Date	**15/04/2025**
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 - 15 April 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 11 February 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, 30 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

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

2.6 **Standing Orders, Standing Financial Instructions and Scheme of Delegation**

10:05, 5 min
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

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3 **Audit Wales**

10:10, 0 min

3.1 **Audit Wales Update Report**

10:10, 5 min
Urvisha Perez

3.2 **Audit Wales Audit Plan 2025**

10:15, 10 min
Anne Beegan, Urvisha Perez, David Williams

3.3 **Review of Urgent and Emergency Care**

10:25, 0 min
Anne Beegan, Urvisha Perez, Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

3.4 **Planned Care Review**

10:25, 0 min
Anne Beegan, Urvisha Perez, Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

3.5 **Cancer Services in Wales: A review of the strategic approach to improving the timeliness of diagnosis and treatment**

10:25, 20 min
Anne Beegan, Urvisha Perez, Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Keith Jones (Hywel Dda UHB - Director of Operational Planning & Performance)

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4 **Clinical Audit**

10:45, 0 min

4.1 **Clinical Audit Update**

10:45, 15 min
Sharon Daniel (Hywel Dda UHB - Interim Executive Director of Nursing, Quality & Patient Experience), Ian Bebb (Hywel Dda UHB - Clinical Audit Manager), Mandy Davies (Hywel Dda UHB - Assistant Director of Nursing & Quality Improvement)

5 BREAK

11:00, 10 min

6 NWSSP – Audit and Assurance Services - Internal Audit

11:10, 0 min

6.1 Internal Audit Plan Progress Report

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

6.2 Internal Audit Plan 2025

11:15, 10 min
James Johns (NWSSP - Internal Audit)

6.3 Learning Lessons (Reasonable Assurance)

11:25, 10 min
James Johns (NWSSP - Internal Audit), Sharon Daniel (Hywel Dda UHB - Interim Executive Director of Nursing, Quality & Patient Experience), Louise O'Connor (Hywel Dda Health Board - Assistant Director), Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding)

6.4 Elective Waiting List Management (Substantial Assurance)

11:35, 10 min
James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Keith Jones (Hywel Dda UHB - Director of Operational Planning & Performance)

6.5 Consultant Job Planning Follow-up (Reasonable Assurance)

11:45, 10 min
James Johns (NWSSP - Internal Audit), Mark Henwood (Hywel Dda UHB - Interim Medical Director)

6.6 Financial Management (Reasonable Assurance)

11:55, 10 min
James Johns (NWSSP - Internal Audit), Huw Thomas (Hywel Dda UHB - Director of Finance)

6.7 Performance Management (Substantial Assurance)

12:05, 10 min
James Johns (NWSSP - Internal Audit), Huw Thomas (Hywel Dda UHB - Director of Finance)

6.8 Executive Team Working

12:15, 0 min
James Johns (NWSSP - Internal Audit), Philip Kloer (Hywel Dda UHB - Chief Executive), Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

6.9 Cleanliness/Cleaning Standards Follow-up

12:15, 0 min
James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

6.10 Withybush Hospital (WGH) RAAC

12:15, 0 min
James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

6.11 Continuing Healthcare – Database Maintenance and Finance Processes

12:15, 0 min
James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Jill Paterson (Hywel Dda Health Board - Director of Primary Care, Community and Long Term Care), Huw Thomas (Hywel Dda UHB - Director of Finance)

6.12 Annual Planning

12:15, 0 min
James Johns (NWSSP - Internal Audit), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning)

6.13 Discharge Management Follow-up

12:15, 0 min
James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

6.14 Contract Management

12:15, 0 min
James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Huw Thomas (Hywel Dda UHB - Director of Finance), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning)

6.15 Medical Workforce (Medical Locums Planned Care)

12:15, 0 min
James Johns (NWSSP - Internal Audit), Mark Henwood (Hywel Dda UHB - Interim Medical Director)

7 Financial Focus

12:15, 0 min

7.1 Financial Assurance Report

12:15, 5 min
Huw Thomas (Hywel Dda UHB - Director of Finance)

7.2 Counter Fraud Annual Report 2024/25

12:20, 5 min
Benjamin Rees (Hywel Dda UHB - Local Counter Fraud Specialist)

7.3 Counter Fraud Work Plan 2025/26

12:25, 5 min
Benjamin Rees (Hywel Dda UHB - Local Counter Fraud Specialist)

7.4 NHS Counter Fraud Authority Draft SRT Return

12:30, 5 min
Benjamin Rees (Hywel Dda UHB - Local Counter Fraud Specialist)

8 Assurance and Risk

12:35, 0 min

8.1 Risk Assurance Report

12:35, 10 min
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

9 For Information

12:45, 0 min

9.1 ARAC Workplan 2025/26

12:45, 0 min

10 Any Other Business

12:45, 0 min

11 Review of Meeting

12:45, 0 min

11.1 Matters and Risks for Escalation to the Board

12:45, 0 min

12 Date and Time of Next Meeting

12:45, 0 min

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09:30, 0 Mins

1 - 1 Introductions

1.1 **09:30, 0 Mins**

1.1 - Apologies

Rhodri Evans (Hywel Dda UHB - Independent Member)

For information

1.2 **09:30, 0 Mins**

1.2 - Declaration of Interests

All

For information

2

09:30, 0 Mins

2 - Governance

2.1

09:30, 0 Mins

2.1 - Minutes of the Meeting held on 11 February 2025

Rhodri Evans (Hywel Dda UHB - Independent Member)

For approval

Attachments

2.1 Unapproved ARAC Minutes 11 February 2025.pdf

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

Date of Meeting:	09:30, Tuesday 11 February 2025
Venue:	Board Room, Ystwyth Building, St David's Park, Carmarthen and via Microsoft Teams

Present:	Cllr. Rhodri Evans, Independent Member (Committee Chair) Mr Winston Weir, Independent Member (Committee Vice-Chair) (VC) Mr Maynard Davies, Independent Member Mrs Eleanor Marks, Vice-Chair, HDdUHB
In Attendance:	Ms Anne Beegan, Audit Wales (VC) Mr David Williams, Audit Wales (VC) Mr James Johns, Head of Internal Audit, NWSSP Ms Sophie Corbett, Deputy Head of Internal Audit, NWSSP (VC) Mr Gareth Heaven, Audit Manager, NWSSP (VC) Mr Martyn Lewis, IT/Digital Audit Manager, NWSSP (VC) (part) Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary Miss Charlotte Wilmshurst, Assistant Director of Assurance and Risk Mr Huw Thomas, Director of Finance Mr Ben Rees, Head of Counter Fraud (part) Professor Philip Kloer, Chief Executive (part) Mr Andrew Carruthers, Chief Operating Officer (part) Mr Peter Skitt, County Director Ceredigion (VC) (part) Ms Sharon Daniel, Interim Director of Nursing, Quality and Patient Experience (part) Dr Jonathan Arthur, Deputy Director of Health Sciences (part) Mr Dylan Jones, Head of Pathology Service(VC) (part) Mr Craig Baker, Cellular Pathology Service Manager (VC) (part) Dr Ardiana Gjini, Director of Public Health (VC) (part) Dr Bruce Bolam, Deputy Director Public Health (VC) (part) Mr Tim Harrison, Head of Health, Safety and Security (VC) (part) Mr Anthony Tracey, Digital Director (part) Mr Lee Davies, Director of Strategy and Planning (part) Mr Shaun Ayres, Deputy Director of Operational Planning and Commissioning (VC) (part) Ms Clare Moorcroft, Committee Services Officer (minutes)

Minutes Ref.	Item	Action
AC(25)01	**Introductions and Apologies for Absence** Cllr. Rhodri Evans, Audit and Risk Assurance Committee (ARAC) Chair, welcomed everyone to the meeting. Members heard that there were some changes to the agenda order, to facilitate attendance by Executive Leads. Apologies for absence were received from: • Mr Michael Imperato, Independent Member • Ms Urvisha Perez, Audit Wales	

- Mr James Severs, Director of Allied Health Professions and Health Science

AC(25)02 **Declaration of Interests**

No declarations of interest were made.

AC(25)03 **Management of Bed Capacity (Limited Assurance)**

Mr James Johns introduced the Management of Bed Capacity Internal Audit report, explaining that the purpose of the audit was to provide assurance on the arrangements of established bed capacity baselines, and the allocation and utilisation of beds including the use and de-escalation of surge beds. Whilst positive actions have been undertaken in various areas, the audit has concluded Limited Assurance. Four high priority Management Actions were identified, around: Lack of evidence to support established core bed numbers for Section 25A wards; Variances in the established core bed numbers; Multiple sources of established core bed numbers with varying figures; Lack of a formal service change process, including the adjustment of established core bed numbers. One medium priority Management Action related to: Interpretation of surge and 'flex' beds potentially leading to variances in established core bed numbers.

Mr Andrew Carruthers thanked the Internal Audit team for their work on this audit. Issues around bed capacity have been the source of frustration for some time. A variety of different factors is involved, not least the terminology of surge capacity versus flex capacity. There has also been a lack of a clear and consistent mechanism to capture, track, monitor and triangulate bed capacity data with other data around finance and performance. Whilst many of the responses in the report discuss solutions which rely on the new Pt-Flow and E-Obs system, this cannot be viewed as the only answer. A more immediate response is required, around ensuring a more rigorous approach going forward. Mr Peter Skitt agreed that there is a need for an interim position, albeit one which is more 'manual' than would be desired. Implementation of the new Pt-Flow and E-Obs system will further improve the situation. It will be important to clarify the process for surge and flex, particularly as the organisation enters a position where it is boarding patients on wards and potentially moving to a continuous flow system, which will be essential anyway. The team is working on this issue, and intends to have it resolved by the end of March 2025.

