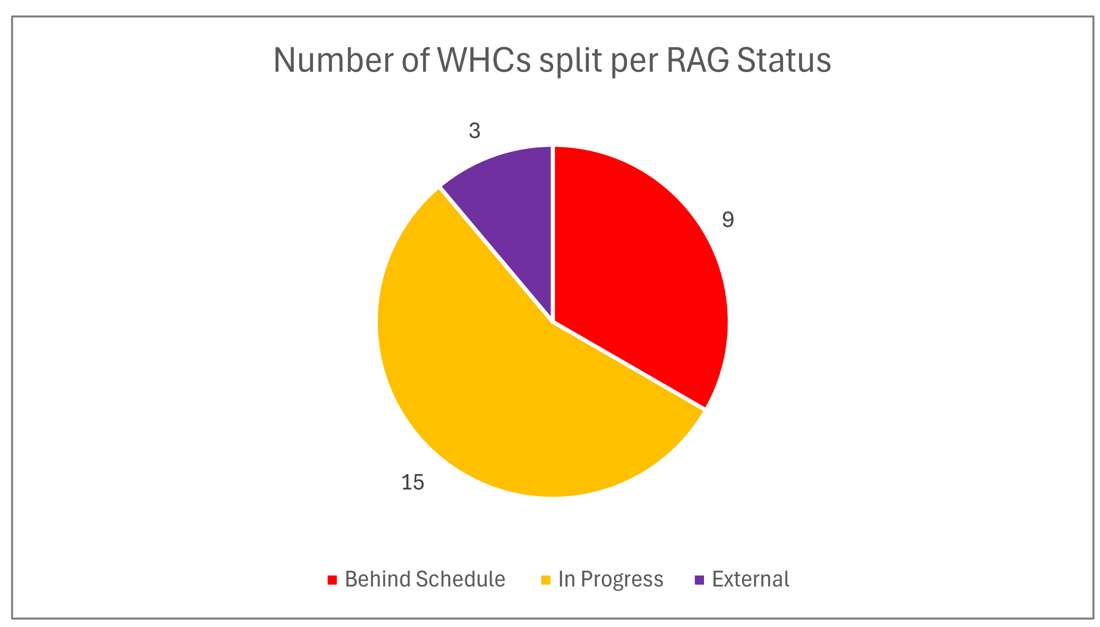
Oversight of the delivery of WHCs has been included in new Clinical Care Group (CCG) Terms of Reference, with the requirement to escalate appropriately in instances of non-compliance.

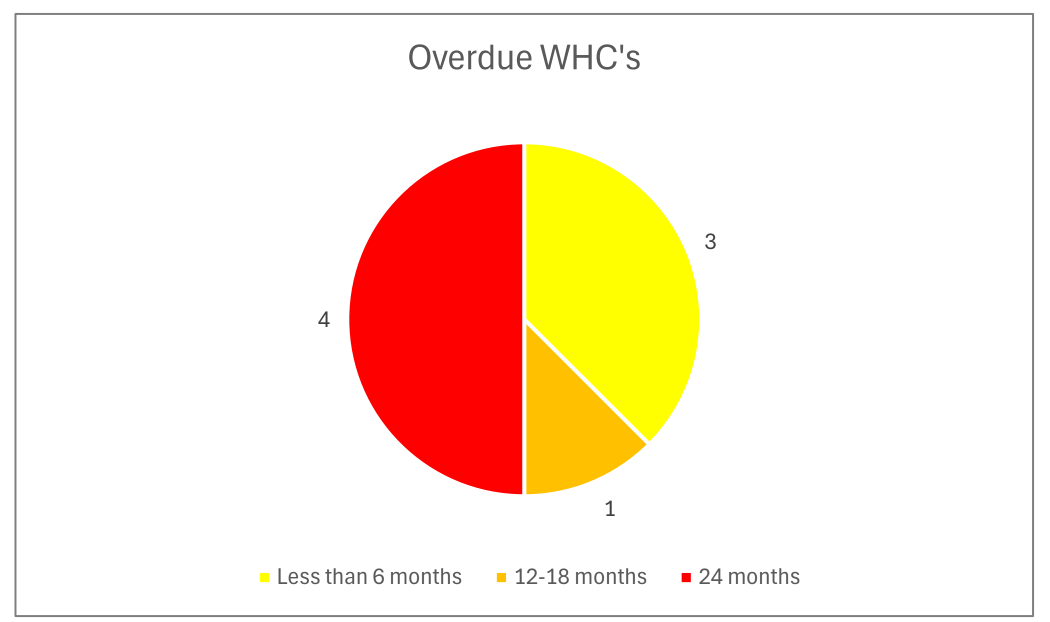
The timely implementation of WHCs is included within the Governance domain of the Health Board's internal escalation framework, with services escalated in instances of non-compliance.