Suggesting that the report makes for uncomfortable reading, Cllr. Evans focused particularly on the four high priority Management Actions. He queried why the 25A and 25B wards are being treated differently. In response, Mr Skitt explained that the requirements for these wards under the Nurse Staffing Levels (Wales) Act differ, as does the way they are run. From a bed point of view, however,

it is not viable to have two separate approaches and the intention is, therefore, that a single approach will be implemented.

Mrs Eleanor Marks requested clarification around the current process for managing bed capacity. Mr Carruthers advised that challenges in surge and flex reflect the ongoing pressures on healthcare since the COVID-19 pandemic. Use of both was much more infrequent previously, restricted mainly to winter pressures. Each site has a clear escalation plan; there are minimally two meetings/calls per day, at 10am and 4pm; sites consider demand and capacity and utilisation of space; movement of patients between sites is also discussed. There are regular conversations around the position, and there can be as many as three or four calls per day. He emphasised there is a rigorous daily process in place for discussing and assessing use of capacity. Where the issue has become challenged is that (due to the demand and pressures already mentioned) this additional capacity has almost become viewed as core, due to an inability to de-escalate. Also due to the pressures, it is difficult to change this mindset and culture. There has also been an ongoing challenge around establishing a 'real time' map of bed capacity; having this information available 'at a glance' would make it much easier to respond operationally.

Fundamentally, Mr Carruthers felt that there were two issues: Due to demand on the system, the culture has become that this additional capacity is always available. The reality on wards is that, as soon as a patient is discharged from a surge or flex bed, this is then reused immediately. This prevents de-escalation, removal of capacity and a 'reset' in approach. In addition, as mentioned earlier, there is a boarding process, whereby patients are added to wards but not in a bed space. This is generally in anticipation of a planned discharge later that day. There is a risk associated with this, however, in terms of discharges not taking place. In all, the process has become quite fluid. Mr Skitt agreed that, whilst there are the daily bed meetings, the situation is dynamic. In the time that this morning's discussions have taken, the situation will have changed. The current system requires manual data entry; however, the new Pt-Flow and E-Obs system will update the position as and when discharges and admissions take place.

In response to a query from Mrs Marks, Mr Carruthers confirmed that the issue was people/data entry dependent rather than systems dependent. He added that it was further impacted by the fact that the Health Board does not have ward clerks on every ward to undertake this data entry. Returning to the issue of culture and mindset, Mrs Marks enquired how this can be shifted, and how staff are coping in the current system. Mr Carruthers felt that this was a real challenge. With the system as it is, the organisation will only ever mitigate some of the risk, the resultant pressure on staff, and patient experience, safety and quality. There needs to be a more radical redesign of the service model in Urgent and Emergency Care, as mentioned at the most recent Public Board.

There has been a development session around this, and how the current system might be changed from an unscheduled, self-presentation model to a more scheduled, directed, signposted, appointment-driven, with alternative points of access. Mrs Marks final comment was one around lived experience and feedback from patients. Whilst accepting that any change in this area is challenging, it is not yet impacting on current patient experience and waits in A&E, for example, which are not acceptable.

Referencing the report's Action Plan, Mr Maynard Davies noted that the officer for all actions is the Deputy General Manager for Carmarthenshire. He queried this, requesting assurance that a three-counties approach was being taken. Mr Skitt explained that the individual in question has an interest in bed management and is keen to be part of the solution. He assured Members that this officer would be acting on behalf of all three counties. Noting the statements that the system is extremely manually intensive, Mr Davies suggested that improved data managed may be achieved by use of some of the current Wales Patient Administration System (WPAS) functionality and was concerned this was not being used. He expressed concern around the potential timescales for improvement otherwise, if dependent on implementation of a new Pt-Flow and E-Obs system.

Mr Carruthers suggested that there are several possible approaches. One would be to wait for implementation of the new Pt-Flow and E-Obs system. Another would be to improve, to some extent, the current manual process. Whilst he would like the latter to provide a daily position, this would be too time consuming in terms of data entry for every individual ward. Mr Skitt confirmed that a clear directive has been given that it is not acceptable to wait for the new system and that an interim solution is required. There is a system in place; it needs to be used more effectively. Due to constraints around data entry, it is likely that this will comprise a weekly position, update and reconciliation. With regard to implementation of the new Pt-Flow and E-Obs system, Mrs Joanne Wilson and Mr Huw Thomas reminded Members that the Board had only approved this in principle; recognising the WPAS system, although not perfect, is operational. Full implementation will be dependent on budgetary discussions and a Board decision. This is, however, being progressed as fast as possible.

Mr Davies agreed that it is not acceptable to wait for a new system, noting that a Limited Assurance Internal Audit report on Data Quality is also being considered today. He felt that there is a lack of ownership of data quality, and that this needs to be addressed before any new system is implemented, so that it is not seen as an 'additional responsibility'. Mr Davies reiterated that the potential of WPAS be explored in terms of producing a daily position; however, welcomed plans to improve the current process. Mr Carruthers agreed that there needs to be a concerted focus on data quality prior to implementation of the new Pt-Flow and E-Obs system, should the Board approve this.

Reiterating his concerns around the audit findings, Cllr. Evans highlighted in particular statements around the lack of evidence to support the established core bed numbers and differences between bed numbers on the patient flow daily 'sitrep' and data held by Informatics. Without these, he questioned how beds and finances can be effectively managed and was exceptionally concerned regarding this matter. Whilst stating that the report had provided interesting learning, Cllr. Evans requested assurance that there is a clear way forward. He also enquired whether the target dates are achievable. Mr Carruthers assured Members that he is clear on his expectations around this extremely important matter. He anticipated that there will be a stronger position, on a weekly basis as described above. He suggested that an element of the challenge has been created by the Health Board's deficit and how budgets have had to be set as a result. This has impacted on surge and flex and brought in an element of confusion, with the system not functioning optimally.

Another area which is being explored is the concept of an operational delivery unit to help coordinate the daily response. This would allow this task to be separated from the 'day job' of general managers. Such a unit would lend itself to development of a 'live' position with regard to data. Returning to the description of the process being dynamic, Mr Skitt explained that in some instances, beds are put in place for a matter of hours, to accommodate an anticipated discharge later that day, then removed. Introduction of a Pt-Flow and E-Obs system would provide not only live data around beds, but also live data on the care and monitoring of patients.

Whilst recognising where the organisation is currently, and that this is a dynamic situation (with the associated challenges), Mrs Marks wished to focus on pace of change, grip and accountability, and how the latter two can be assured. Mr Skitt welcomed this comment, indicating that he is utilising various aspects as 'levers' to achieve the target dates – for example, budgetary management, staffing profiles, the skill-mix on wards. Rather than presenting this as a requirement, he is presenting it as a positive tool to support teams. In response to a request for a financial input, Mr Thomas indicated that – from a financial planning perspective – this issue would be perhaps second in order of importance to the nurse rosters which need to reflect the Nurse Staffing Act requirements. Members were reminded that the recent Nursing Management Internal Audit had also returned a Limited Assurance rating. There is, however, probably another contribution into surging in A&E, which is more of a direct financial issue, as this is driving a significant level of cost through the system. Unlocking bed management more broadly would hopefully help to address how often the Health Board has to surge in A&E, and therefore support the system and facilitate a better response from a financial perspective.

Cllr. Evans enquired, with regard to Key Finding 4, around service change procedure and the associated safety, quality, staffing and

financial consequences, who will be approving these. Mr Carruthers advised that ultimately this will be him, but highlighted the upcoming revised operational governance arrangements item and that this would need to be aligned. Within the new structure and the operational governance arrangements, there will be a clear scheme of delegation via the Clinical Care Groups (CCGs). In this specific case, the actions will be progressed through Mr Skitt's leadership and the Community and Integrated Medicine CCG. Thence into the Integrated Quality, Finance and Performance Delivery Group (IQFPDG), which will be chaired by Mr Carruthers but would include other Executive Director colleagues. It is this group which would oversee these decisions.

Noting that, this is a procedure in governance terms, and potentially quite significant, Mrs Wilson advised that it will need to follow the written control policy process and go through this with the sponsoring group to get signed off. Timescales may be tight to achieve this by 31 March 2025. It was suggested that Mr Carruthers and/or Mr Skitt liaise with Ms Christine James from the Corporate Governance team, who can advise. Recognising the Limited Assurance rating, Mr Johns advised that a follow-up audit will be required. This will be incorporated into the Internal Audit Plan for 2025/26. Consideration will need to be given to the scope of this audit and whether it assesses the interim solution or implementation of the new system. **AC/PS**

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

The Committee agreed to **ADVISE** the Board in relation to the Management of Bed Capacity (Limited Assurance) Internal Audit report, due to the findings and the significant concerns highlighted therein.

Mr Peter Skitt left the Committee meeting.

AC(25)04 **Mortuary Services (Limited Assurance)**

Dr Jonathan Arthur, Mr Dylan Jones and Mr Craig Baker joined the Committee meeting.

Ms Sophie Corbett introduced the Mortuary Services Internal Audit report, explaining this was a joint review of the arrangements in place between Swansea Bay University Health Board (SBUHB) and Hywel Dda University Health Board (HDdUHB) to support the effective provision of mortuary services, ensuring compliance with Human Tissue Authority regulations. The audit focussed on the arrangements in place for mortuary services only and did not review the wider pathology service. A Strategic Outline Case to support the development of a regional pathology service was approved by Welsh Government in November 2020 and an Outline Business Case (OBC) is being developed. However, the programme is effectively ‘on hold’ pending confirmation from

Welsh Government over capital funding. Independently of any decisions relating to the capital financing of the wider programme, both health boards agreed a transitional Memorandum of Understanding (MOU) to support joint working.