Overview of Welsh Health Circulars

This report provides an overview of the open Welsh Health Circulars, based on the most recent analysis point at the time of preparation (31 August 2025).

As at 31 August 2025, there are currently 27 open Welsh Health Circulars assigned to the Health Board. The graphs below denote their RAG status, and an analysis of the length of time these WHCs have been noted as overdue.





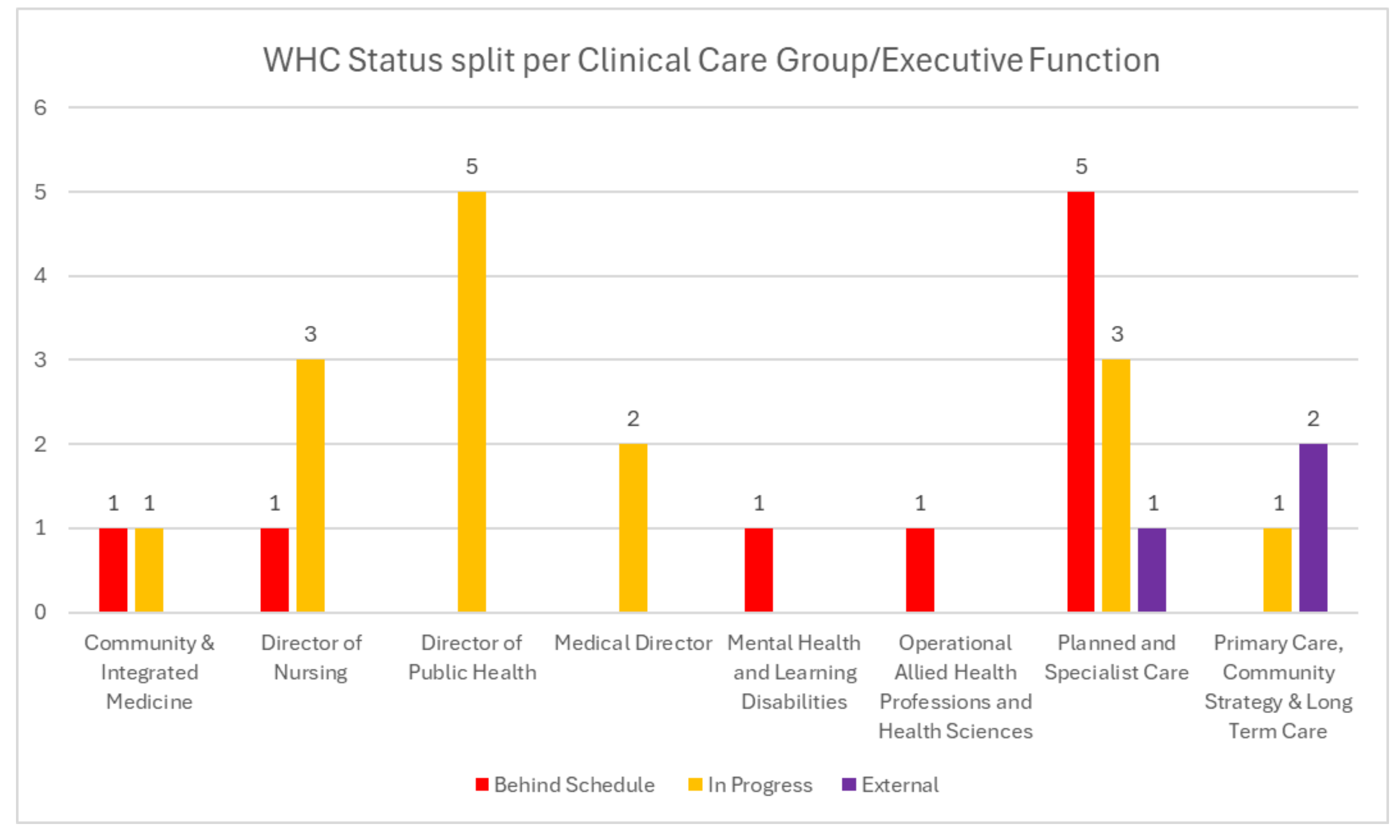
Of the 9 WHCs noted as behind schedule, 4 (50%) are behind schedule by more than 24 months (3 assigned to Planned and Specialist Care, and 1 to Nursing, Quality and Patient Experience). The main barriers preventing the implementation of these WHCs include lack of funding and ongoing challenges in recruiting staff.