Overall, progress with the programme has been slow due to funding and staff capacity issues. Four high priority and five medium priority Management Actions have been identified requiring attention by each health board, around: the need to strengthen the documentation of roles and responsibilities and to clarify the financial arrangements between the health boards; The need to review the programme management structure for the mortuary element of the Regional Pathology Programme; Funding issues which have clearly impacted capacity to deliver the Programme; Key leadership roles not having been recruited resulting in a lack of robust business continuity arrangements; A need to review governance structures, to ensure they are effective and provide sufficient oversight over the mortuary element of the Programme. A rating of Limited Assurance had been returned.

Mr Carruthers clarified that Mortuary Services and the associated MOU are part of a broader workstream looking at a regional management structure for pathology services across south west Wales. A transitional MOU had been agreed to facilitate progress in this area. He acknowledged that there have been challenges in progressing the programme. National discussions around the capital aspect have probably distracted from the wider ambitions in this regard. It is still intended, however, to bring a report to both HDdUHB and SBUHB Boards in March 2025 which sets out a way forward from the transitional MOU to a more formal arrangement, at least for cellular pathology services, which would cover mortuary services. A couple of key meetings are planned to enable development of this report.

Mr Davies noted that, whilst the Regional Pathology Programme Director's two-year secondment ends in February 2025, there are a number of actions for which they are responsible with completion dates of March 2025 and the associated work is likely to go on longer. Mr Carruthers confirmed that this individual's secondment has been extended to facilitate completion of these actions. However, Pathology is recognised as a key regional programme, which will form part of the work overseen by the Regional Joint Committee (RJC). Mr Carruthers, Mr Lee Davies and others are engaged with colleagues in SBUHB in discussions around the potential for an office or function to support delivery of these key regional programmes. As such, steps are being taken in preparation, and to address business continuity concerns.

Mr Davies referenced Management Action 5, to 'ensure that all key issues and lessons learnt relating to the programme are documented. These will be shared at the Regional Management Meeting and Regional Mortuary Operations meeting'. He felt that this does not provide assurance regarding the actions which will be taken to address the concerns, only that they will be

documented, and suggested that the outcome of discussions at this meeting should be reported. Mr Carruthers committed to do so. Mr Davies' final query was around transitioning from the spreadsheet mentioned in Key Finding 3 to the full Service Level Agreement (SLA). He requested assurance that there will be no increase in costs to the Health Board as a result. Or, if there are, whether these are known and taken into account in financial plans for next year. **AC**

Mr Carruthers responded that work is being undertaken at the moment around the move from a transitional arrangement to the established Pathology Operational Delivery Network (ODN). This includes consideration of the current SLAs, budgets and finance positions for both organisations. The intention is that this would form part of the Board report in March. There are risks involved in the model; for example, job planning arrangements differ between the two health boards, with SBUHB operating a points system. A standardisation of approach may see HDdUHB losing productivity from its current capacity, with a potential impact on patient waiting times; something which is of concern to the operational team. In response to a query around a date for refurbishment of the mortuary, Mr Craig Baker advised that the Glangwili Hospital (GGH) facility is relatively new. An exercise is being undertaken, however, around body storage capacity and facilities on a Health Board wide basis.

Welcoming the report, Mrs Marks agreed that this does very much fall into the regional working domain, advising that she and the Vice-Chair at SBUHB have each been requested to explore Pathology governance and service delivery. In terms of the governance structure, Mrs Marks enquired where this reports and who holds accountability for delivery. In response, Mr Carruthers advised that he is the SRO for the ODN, which ultimately reports into the Programme Group and then into what has been the ARCH Recovery Group and into the two Executive Teams and then the Boards. Mrs Marks felt that this reporting structure was unwieldy. Agreeing, Mrs Wilson stated that the governance is not optimal, suggesting that the RJC would be a more appropriate route. Work needs to take place around governance, and the potential for freeing-up capacity to address this is being explored. Mrs Marks welcomed this context, recognising the challenges involved in taking proposals through two sovereign Boards.

Mrs Marks advised that she is visiting the Pathology Lab to meet with Mr Baker tomorrow, but in the meantime enquired why the system is not working. In response, Mr Dylan Jones assured Members that, operationally, the service does work. It is in a much more robust position today as a result of joint working. Both health boards had passed Human Tissue Act (HTA) audits with only minor recommendations, which have since been resolved. It is in the governance arena where more work is probably required. Mr Jones reminded Members that – as the first regional mortuary service – this is very much a 'test bed'. Mr Carruthers agreed that the complexity of establishing how to manage the joint service

was a major challenge, particularly as there are very few similar models from which to learn. The work involved in developing the MOU for mortuary services alone was significant. It has been extremely complex and difficult to navigate. Looking forward, however, Mr Carruthers felt that the more formal RJC arrangements between the two health boards puts it in a different position, and facilitates the necessary scrutiny.

Referencing Management Action 2, Cllr. Evans noted that reference to a doctor by their initials and suggested that it may be possible to identify them. It was agreed that this should be redacted in the version of the report published on the Health Board website. Cllr. Evans queried who specifically will be responsible for delivery of the Mortuary Service Delivery Plan (Management Action 6). In response, Mr Carruthers advised that there is a joint management structure for Mortuary Services across the two organisations in south west Wales, which he would expect to lead on this. The Regional Mortuary Manager is Ms Yasmin Brown. Dr Jonathan Arthur indicated that Mr Jones and Mr Brown have developed an action plan which sits below the Mortuary Service Delivery Plan. This will help to identify key individual responsibilities. **JW**

Referencing Key Finding 7, Cllr. Evans enquired whether issues with poor risk management have been resolved. In response, Mr Baker confirmed that the majority have, with only those around body storage outstanding. The team is working with the Executive Team on this matter. Mr Baker advised that there is a robust governance structure, risk register and action log. The two health boards are in the process of establishing a joint management meeting, at which they will share their risk registers and action logs for full disclosure of risks. In terms of assurance around Key Finding 8, Mr Carruthers advised that actions to address this are ongoing. There have been engagement processes around the changes over the last 12 to 18 months, including with staff. There will be an updated version of the Communications and Engagement Plan for this year.

Finally, Cllr. Evans requested assurance that the completion dates proposed for actions are realistic. Mrs Wilson noted that this is an important point, as failure to meet deadlines will result in higher levels of escalation, triggering a different set of processes. In response, Mr Jones indicated that his one concern is around the roles and responsibilities, given that there is no Pathology Director or Clinical Director appointed yet. The hierarchy in terms of the management structure and regional pathology is therefore not established, and Mr Jones was not sure that this was achievable within the proposed timescales. Mr Carruthers suggested that this issue be discussed at the upcoming planning meeting, and that the timescales be ‘tested’ there. In view of the fact that this is a finalised and joint report, it was agreed that there should be a discussion around the feasibility of adjusting this date. **AC** **JJ/AC/ JW**

Mr Winston Weir reflected on the risk management arrangements, noting that, whilst there may not be a full management structure in place, there are still serious operational risks around this service. His concern was, although the teams are proposing to share the risk registers at their meeting, they should not wait that long. He suggested that the risk registers be shared now, to facilitate collaboration around management of the operational risks. Also, if capital resource is an issue, whether the two health boards can work together around securing this. Whilst Mr Weir was satisfied with the responses provided, he felt that this is an area which should be revisited. Due to this being a Limited Assurance report, Mrs Wilson assured Members that there will be a follow-up audit. There may also be links made to the internal escalation process.

Noting that the report will be considered by SBUHB's Audit Committee, that a report to both Boards is planned, and that the Vice-Chairs have been requested to undertake work in this area, Mr Davies felt that it would be useful to have a timescale for consideration of this topic by the RJC.

Decision: The Committee **NOTED** the Mortuary Services (Limited Assurance) Internal Audit report.

The Committee agreed to **ADVISE** the Board in relation to the Mortuary Services (Limited Assurance) Internal Audit report, due to the findings and concerns highlighted therein.

Dr Jonathan Arthur, Mr Dylan Jones and Mr Craig Baker left the Committee meeting.

AC(25)05 **Revised Operational Governance Arrangements**

Mr Carruthers presented the Revised Operational Governance Arrangements report, which he suggested is relatively self-explanatory. He recorded his thanks to Mrs Wilson, Miss Charlotte Wilmshurst and Ms Alison Gittins for their contribution. Whilst the report may be straightforward, the structure is not, and neither has the process been to reach this point. This exercise has involved a significant amount of work, which has extended to other teams across the Health Board. Its purpose was to address, for example, some of the concerns raised in previous Structured Assessments. As indicated in the report, there will be five CCGs, and each Group will hold a fortnightly Integrated Governance Group meeting. A standard agenda will cover, on rotation, planning and performance (including financial performance, workforce management, risk management), and quality, health and safety.

In a standardised approach across all five CCGs, each of their Integrated Governance Groups will report into the fortnightly IQFPDG meetings. The Terms of Reference for the latter will need to be amended accordingly. This should provide a much strengthened position, because the Executive Team will be in regular dialogue with the senior operational leadership around

matters of management and business accountability. Mr Carruthers would like to see these groups established in 'shadow form' during March, in preparation for full implementation in April. Members heard that a Standard Operating Procedure (SOP)/ framework for CCGs is being developed, which will seek to set out roles and accountabilities and align these to the organisational values. This will also include leadership expectation and indicators and a Scheme of Delegation.