In instances where WHCs cannot be implemented, the relevant lead is required to update AMaT to reflect the barriers to implementing the WHC, and the addition of corresponding risk the Clinical Service Sub-Group's risk register on Datix. A QIA (where appropriate) is also required to be undertaken, as well as escalate the WHC to the attention of the relevant CCG Leads via their CCG IGG meetings.

Three Lines of Defence: 1st Line - WHCs

The graph below provides a summary of the status of each WHCs assigned to the Clinical Care Groups and Executive Functions as at the end of August 2025.

As illustrated in the graph below, Planned and Specialist Care have 5 (56%) WHCs which are noted as behind schedule (red). The CCG has followed due process and has added corresponding risks to the Risk Register and completed QIA's for the overdue WHC.



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

Service	April 2025	May 2025	June 2025	July 2025	August 2025
Chief Operating Officer Management	2	2	1	1	1
Community & Integrated Medicine	2	2	2	2	3*
Estates & Facilities	3	3	2	2	2
Executive Director of Allied Health Professions and Health Sciences	1	2	1	1	1
Executive Director of Finance	2	2	2	1	1
Executive Director of Nursing, Quality and Patient Experience	2	2	2	2	2
Executive Director of Public Health	2	1	1	1	1
Executive Director of Strategy and Planning	2	2	2	1	1
Executive Director of Workforce and Organisational Development	1	1	2	1	1
Executive Medical Director	2	2	1	1	1
Governance and Communication	1	1	1	1	1
Mental Health and Learning Disabilities	3	3	2	2	2
Operational Allied Health Professions and Health Sciences	2	2	2	2	2
Planned and Specialist Care	3	3	3	3	3*
Primary Care, Community Strategy & Long Term Care	2	2	2	2	2

A summary of each CCG / Executive Function's performance for the Governance domain can be found in the table to the left.

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

The minimum requirement for a service to be awarded their escalation level is noted on the next slide, followed by a detailed analysis of those CCGs / Executive Functions who have been awarded either a Level 3 status as at August 2025.

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

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

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

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

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

Planned and Specialist Care

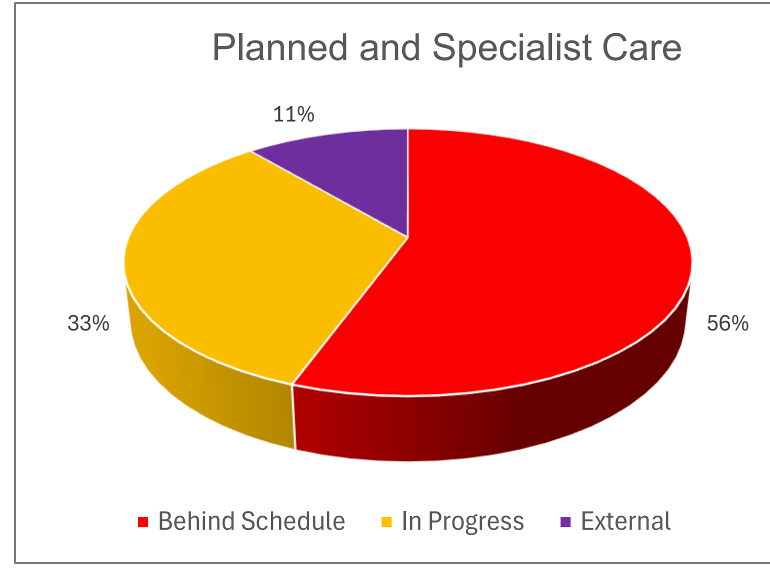
As at 31 August 2025, there are 9 Welsh Health Circulars assigned to the Planned and Specialist Care Clinical Care Group, of which 5 (56%) are noted as behind schedule. 4 of these have appropriate risks added the risk register and QIA's have been completed for 3 of them and sent to the Quality, Assurance and Safety team.