Noting that this was a recommendation arising from the Structured Assessment in 2022, and recognising that progress has been limited, Cllr. Evans enquired regarding the intended timescale for implementation. In response, Mr Carruthers indicated that this will be 1 April 2025. There is work being undertaken in the background to facilitate the transition from current arrangements to the new structure, for example in terms of data transfer. Mrs Wilson confirmed that the majority of the elements required for implementation are ready and this will now be handed over to the operational structure to implement. However, as indicated by Mr Carruthers, the issue is around data and systems such as Datix, which will need to be shut down for a short time. This topic had been discussed at the Executive Risk Group last week.

Mr Weir welcomed both the report, which sets out clearly the intentions going forward, and the changes it describes. He queried, however, where in this structure quality, innovation and quality improvement are considered, particularly in a forward-looking sense around potential service change. Mr Carruthers advised that one of the integrated governance groups will consider issues around quality, safety and experience. With regard to the future service change issue, in addition to the governance structure described, Mr Carruthers also plans to establish a leadership group or community across the operational teams. This will also draw in corporate deputies at various points. It will offer a forum for clinical and management colleagues to debate topics and share ideas, in a peer group setting. Mr Carruthers is also planning a monthly meeting with the Care Group Service Directors and deputies, aimed at ensuring there are no interface issues between the CCGs. Mr Weir welcomed this response.

Mrs Wilson advised that the Chief Executive has requested that governance work be undertaken around 'rewiring' the Executive Team structure which sits above the new operational structure. However, this would be in addition to other governance 'rewiring' work and implementation of the new committee structure. As such, there will need to be prioritisation and management of expectations. It was recognised the corporate governance arrangements regarding the revised committee structure has to take priority for the governance team. Mr Davies thanked Mr Carruthers for the useful report. Returning to the issue of data quality, he suggested that there are opportunities to reinforce to CCG Directors that they are responsible for data quality within their directorates. Agreeing, Mr Carruthers advised that he is keen to schedule a series of 'masterclasses' around various topics,

which will set out roles and expectations. This would include data quality.

Also welcoming the report, Mrs Marks enquired who in the operational team – once the new structure is in place – will take responsibility for ensuring that the governance works effectively. In response, Mr Carruthers indicated that he had originally intended for this responsibility to be dispersed among the CCGs. However, he now felt that there is an opportunity to consider a central team to provide operational oversight, and would be giving this further thought. Mrs Marks' second query was around how the CCGs link with their various professional leads. Mr Carruthers replied that, within the structure are included assistant and associate directors (of nursing, for example), all of whom have accountability to their respective professional Board Member. There are also discussions taking place among the Executive Directors responsible for specific professions around the potential for multidisciplinary collaboration. Again, an ambition would be a quarterly leadership forum to include a focus on organisational development and multiprofessional leadership development.

In terms of taking this matter forward, Mrs Wilson advised that a final proposal is due to be considered for approval at Executive Team next week. Following this, it will be handed over to Mr Carruthers and his team for implementation. There will also be a requirement to change the performance management framework to align to the new structure, which Board Members will need to aware of and have assurance around, including changes in how escalation works. Mrs Marks highlighted that, as well as driving results and performance, the operational structure cannot be separated out from quality and safety. It will also need to interface with the Clinical Services Plan. Mrs Wilson suggested that all of this information be compiled into a 'package' for Board Seminar, to allow discussion and for queries to be addressed. **AC**

In response to a query from Cllr. Evans, Members heard that it is intended to schedule an Internal Audit on the new operational governance arrangements, their impact and outcomes. This is likely to report in the autumn. **JJ**

Decision: The Committee **TOOK ASSURANCE** on the Operational Governance arrangements to be put in place to establish the new Operational Structure within HDdUHB, in response to recommendation R2 from the 2022 Structured Assessment process; however, would **ADVISE** the Board regarding the capacity of the operational managers to implement this fully alongside all other requirements.

AC(25)06 **Structured Assessment - 2023 Management Response Update and 2024 Management Response**

Dr Ardiana Gjini and Dr Bruce Bolam joined the Committee meeting.

Mrs Wilson introduced the report, which focuses on the management response to recommendations from the 2024 Structured Assessment and outstanding actions from 2022 and 2023. With regard to the latter, the Health Board should be in a position to close both reports following implementation of the new operational governance structure. In terms of the 2024 Structured Assessment report, Mrs Wilson hoped that Audit Wales are content with the management response as presented.

In considering completion dates for these recommendations, Members heard that R1 and R2 are on track. For R3, whilst Mr Davies recognised the key role of the Director of Public Health, he felt that the Director of Strategy and Planning should also be involved. Mrs Wilson explained that, whilst responsibility for this sits with Dr Ardiana Gjini in the Scheme of Delegation, it is anticipated that there would be collaboration with Mr Lee Davies. Dr Gjini confirmed that this would be the case; however, it was noted that only one owner can be included within the AMAT system.

Ms Anne Beegan confirmed that Audit Wales are satisfied with the management response. Whilst the recommendation around the Well-being Objectives and strategy refresh is more involved, the others are relatively straightforward. Mrs Wilson advised that all recommendations will be added to the Audit Tracker and updates on progress provided.

Decision: The Committee **TOOK ASSURANCE** from the management response in that the recommendations within the Structured Assessment 2024 report, and the outstanding recommendations from Structured Assessments 2022 and 2023, will be addressed appropriately.

Mr Andrew Carruthers, Dr Ardiana Gjini and Dr Bruce Bolam left the Committee meeting.

AC(25)07 **Audit Wales Update Report**

Mr David Williams introduced the Audit Wales Update Report, advising that in terms of financial audit work, the Charitable Funds audit work had been completed in January 2025. Preparatory work for the main audit of Health Board accounts has commenced. In terms of performance audit, Ms Beegan noted that the Structured Assessment report has already been discussed. Audit Wales is seeking to conclude the Unscheduled Care and Planned Care review work by the end of March, for reporting to the April 2025 ARAC meeting. Work on the Digital Deep Dive has commenced, with a meeting to discuss the scope of this review. In terms of local work, the Capital Programme Prioritisation review has been delayed for various reasons; the project brief for the Outpatients review has been issued. In terms of the national report into Cancer Services, this will be presented to Audit

Committees on receipt of the management response from Welsh Government. The projected timescale for this coming to ARAC is also April 2025. Ms Beegan noted that the completed National Fraud Initiative checklist mentioned at the previous meeting has been included as part of the Counter Fraud Update report.

Referencing the planned Digital Deep Dive, Mr Thomas was conscious of the interface with Welsh Government and Digital Health and Care Wales (DHCW) and the impact at policy level. He suggested that it would be helpful to include, within the overall scope, clarity around the resource allocation approach taken by Welsh Government. Ms Beegan advised that this has been the topic of some debate. It is intended that the first phase will focus on local approaches, with a second phase to highlight national, DHCW and Welsh Government aspects, utilising input from the local exercise. In Exhibit 1, Mr Davies noted the deadline of 31 January 2025 for the Charitable Funds accounts; it was confirmed that this deadline had been met, with these having been approved at the Corporate Trustee meeting held on 30 January 2025.

Returning to the Digital Deep Dive, Mr Davies enquired whether Digital Independent Members (IMs) will be involved specifically. Ms Beegan confirmed that they are included on the interviewee list. The first phase will be a self-assessment – it has been agreed that there must be Board 'ownership' of this; therefore it may need to be considered by a Board forum. This would probably be Board Seminar or a Digital Committee rather than Public Board. IMs, including Digital IMs, will be part of the interview phase. As Chair of the All Wales Digital IMs Group, Mr Davies extended an invitation to Audit Wales to attend a meeting of this group. Ms Beegan agreed to pass this on to the staff involved. Regarding Board endorsement of the self-assessment, Mrs Wilson reported that different approaches were being proposed across Wales for Board endorsement, and that this will need to be considered. **AB**

Cllr. Evans was pleased to hear that the Unscheduled Care and Planned Care reviews are to be finalised for the April 2025 ARAC meeting. Mrs Wilson requested that it be ensured sufficient time is provided to Mr Carruthers and his team to agree the reports and their response to any recommendations. Members were advised that the reports should be available by the end of February 2025. There is one issue, in that the Unscheduled Care report also needs to be agreed by the Local Authorities; however, the Regional Partnership Board is being used as the mechanism to finalise that report, to save multiple clearance hurdles. Mr Thomas emphasised that the issue of clearance is significant for all audit reports. He had not been taken through the Charitable Funds accounts audit findings at a clearance meeting, and felt that the discipline of scheduling a clearance meeting was important and that these should be reinstated. Mr Williams acknowledged and this feedback and advised that it would be acted upon.

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

AC(25)08 **Audit Wales Outline Audit Plan 2025**

Ms Beegan presented the Outline Audit Plan, advising that the detailed Audit Plan will be provided for the April 2025 ARAC meeting. Mr Williams explained that this document includes information around the financial audit responsibilities, audit fee (with further information to be provided in the detailed Audit Plan), audit team (no changes) and timelines. Ms Beegan drew Members' attention to page 8, where the three main areas in respect of performance audit work are outlined. A Deep Dive into estates management is proposed; along with a thematic review of Cancer Services in Health Boards.

Noting that there are no details around timescales for performance audit, Cllr. Evans enquired whether there are likely to be delays in delivery, or capacity issues. In response, Ms Beegan suggested that this year should see an improved picture in terms of delivery. Audit Wales is still experiencing the impact of COVID-19, but is hoping to get back on track soon.

Decision: The Committee **NOTED** the Audit Wales Outline Audit Plan 2025.