Children, Women And Family Health (CW&FH) Clinical Service Group are in the process of recruiting for a specialised nurse to address the requirements of the *Guidance for the provision of continence containment products for children and young people: a consensus document* WHC. CW&FH are currently compliant with all aspects of *The NHS Wales: Newborn and Infant Physical Examination Cymru (NIPEC)* WHC, apart from the data capture requirements, for which no national system is currently available. Compliance with this WHC is therefore currently outside the gift of the Health Board until an all-Wales data system becomes available (i.e external).

In September 2025, the CCG Director has met with Director of Corporate Governance. It was discussed that the following WHCs require investment in order to be implemented, and will need to be considered as part of HB's priorities and planning process for 2025/26:

- 006-18: Framework of Action for Wales, 2017-2020
- 009-21: School Entry Hearing Screening pathway
- 017-19: Living with persistent pain in Wales guidance.

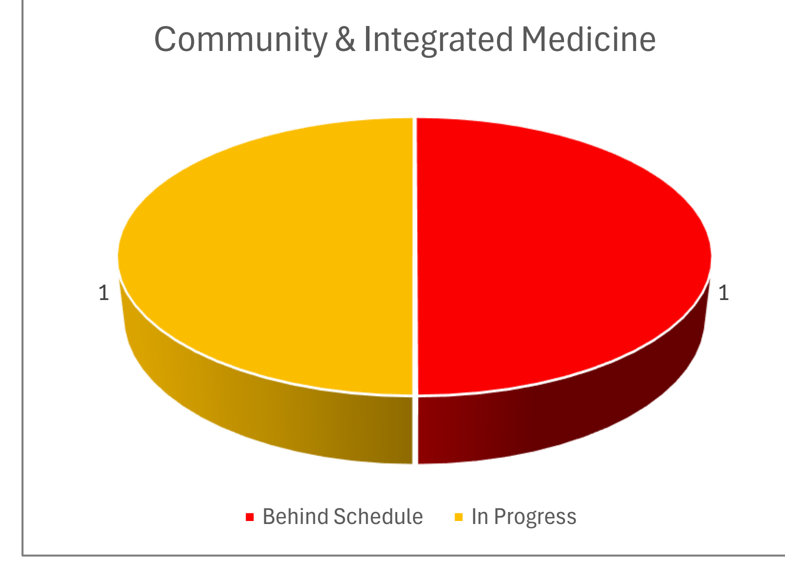
The Non-Specialised Paediatric Orthopaedic Services WHC requires information to be added to AMaT to outline what aspects of the WHC has already been addressed by the Trauma and Orthopaedic service and what requirements of the WHC can be addressed by Primary Care, Community Strategy & Long-Term Care Clinical Care Group.



Community & Integrated Medicine

As at 31 August 2025, there are 2 WHCs assigned to Community & Integrated Medicine Clinical Care Group. 1 WHC is in progress (Ambulance patient handover guidance (WHC/2024/041)) and due for implementation in December 2025.1 WHC is overdue relating to The national clinical guideline for stroke (WHC/2024/006).

The overdue WHC has an appropriate risk on the risk register, and a Quality Impact Assessment has been completed and sent to the Quality, Assurance and Safety team. The WHC cannot be implemented until the Clinical Services Plan has been developed. Stroke Services are part of this wider plan as there is a current lack of resource, including staffing, equipment and environment.