AC(25)09 **Review of Urgent and Emergency Care**

DEFERRED to 15 April 2025 meeting

AC(25)10 **Planned Care Review**

DEFERRED to 15 April 2025 meeting

AC(25)11 **Review of Arrangements for Capital Programme Prioritisation**

DEFERRED to 24 June 2025 meeting

AC(25)12 **Internal Audit Plan Progress Report**

Mr Johns introduced the Internal Audit Plan Progress Report, which was of the usual format. The report includes, in Section 2, details of the five audits finalised since the previous meeting. In terms of progress, a number of areas of work have moved on since the report was prepared. Several meetings have taken place to discuss next year's Internal Audit Plan, which will be presented to the April 2025 ARAC meeting.

Cllr. Evans requested assurance regarding delivery of the remaining Internal Audits. Mr Johns confirmed that all reports will be completed in time to deliver the Head of Internal Audit Opinion. In response to a query around whether he has a sense of what this year's Opinion is likely to be, Mr Johns indicated that he has

discussed this with Mrs Wilson. There are a number of key pieces of work which need to be delivered prior to determining the Head of Internal Audit Opinion. Mr Davies highlighted that there are 10 Internal Audit reports and two Audit Wales reports scheduled for the next ARAC meeting. He did not feel that it was feasible to consider this many reports and give them the scrutiny they deserve. Mrs Wilson advised that it is 13 Internal Audit reports, and agreed that it is unreasonable to expect Members to scrutinise this many reports. It was suggested that there may need to be an extraordinary or extended meeting, with this to be discussed at today's agenda-setting.

Decision: The Committee **TOOK ASSURANCE** with regard to the delivery of the Internal Audit plan for 2024/25 year and the outcomes of the finalised audit reports.

AC(25)13 **Health and Safety (Limited Assurance)**

Ms Sharon Daniel, Dr Jonathan Arthur and Mr Tim Harrison joined the Committee meeting.

Ms Sophie Corbett introduced the Health and Safety Internal Audit report, advising that the purpose of this audit was to review the arrangements for ensuring compliance with Health and Safety regulations. Two high priority and three medium priority Management Actions had been identified, around: Lack of oversight of (non-mandatory) Health and Safety training participation rates; Insufficient monitoring of actions arising from Health and Safety site visits, significant volume of outstanding actions and weakness in the methodology for prioritising actions; Non-compliance with RIDDOR reporting timescales; Poor Executive Director attendance at Health and Safety Committee; Gaps in assurance reporting to the Health and Safety Committee. Some of the issues in regard to the latter had been identified in the recent governance review. A rating of Limited Assurance had been concluded.

Ms Sharon Daniel noted that the new operational governance arrangements have already been discussed. She advised that, in terms of the operational quality, health and safety arrangements going forward, this will be managed via the new Clinical Care Groups. It would be integrated; the agenda would be set and would incorporate the health and safety issues as well as the quality issues. She hoped that this would assist in monitoring any issues identified. Dr Arthur welcomed the audit and thanked the team. He advised that colleagues in Health and Safety have developed a sub action plan. They have also undertaken discussions with the Learning and Development team around Health and Safety training and taken steps to 'close the loop' on site visits. This will involve recording actions on the AMAT system. There are a number of other actions to be agreed as part of the forward workplan for the Health and Safety Committee (HSC). Mr Tim Harrison reported that the team has begun to consider how

Mandatory Training data can be improved. He was confident that an action plan is in place to meet recommendations. In terms of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) compliance, the team is working with directorates to seek the return of information in a timely fashion, as this has been an issue until now. The importance of meeting deadlines has been reinforced. Use of the AMAT system will provide assurance around the monitoring of actions going forward, and these will be progressed via the quality and safety meetings within the CCGs.

Cllr. Evans noted reference to the additional bespoke training courses, which are not mandatory, and are not necessarily well attended. He enquired how staff are alerted to the availability of these courses and whether, for example, they are available via the ESR system. Mr Harrison advised that there is a mandatory Health and Safety course, which is delivered online and which has a compliance rate of 80-90%. The courses identified by the Internal Audit are those delivered by the Health and Safety team; for example, induction training for managers and the Control of Substances Hazardous to Health (COSHH) course. These tend to be targeted to specific groups, for example the COSHH course is targeted to those departments which use chemicals, etc. Where improvement is needed is in recording compliance figures. Ms Daniel emphasised that, whilst these courses are not mandatory, it is important to consider them from a training needs analysis perspective. Hence the involvement of the Learning and Development team.

Cllr. Evans requested assurance that there is clarity around the approach going forward. For example, in relation to Health and Safety site visits, the audit noted that 75% of actions were classed as unresolved. He enquired whether this figure has reduced. In response, Mr Harrison advised that, whilst the figure has reduced, this area still requires further work. Ms Daniel reminded Members that on the AMAT system, to close an action, the individual responsible must update the relevant evidence. Use of AMAT will, therefore, provide a robust mechanism for monitoring and closing actions. In response to a query around how actions are prioritised, it was confirmed that this was on a risk-based approach. It is both based on incidents that have occurred within departments and the type of department being visited, and whether these are higher risk (eg using hazardous chemicals). The aim is to visit at least eight departments per month, equating to 100 visits per year. This target is being met over a five year plan. Cllr. Evans expressed concern that this means a five year gap between visits to any one department. Mr Harrison replied that the programme of visits is constrained by the team’s capacity; however, he emphasised that there will be focused work if a specific risk is identified.

Mrs Wilson highlighted that Mr Harrison’s role is that of a professional Health and Safety advisor. Individual Health and Safety risks are not for his team to manage; they need to be owned in the operational structure. Mrs Wilson felt that this may

also potentially feed into the internal escalation process; however, this would require the audits being managed by the AMAT system. Concern was expressed that it had taken an Internal Audit to identify some of these areas, and it was suggested that there be a review, to ensure that Health and Safety data informs the HSC workplan. Mrs Wilson would discuss this matter with Mr James Severs. Mrs Marks expressed concern around the potential that certain of these issues might be 'lost' in the transition to the new operational structure. She emphasised that they are an issue not just for the CCGs, but also for the professional leads. She agreed with Mrs Wilson regarding the need to examine the data feed into HSC. **JW**

Mr Thomas shared these concerns, suggesting that there are a great deal of expectations of the new operational structure. He was concerned both around the transition to this, and around the 'bandwidth' of those within it to manage all of the various demands. It was suggested that there needs to be a clear articulation around the core expectations of the new operational managers. Mrs Marks agreed, emphasising again the need for grip and accountability. Mrs Wilson would communicate this suggestion to Mr Carruthers. Members were advised that work is ongoing around the Scheme of Delegation. Mr Davies wished to highlight that Health and Safety is a legal responsibility. The Health Board has a corporate responsibility for the health and safety of its employees. The Committee agreed that Health and Safety must be regarded as a collective responsibility. **JW**

Cllr. Evans concluded by asking whether Mr Harrison was content that the completion dates are achievable, to which he responded that they had been agreed within the team and that work has already commenced. Ms Daniel noted that, whilst actions are aligned to the process, more wide-ranging discussions are also required around the topics mentioned above.

Due to this being a Limited Assurance report, Members noted that there will be a follow-up audit in next year's Internal Audit Plan.

Decision: The Committee **NOTED** the Health and Safety (Limited Assurance) Internal Audit report.

The Committee agreed to **ADVISE** the Board in relation to the Health and Safety (Limited Assurance) Internal Audit report, due to the findings and concerns highlighted therein.

Ms Sharon Daniel, Dr Jonathan Arthur and Mr Tim Harrison left the Committee meeting.

AC(25)14 **Data Quality (Limited Assurance)**

Mr Anthony Tracey joined the Committee meeting.

Mr Martyn Lewis introduced the Data Quality Internal Audit report, advising that the purpose of this audit was to review the structures and processes for ensuring data quality within the Health Board. The audit had identified that there is guidance in place; there is an Information Quality Assurance policy which clearly sets out the characteristics of good quality data, and responsibilities across the Health Board. There is an Information Quality Assurance (IQA) team in place. Due to their resource constraints, they focus on WPAS data, but they do have good processes in place for checking and monitoring data quality within WPAS and reporting issues back to the services for resolution. Also, there is reporting to the Information Governance Sub-Committee, and the data quality team have developed a self-service data quality dashboard for staff to use. In terms of use of data, there is a Data Warehouse BI system in place to provide intelligence to staff, and a data science team who can start to build more products to provide more intelligence. It should be noted that the responsibility for fixing data quality issues lies with the services, because they are entering the data at source. If they do not resolve the issues and put in plans to prevent issues recurring, the Information Quality team is repeatedly having to pick up and report the same issues.

Three high priority and one medium priority Management Actions had been identified, around: A gap in the resources needed to fully implement and maintain data quality standards across all Health Board systems; Lack of accountability for data quality within service areas; Absence of data quality metrics to aid performance monitoring; Absence of a formal Information/ Intelligence Strategy to ensure a coordinated and systematic approach to utilising intelligence across teams and services. An overall rating of Limited Assurance had been returned.

Mr Thomas thanked Mr Lewis for the audit and report, and Mr Anthony Tracey for developing the response. Whilst appreciating that the audit has a Limited Assurance rating, Mr Thomas did take assurance from the arrangements in place and the design of these. The challenge, he felt, was the implementation of this at operational level and responsiveness in fixing issues at an operational level – a common theme. Mr Anthony Tracey echoed this view, stating that the processes in place are robust. The IQA team is mindful of the pressures on operational staff, and try to fix issues on their behalf; however, they should be fixed ‘at source’, which would free up capacity in the IQA team. Steps are being taken to address some of the ‘low hanging fruit’ particularly the recurring themes identified by the audit. An example is duplicate registrations – when services are busy, it can be quicker to register a patient rather than try to find their record via WPAS. The team is trying to develop training to assist services in searching for patients on the system. There are also plans to strengthen, via the Directorate Improving Together Sessions (DITS) and governance processes how data quality is reported. Mr Tracey has discussed with the team allocating a score to issues, to facilitate a risk assessment.