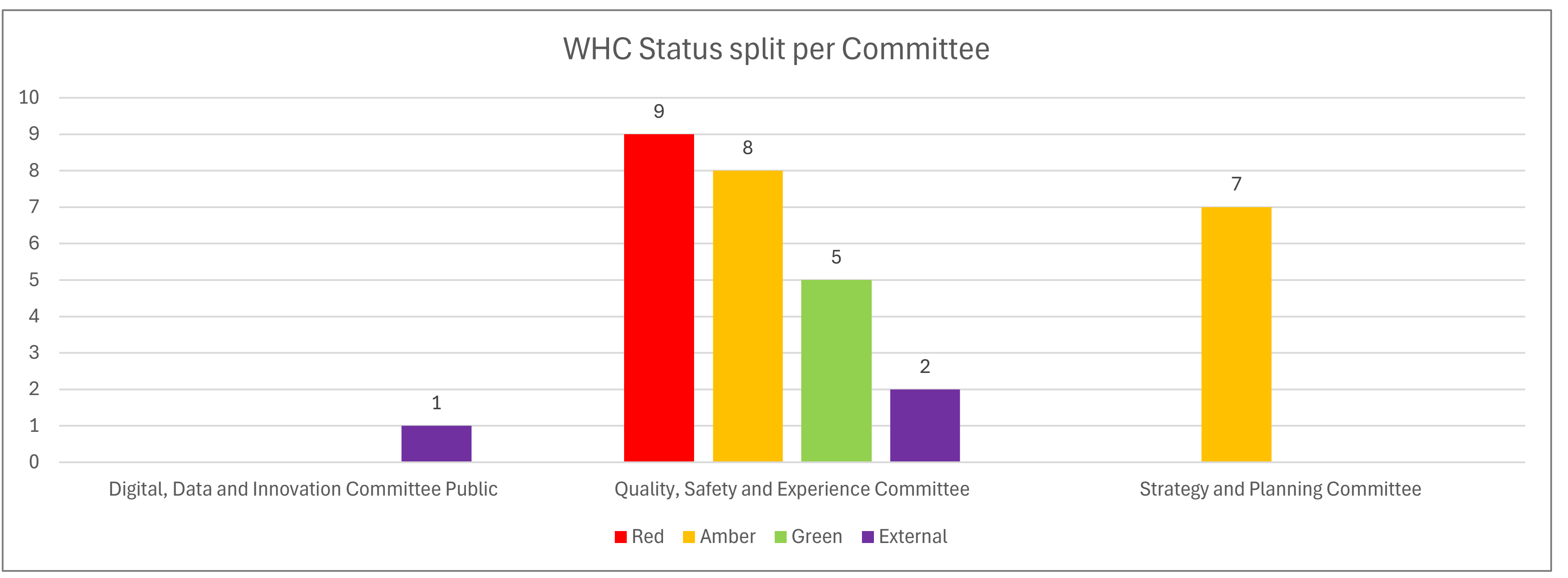


Three Lines of Defence: 2nd Line: Board and Committee Oversight - WHCs

Board level Committees are to receive assurance of the timely implementation of the WHCs. The Committees are responsible for seeking assurance that the Health Board is compliant with the requirements of WHCs, and that these are implemented in line with stated and/or agreed timescales. In instances where this has not been possible, the Committees are asked to receive assurance that the impacts resulting from late/non-delivery are understood and managed appropriately.

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

The Assurance and Risk team have produced a new template for presentation to all Board Committees which includes on the progress made in implementing recommendations which are aligned to them in order to provide oversight and assurance, highlighting any barriers to implementation. Below is a breakdown of the number of Welsh Health Circulars assigned to each Board level committee.



Next Steps and Recommendations

Next Steps

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

- To address any feedback from Board Committees since the introduction of the Assurance and Risk Report to further strengthen the assurances provided on the progress being made to the implementation of recommendations raised;
- To continue to work with the Performance team and explore and confirm timescales, when capacity allows, to develop the audit tracking performance dashboard via 'Power BI', replicating the detail as utilised for the monitoring of risks via the internal escalation framework, so that this information is readily available to users across the Health Board.

Recommendations

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

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

8

12:30, 0 Mins

8 - For Information

8.1

12:30, 0 Mins

8.1 - ARAC Workplan 2025/26

For information

Attachments

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

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

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
AUDIT WALES									
Review External Audit Plan via update reports	**Audit Wales**	✓		✓	✓	✓	✓	✓	✓
Approve External Audit Strategy & Annual Audit Plan (designed to implement the strategy) & assoc fees	**Audit Wales**	✓						✓	✓
Review of External Audit Reports including results & the adequacy of executive & mgmt responses to any issues identified and ensure that the other Cttees monitor & report back	**Audit Wales**	✓		✓	✓	✓	✓	✓	✓
Consider any Audit Wales National Value for Money Examinations & Performance Reports	**Audit Wales**	✓		✓	✓	✓	✓	✓	✓
Receive the Auditor's General report to those charged with governance (Year-end)	**Audit Wales**		✓						
Structured Assessment 2024 Management Response Update	**Audit Wales/JW**				✓			✓	
Structured Assessment 2025	**Audit Wales**						✓	✓	
Review of Urgent and Emergency Care (Part 1 and Part 2)	**Audit Wales/AC**	D		✓	D	✓			
Planned Care Review	**Audit Wales/AC**	D		✓					
Review of Capital Investment Prioritisation	**Audit Wales/LD**			✓					
Cancer Services in Wales: A review of the strategic approach to improving the timeliness of diagnosis and treatment	**Audit Wales/AC**	✓							
Review of the Management of Outpatients	**Audit Wales/AC**				D	D	✓		
Deep Dive - Review of Investment in Digital Systems	**Audit Wales/HT**				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	April 2026
Review of Radiology Services	**Audit Wales/AC**							✓	
Deep Dive - Review of the Arrangements to Manage Estates	**Audit Wales/JS**								✓
Review of Cancer Services	**Audit Wales/AC**								✓
National Fraud Initiative Briefing Note	**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**	✓							
Executive Team Governance (Substantial Assurance)	**JJ/PK/JW**	D	✓						