Conscious that this area is impacted by external factors, including the new operational structure, Cllr. Evans enquired whether the completion dates are realistic. In response, Mr Tracey indicated that they are, as the IQA team is already working with services who are involved with data quality. Mr Thomas suggested that, whilst it will be possible to respond to the audit recommendations within the proposed timescales, achieving more widespread improvements in data quality may well take longer. In response to a request for clarity around accountability, Members noted that Mr Tracey, as Digital Director, has officer responsibility and, at Board level, the responsibility sits with Mr Thomas.

In terms of future and ongoing implementation, Mrs Marks emphasised that data quality is only as good as the data which is input. She enquired whether consideration is being given to how improved data quality might be achieved, including the use of Artificial Intelligence (AI). Mr Tracey drew Members' attention to his management response to Key Finding 3, which mentions exploring investment in automated data quality monitoring tools, these being a form of AI. In addition, for any new Health Board system being implemented, it is intended to include more stringent data quality checks than has been the case previously. For example, the new Patient Flow system has more data quality checks built in, so staff cannot move to the next stage without completing the information. Whilst this may hamper them initially, it will hopefully change the mindset and culture longer term. Consideration is also being given to communicating the impact of poor data quality/entry in one area, on workload elsewhere.

In response to a query around whether Internal Audit is content with the management response, Mr Lewis confirmed that they are. From a governance perspective, Mrs Wilson highlighted the need to strengthen statements around data quality in the Digital, Data and Innovation Committee Terms of Reference. With regard to Key Finding 4, she also noted reference to an Information/ Intelligence Strategy, and requested – for consistency across the Health Board – that the terminology 'Strategic Plan' be used in such instances. Mr Davies wished to record that this topic is regularly discussed at the Information Governance Sub-Committee, and that HDdUHB is the second best in Wales in terms of Clinical Coding quality. He felt this distinction was important. He also agreed, however, that the importance of data quality processes must be emphasised across the organisation.

Due to this being a Limited Assurance report, Members noted that there will be a follow-up audit.

Decision: The Committee **NOTED** the Data Quality (Limited Assurance) Internal Audit report.

The Committee agreed to **ADVISE** the Board in relation to the Data Quality (Limited Assurance) Internal Audit report, due to the findings and concerns highlighted therein.

Mr Anthony Tracey left the Committee meeting.

AC(25)15 **Financial Management**

DEFERRED to 15 April 2025 meeting

AC(25)16 **Performance Management Arrangements**

DEFERRED to 15 April 2025 meeting

AC(25)17 **Executive Team Working**

DEFERRED to 15 April 2025 meeting

AC(25)18 **Elective Waiting List Management**

DEFERRED to 15 April 2025 meeting

AC(25)19 **Learning Lessons**

DEFERRED to 15 April 2025 meeting

AC(25)20 **Medical Workforce (Medical Locums Planned Care)**

DEFERRED to 15 April 2025 meeting

AC(25)21 **Financial Assurance Report**

Mr Thomas introduced the Financial Assurance Report, indicating that this is of the standard format. He wished to highlight in particular Figure 3, which details the positive progress in reducing Single Tender Actions (STAs). Less positive is the list of breaches of Standing Financial Instructions (SFIs), which is reported for the first time. The background to this is that representatives from the Procurement team attended a Sustainable Resources Committee meeting, at which the issue of breaches of SFIs was mentioned. Mr Thomas had been alerted to the fact that these have not been reported to ARAC, so had requested the team to produce a retrospective list of breaches in excess of £5k from the beginning of the current financial year. The list also includes actions to mitigate and avoid recurrence of breaches. Finally, the write-off of one loss over £5k, relating to a debtors invoice in respect of an Overseas Patient, is presented for approval.

With regard to the breaches of SFIs, Mr Davies enquired whether any have raised particular concern. In response, Mr Thomas highlighted Estates and Facilities, which is being discussed with the department. These are generally lower-level breaches. In respect of 2.3.1, Overpayments of Salaries, Mr Davies noted that

a number of these result from process issues. He enquired whether the automation of payroll systems mentioned some time ago is being taken forward or whether this has been suspended. It was confirmed that automation was still being progressed. Referencing Figure 4, Mr Thomas noted that the number and value of overpayments of salary showed an increase in December 2024, which has continued into January 2025. He is trying to establish the reason for this and address it with managers. His next set of meetings with those managers responsible for most salary overpayments is scheduled; at these, Mr Thomas will be clear on the impact and establishing the actions being taken to avoid recurrence.

With regard to 2.6.1, Compliance with VAT Requirements, Mr Davies requested clarification around the cost to the Health Board of tax advisors and whether they provide good value for money. Mr Thomas explained that tax advisors are employed on a contingency basis, with a percentage fee paid on recovery of monies. Where there are opportunities to save is ensuring that lessons are learned from the times they are used. The Health Board also now has an 'in-house' tax accountant who contributes in this respect. Referencing Appendix 1, Mr Davies noted use of the statement 'This contract award does not allow for an extension' in a number of instances. He queried this, in view of the fact that a number relate to hardware and software provision, which the Health Board is unlikely to be ceasing use of. Mr Thomas advised that most of these contracts are digital. He has requested that Mr Tracey looks to consolidate all digital contracts into the control of Digital Services. A similar process has already been applied to Mental Health and Learning Disabilities (MHLD) contracts. This enables larger, longer-term contracts, with the aim of reducing overall spend. In the interim, annual contracts are being awarded on framework. He agreed, however that the aim would be for fewer, but longer, higher-value contracts which provided better value for money.

Referencing 2.2.1, Invoices on Hold, and the increase in these, Cllr. Evans queried actions being taken to address this issue. Members noted that the biggest single contributor to the numbers of Invoices on Hold is Just Wales Ltd. There are questions around value for money, and it is anticipated that the Health Board will move to another supplier for courier services. Another of the suppliers, Totally Welsh, provides food and these invoices are low value. Members were assured that Procurement is working on this issue. Cllr. Evans requested and received confirmation that the two contracts mentioned in 2.2.5, Consultancy Contracts, were approved at Board.

For assurance, Cllr. Evans advised that he, Mr Thomas and Mrs Wilson had met to discuss the issue of SFI breaches. Mr Thomas committed to ensuring that there is education around this area, and that the correct procurement processes are in place. With the new operational structure, consideration will need to be given to the 'owners' of contracts. Some single suppliers have activity

across various parts of the Health Board. Despite this, there needs to be one identified operational owner of the contract. Mr Thomas is taking this work forward with Mr Carruthers' team.

The Committee agreed to **ADVISE** the Board in relation to the SFI breaches, noting the mitigation around work being undertaken with the operational team.

Decision: The Committee:

- **DISCUSSED** the addition of reporting on breaches of SFIs, which are reported for the first time
- **TOOK ASSURANCE** from the actions taken to reduce the instances of non-compliance with the No PO No Pay policy
- **TOOK ASSURANCE** from the controls in place to manage Single Tender Actions
- **DISCUSSED** staff overpayments and **TOOK ASSURANCE** that actions to control them are sufficiently embedded
- **APPROVED** the write-off of loss exceeding £5,000
- **SCRUTINISED** the award of contracts listed

AC(25)22 **Annual Statement of Financial Procedures**

Decision: The Committee **NOTED** the Annual Statement of Financial Procedures.

AC(25)23 **Counter Fraud Update**

Mr Ben Rees introduced the Counter Fraud Update report, highlighting the issue of whether the existing Counter Fraud E-Learning package needs to remain mandatory. At a meeting last week, it had been decided that it should remain mandatory for new members of staff; however the requirement to renew certification every three years will be removed. To address any risks associated with this change, it is proposed that a refresher programme be included within the team's Inform and Involve work and that the online training package continue to be mandated for specific groups such as Procurement Officers. Referencing Appendix 1, the Audit Wales National Fraud Initiative Self-Appraisal Checklist, Mr Rees emphasised that completion of this will require the assistance of others across the organisation. The work will, however, be led by Counter Fraud, in partnership with Shared Services, and has already commenced. A report on progress will be shared In-Committee, with the aim of completing this by the end of Quarter 2 of next year.

With regard to the latter, Cllr. Evans highlighted question 11 'Have we documented our approach for risk assessing data match reports and investigating data matches?' and the answer of 'No'. Mr Rees explained that the process of what the organisation aims to achieve has been assessed and is documented. However, the body of work involved will need to be undertaken in partnership

with finance and other colleagues, spearheaded by Counter Fraud. On the same report, Mr Davies noted the intention to match data from different organisations, and assumed that this has been subject to the relevant data sharing protocols. He queried what sort of data the Health Board is being asked to produce and whether there are any problems in doing so.

Mr Rees confirmed that the data was matched and supplied to the Cabinet Office by Audit Wales last year. The data submitted relates to payroll and procurement. The data was matched on organisations' behalf and the results provided back to them. It will be this which is used to take the work forward. Returning to earlier discussions around data quality, Mr Rees noted reliance on the data received, which is derived from ESR. The exercise will provide an opportunity for the Health Board to identify potential issues around data on leavers, as it should identify who is leaving the Health Board and joining other public sector organisations. The data can be analysed for potential future improvements with regards to data quality on ESR and how this could be utilised going forward. Mr Thomas advised that there is a great deal of data comparators and cross-checking being undertaken as part of this work. For example, comparing public sector payroll data to Companies House data on company directors, and benefit claims.

Mrs Marks noted the planned exercise around 'Two workers, one shift' and enquired whether this was a widespread issue. In response, Mr Rees advised that there have been two instances reported recently. Detection is very much reliant on local checks; therefore Counter Fraud are reinforcing the message with the Nurse Bank and others. The risk is deemed relatively low, due to local controls. Mr Thomas indicated that it is less of a risk now, with lower nurse agency usage.

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

AC(25)24 **Audit Tracker**

Professor Philip Kloer joined the Committee meeting.

Mrs Wilson advised that Professor Kloer had been requested to attend for this item due to concerns raised at the previous meeting around the number of outstanding recommendations.

Miss Charlotte Wilmshurst introduced the Audit Tracker report, advising that there are a few concerning trends contained therein. The number of overdue reports has increased from 54 to 71; the number of red (overdue) recommendations has increased from 242 to 274; the number of recommendations without revised timescales has increased from 106 to 157. Further analysis is provided within the report. A breakdown by service is provided from page 8 of the report and the escalation status of services on page 10. Five directorates are in Level 3 escalation for the

Governance domain: Director of Operations, MHLD, Pathology, Radiology and Planned Care. Members were assured that support is being provided to directorates. Mrs Wilson advised that, due to concerns around recommendations going beyond due dates, Facilities are also to be escalated to Level 3.

Cllr. Evans reported that he had met with the Chief Executive to express his concern around the issue of outstanding audit recommendations and a lack of traction in this area. This dialogue had been positive, and he requested an update on progress. Professor Philip Kloer thanked ARAC for the invitation and recognised that this is an unacceptable position, with too many recommendations overdue. There have also been a number of recent Limited Assurance Internal Audit reports, following a Limited Assurance Head of Internal Audit Opinion last year. Professor Kloer, Mrs Wilson and Miss Wilmshurst have met with key Executive Directors to discuss each of these issues. He had left this meeting feeling more positive. Professor Kloer suggested that the organisation sometimes does not recognise that there are actions which involve factors outside its control. In such cases, it needs to be more proactive in flagging this. It also needs to ensure that recommendations and agreed actions are realistic, and that they have realistic timescales. Members heard that a report will be submitted to an Executive Team meeting. It is also intended that those directorates in Level 3 escalation with overdue recommendations are required to attend ARAC, to provide the necessary scrutiny. Professor Kloer would also hope to see improvements in those areas which have returned Limited Assurance Internal Audits; however, this remains to be seen.

With regard to MHLD, given the number of outstanding recommendations, the significance of the number of actions to be implemented has been recognised. Mrs Wilson advised that all are to be reviewed, and it will be determined how to take this forward. Should changes to recommendations be required, this will need to be agreed at ARAC. Mr Thomas, who chairs the internal escalation process and DITS, stated that, whilst it is disappointing to be in this position, it should be acknowledged that some directorates are being de-escalated. It is important to reflect on the effectiveness of the escalation process and develop new proposals which align with the new operational structure.

Cllr. Evans agreed that directorates are effectively ‘setting themselves up to fail’ if they set unrealistic actions or completion dates. Professor Kloer pointed out that the latter can always be challenged if they are considered too far ahead. Behind everything is and should be the aim of improving patient care and recognising that the Health Board is an organisation in Targeted Intervention (TI). Mrs Wilson added that recommendations should also be challenged if directorates feel that they are inappropriate, or the capacity to fulfil them is not available. This applies not only to Audit Wales and Internal Audit recommendations, but also to Healthcare Inspectorate Wales and other regulators.

Referencing earlier discussions, Mr Davies queried why Facilities is not red RAG rated for escalation. Mrs Wilson and Miss Wilmshurst explained that the report represents a point in time, at which the position had looked better; however, it has since deteriorated. Noting the 869 recommendations under this department, Mr Davies enquired whether any prioritisation or risk assessment process is applied, to target those which will make the most significant difference to patient care, for example. When advised that there is no such prioritisation, it was suggested that this should, perhaps, be encouraged.

Echoing earlier comments, whilst acknowledging that the merits of the new operational structure are clear, Mrs Marks expressed concern around the demands which will be placed on a relatively small group of managers as well as the small corporate teams who provide support. She emphasised the need for support, as well as grip and accountability, particularly during the transition between the current and new structures. Mrs Marks noted that information around outstanding recommendations is publicly available and subject to Freedom Of Information (FOI) requests, and suggested that it would be helpful to give consideration to further explanation of the external perception. On the first matter, Professor Kloer agreed that this is a concern, and is an issue of which Mr Carruthers is aware. However, following the meeting mentioned above, he felt that there are plans in place in relation to most of the Limited Assurance Internal Audits. The plans supporting this progress appear to be, in the main, independent from the new operational structure. In response to a query around whether any other interventions should be applied, Mrs Wilson suggested that this be reviewed following the next exercise with services. It was agreed, however, that an update on implementation of the new operational structure should be provided to the next meeting. **AC**

Decision: The Committee **TOOK ASSURANCE** on the rolling programme to collate updates from services in order to report progress to the Committee, including the revised performance management arrangements.

AC(25)25 **Minutes of the Meeting held on 10 December 2024**

Decision: RESOLVED – the Minutes from the meeting held on 10 December 2024 were approved as an accurate record.

AC(25)26 **Table of Actions**

An update was provided on the Table of Actions from the meeting held on 10 December 2024 and confirmation received that outstanding actions had been progressed. In terms of matters arising:

AC(24)171 – Cllr. Evans queried the extended timescale for this action. Mrs Wilson advised that release of the National Audit of Inpatient Falls data is anticipated to be April 2025. If not resolved by that point, this will be addressed.

AC(24)200 – Mrs Wilson advised that this reporting is now scheduled for the relevant committees; this action can be closed.

AC(24)198 – Members heard that Mrs Wilson, Mr Thomas, Ms Daniel and Mr Mark Henwood met on 10 February 2025. Mr Thomas reported the outcomes of this meeting:

- A Quality Impact Assessment (QIA) will be undertaken where there is non-participation in a mandatory clinical audit
- Under the revised governance arrangements, in each CCG, the annual clinical audit plan will be presented, national clinical audit recommendations and findings will be discussed
- Outcomes and participation compliance will be escalated to IQFPDG before any reporting to the Quality, Safety and Experience Committee (QSEC) or any Board Committee
- The aim being that the CCGs can demonstrate grip and control over the process they have in place

This work is being led by Ms Daniel.

AC(25)27 **Matters Arising not on Agenda**

There were no other matters arising.

AC(25)28 **Escalation Status Update Report**

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

Mr Lee Davies presented the Escalation Status Update Report, which he hoped was self-explanatory. Key highlights are drawn out, including the criteria assigned to ARAC, which contain no 'Alert' items. The report also provides updates on the 'Alert' items across other Board level Committees, which are mainly around finances and key performance areas, particularly Urgent and Emergency Care.

Mr Shaun Ayres noted that the report details nine 'Alert' items, which has subsequently reduced to seven, since the report was prepared. The two which have been changed to 'Advise' are Criterion 4 and 6, which are around the ability to meet Welsh Government expectations within the Plan. It is anticipated that the Health Board will achieve (if not exceed) the Control Total requirement, and identify £17m of £20m of savings for next year. These will, however, need to be monitored. Mr Ayres counselled that there is a potential risk in terms of capability and capacity; there is a significant programme of planning work in addition to

those around the Clinical Services Plan, etc. Consideration will need to be given to how this is resourced and prioritised. It needs to be undertaken in a financially sustainable manner, with cognisance around the consequences for other programmes of work. Thought also needs to be given to succession planning for key roles.

Thanking Mr Ayres for his report, Cllr. Evans enquired whether TI reporting has improved. In response, Mr Ayres suggested that the main area requiring focus is the TI Tracker. He explained that the premise behind this is that the 55 TI de-escalation criteria are updated by the relevant Lead Executive. The expectation is that evidence is provided to validate these updates. It is this process which needs to be improved. Following up on this point, Cllr. Evans enquired whether all elements of the TI Tracker are updated prior to consideration by Committees, to which Mr Ayres suggested that this needs to be more robust. Agreeing, Mrs Wilson felt that consideration should be given to how Executive Directors can support Mr Ayres, if he is not receiving updates in a timely fashion.

Mr Lee Davies emphasised that it is not desirable for TI to become an overly bureaucratic process. The Health Board needs to explore with Welsh Government whether there are areas where tracking can be stood down. Professor Kloer wished to highlight that there is a difference between statutory duty, de-escalation criteria and the Health Board's own ambitions as an organisation. In many cases, the latter is higher. Referencing Criterion 34: Demonstrate that all external recommendations (Royal Colleges, HIW, etc.) are discharged, verified, or scheduled under the longer-term improvement plan, Mr Maynard Davies suggested that this illustrates the importance of earlier discussions around outstanding audit/regulator recommendations. Mrs Wilson concluded by assuring Members that the TI Criteria have been reviewed to reflect the new Committee structure.

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

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

AC(25)29 **Targeted Intervention Governance (Reasonable Assurance)**

Members noted that the purpose of this review was to assess and provide independent assurance over the effectiveness of governance arrangements in place for the closure of Targeted Intervention (TI) actions. Professor Kloer thanked the Internal Audit team for their work, drawing Members' attention to the management response to recommendations. Mr Lee Davies felt that the report's findings were, overall, positive; noting that there were a couple of areas identified for consideration.