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
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**					✓			
Vaccination and Immunisation	**JJ/AG**					D	✓		
Operational Governance Arrangements	**JJ/AC**						✓		

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
Level Three / Four Directorates	**JJ/AC**						✓		
Medical Devices Regulations	**JJ/AC**						✓		
Managed Practices	**JJ/AC/JP**						✓		
Cyber Security	**JJ/HT**						✓		
Theatre Stock System Implementation	**JJ/AC**							✓	
Health & Safety	**JJ/JS**							✓	
Escalation Governance	**JJ/PK/JW**							✓	
Decision Making for High Cost Drugs	**JJ/HT**							✓	
Departmental / Local IT systems management	**JJ/HT**							✓	
Estates Assurance - Space Utilisation	**JJ/LD**							✓	
Joint Committee with SBUHB	**JJ/JW**								✓
Medical Workforce Stabilisation	**JJ/MH**								✓
GP Out of Hours	**JJ/AC/JP**								✓
Major Infrastructure Investment Plan	**JJ/LD**								✓
Patient Experience	**JJ/SD**								✓
Infection Prevention & Control	**JJ/SD**								✓
IRMER	**JJ/JS**								✓
Estates/Facilities Directorate - Cleaning Standards	**JJ/JS**								
Commissioning – Third Sector	**JJ/AC**								
Follow up and agreed Action Implementation Tracking -	**JJ/JW**								
Integrated Audit & Assurance Plans (SSU) – Withybush General Hospital Fire – Phase 2	**EJ/LD**								
Glangwili General Hospital Fire – Phase 2	**EJ/LD**								
CLINICAL AUDIT									
Review annual forward clinical audit plan and terms of reference	**SD**	✓				✓			✓
Review the effectiveness of clinical audit – consider recs from the ECPG on suggested areas of activity for review by internal audit	**SD**	✓				✓			✓

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
FINANCIAL FOCUS									
Review risks and controls around financial management (via Financial Assurance Report)	**HT**	✓		✓	✓	✓	✓	✓	✓
Review Annual Summary of Single Tender Actions (STAs)	**HT**			✓					
Annual statement of financial procedures	**HT**							✓	
Receive Post Payment Verification (PPV) report	**HT**			D	✓			✓	
Receive PPV annual report	**HT**			D	✓				
Receive Primary Care PPV report	**JP**			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**								
COUNTER FRAUD									
Review work plan & results from Counter Fraud activities, including anti fraud policies, etc.	**CFO**	✓		✓	✓	✓	✓	✓	✓
To provide an update on the cases highlighted as part of the counter fraud update report (In-Committee)	**CFO**	✓		✓	✓	✓	✓	✓	✓
Review and approve Counter Fraud Annual Report	**CFO**	✓							✓
Review and approve annual forward work plan for Counter Fraud activities	**CFO**	✓							✓
NHS CF Authority SRT Return	**CFO**	✓							✓
Right To Work Governance and Checks (In-Committee)	**AC/RE**	✓		✓					
Annual Review of Requisitions	**CFO**						✓		

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
Counter Fraud, Bribery and Corruption Policy Review (3 yearly)	**CFO**				✓				
Review the Health Board's assessment against NHS Protect Qualitative Assessment Reviews*	**CFO**								
ASSURANCE AND RISK									
Internal & External Recommendations and WHC Tracking 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 *									
REVIEW OF THE MEETING									
Matters & Risks for Escalation to the Board	**Chair/JW**	✓		✓	✓	✓	✓	✓	✓

* To be included on agenda as applicable

Initials

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

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

9

12:30, 0 Mins

9 - Any Other Business

10

12:30, 0 Mins

10 - Review of Meeting

10.1

12:30, 0 Mins

10.1 - Matters and Risks for Escalation to the Board

For discussion

11

12:30, 0 Mins

11 - Date and Time of Next Meeting

9.30am, 9 December 2025