In response to a query around whether completion dates are realistic, Mr Ayres suggested that – if ARAC is satisfied with the new Escalation Status Update report format, with the addition of one further slide – the action for Key Finding 1 can be closed. He was confident that both can be closed by the proposed completion dates. Members noted that, again, this area links with the new operational structure.

Decision: The Committee **NOTED** the Targeted Intervention Governance (Reasonable Assurance) Internal Audit report.

The Committee agreed to **ASSURE** the Board in relation to the Targeted Intervention Governance (Reasonable Assurance) Internal Audit report.

Professor Philip Kloer, Mr Lee Davies and Mr Shaun Ayres left the Committee meeting.

AC(25)30 **ARAC Workplan 2024/25**

Decision: The Committee received and noted the Audit Work Programme 2024/25, which would be updated in line with discussions and to align with Audit Wales and Internal Audit Plans.

AC(25)31 **Any Other Business**

There was no other business reported.

AC(25)32 **Matters and Risks for Escalation to the Board**

As noted.

AC(25)33 **Date and Time of Next Meeting**

9.30am, 15 April 2025

2.2

09:30, 5 Mins

2.2 - Table of Actions

Rhodri Evans (Hywel Dda UHB - Independent Member)

For discussion

Attachments

2.2 Table of Actions ARAC 11 February 2025.pdf

2.2 Appendix 1 - National Audit of Inpatient Falls Summary.pdf

Audit & Risk Assurance Committee
TABLE OF ACTIONS
Arising from Meeting held on 11 February 2025

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
AC(24)171	**15/10/2024**	**Falls Management (Reasonable Assurance)**	To establish how HDdUHB compares with other Health Boards in terms of numbers of falls	**SD/MD**	**~~December 2024~~ ~~February~~ April 2025**	10 December 2024 **In Progress** The National Audit of Inpatient Falls for 2024 has been completed and provides an All Wales position - we are waiting for our local HB data to be released to benchmark with other HBs - likely to be in Q4 now. There are currently no other national benchmarking processes in place. 11 February 2025 **In Progress** HBs across Wales are waiting for individual health board data to be released by NAIF – likely to be April 2025. 15 April 2025 **Complete** The NAIF Report (summary attached at Appendix 1) provides benchmarked data against a broad range of Quality and Assessment criteria which will be scrutinised at the in-patient Falls Group and reported to professional forums to drive improvement. The Nursing Directorate will raise at the All Wales Falls Group, to seek

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
						mechanisms for benchmarked data on the number of falls per 1000 bed days (or agreed denominator) and will report any development via QSEC.
AC(25)03	**11/02/2025**	**Management of Bed Capacity (Limited Assurance)**	To liaise with Ms Christine James regarding taking the service change process through the written control policy process	**AC/PS**	**February 2025**	**Complete** This meeting took place on 26 March 2025 and a clear process was outlined during the meeting. The protocol needs to be completed in accordance with the requirements of policy 190. The EqIA is currently being developed and these documents will then go out for global consultation to ensure all staff have an opportunity to comment before approval.
AC(25)04	**11/02/2025**	**Mortuary Services (Limited Assurance)**	To report the outcome of discussions at the Regional Management Meeting and Regional Mortuary Operations meeting around key issues and lessons learnt relating to the programme	**AC**	**April 2025**	**In Progress** Regional ODN Operations Group has been unable to meet due to quoracy. A review of that is being undertaken. The Mortuary Management Group continues to meet to progress the actions arising from the audit.
			To redact identifiable information in the version of the report published on the Health Board website	**JW**	**February 2025**	**Complete**
			To discuss at the upcoming planning meeting proposed timescales around the management structure and whether these are achievable	**AC**	**April 2025**	**Complete** From a Hywel Dda perspective, all actions in the Audit have been completed, with the exception of the management structure implementation. The structure will be set up through Q1 and Q2 of 2025/26, as discussed at Public Board on 27 March 2025.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
			To discuss the feasibility of adjusting the above date in the finalised joint report	**JJ/AC/ JW**	**April 2025**	**Complete** Internal Audit advised date cannot be changed, as this was agreed by both Health Boards.
AC(25)05	**11/02/2025**	**Revised Operational Governance Arrangements**	To present to a future Board Seminar a 'package' of information relating to the new operational governance structure/ arrangements (and the other frameworks upon which this impacts)	**AC**	**April 2025**	**Complete** Forward planned for 17 April 2025 Board Seminar.
			To schedule an Internal Audit on implementation of the new operational governance arrangements	**JJ**	**April 2025**	**Complete** The audit is included within the draft Internal Audit Plan for 2025/26, which will be presented to the April 2025 ARAC meeting for approval.
AC(25)07	**11/02/2025**	**Audit Wales Update Report**	To pass on to those involved with the Digital Deep Dive an invitation to attend a meeting of the All Wales Digital IMs Group	**AB**	**April 2025**	**Complete** The dates for the all-Wales Digital IMs Group have been shared with the Audit Wales team involved in developing the digital review.
AC(25)13	**11/02/2025**	**Health and Safety (Limited Assurance)**	To discuss with Mr James Severs how to ensure data informs the HSC Workplan	**JW**	**April 2025**	**Complete** Included within HSC work plan.
			To discuss with Mr Andrew Carruthers the need to clearly articulate core expectations of managers in the new operational governance structure	**JW**	**April 2025**	**Complete**
AC(25)24	**11/02/2025**	**Audit Tracker**	To provide an update on implementation of the new operational governance structure	**AC**	**April 2025**	**Complete** Verbal update to be provided at the meeting and on the agenda for Board Seminar on 17 April 2025.

National Audit of Inpatient Falls (2023 Data)

HDUHB Trust Level Data Summary

Report at a glance

In 2023, 1,959 people sustained a femoral fracture as an inpatient; 1,609 (82%) were due to a fall and included as cases in the National Audit of Inpatient Falls.

Proportion of patients with risk factor assessment

In this report, to address the potential for harm caused by hospital-acquired deconditioning, we present a new approach that focuses on promoting activity using assessments to ensure each patient is fit to move as safely as possible. As such, the name of KPI 1 will be changing from multifactorial falls risk assessment (MFRA) to multifactorial assessment to optimise safe activity (MASA).

High-quality MASA

In 2023: **39%** of patients had 5 or more risk factors assessed

In 2022: **37%**

Vision

In 2023: **57%**

In 2022: **45%**
In 2021: **52%**

LSBP

In 2023: **42%**

In 2022: **39%**
In 2021: **39%**

Medication review

In 2023: **78%**

In 2022: **74%**
In 2021: **74%**

Delirium

In 2023: **52%**

In 2022: **52%**
In 2021: **66%**

Mobility

In 2023: **92%**

In 2022: **92%**
In 2021: **92%**

Continence

In 2023: **84%**

In 2022: **82%**
In 2021: **83%**

Post-fall management

Checked for injury

In 2023: **77%**

In 2022: **74%**
In 2021: **77%**
In 2020: **71%**

Safe method for moving from the floor

In 2023: **33%**

In 2022: **32%**
In 2021: **29%**
In 2020: **26%**

Medical assessment within 30 minutes

In 2023: **65%**

In 2022: **74%**
In 2021: **60%**
In 2020: **62%**

Recommendations

1. Trusts and health boards (HBs) should review their policies and practice to ensure older hospital inpatients are enabled to be as active as possible.
2. NHS England and Welsh Government should implement national drivers to ensure that all older people are screened for delirium upon hospital admission using the 4AT and reviewed for changes suggestive of a new onset of delirium for the duration of their admission.
3. Trusts and health boards should ensure that there are robust governance processes in place to understand when post-fall checks fail to correctly identify a fall-related injury.
4. Trusts and health boards should have processes in place to hasten time to administration of analgesia after an injurious fall, to ensure patients who sustain a femoral fracture in hospital are given analgesia within 30 minutes of falling.
5. Trusts and health boards are encouraged to prepare for the audit expansion in January 2025.

The full FFFAP glossary is available on the RCP website.

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The latest report collates data around 4 KPIs:

- KPI 1: High-quality multifactorial assessment to optimise safe activity (MASA)
- KPI 2: Check for injury before moving
- KPI 3: Safe lifting equipment used to move the patient from the floor
- KPI 4: Medical assessment within 30 minutes of the fall that caused the inpatient femoral fractures.

Key recommendations

1. Trusts and health boards should review their policies and practice to ensure that older hospital inpatients are enabled to be as active as possible.

2. NHS England and the Welsh Government should implement national drivers to ensure that all older people are screened for delirium upon hospital admission using the 4AT and reviewed for changes suggestive of a new onset of delirium for the duration of their admission.

3. Trusts and health boards should ensure that there are robust governance processes in place to understand when post-fall checks fail to correctly identify a fall related injury'.

4. Trusts and health boards should have processes in place to hasten time to administration of analgesia after an injurious fall, to ensure patients who sustain a femoral fracture in hospital are given analgesia within 30 minutes of falling.

5. Trusts and health boards are encouraged to prepare for the audit expansion in January 2025.

KPIs/Reports
KPI Benchmark
KPI Chart
Trust Report 2023
Downloadable audit reports

Dashboard for 7A2T. Hywel Dda University LHB - 2023

Dashboard for trust level data for the NAIF clinical audit. Please note that data presented is based on cases relating to inpatient falls between 1 January and 31 December for the year in question. These will include all records that are either completed or in draft at the time of the data cut (31 March of the following year). National median percentages are presented for comparison. These are taken from the related national report. Key performance indicators are not presented in this table, as they are available here and updated quarterly.

- Improvement
- Under national level
- >50% below than national level

Dashboard		Trust level	National level
Cases analysed		24	1633
Multi-factorial assessment to optimise safe activity (see KPI dashboard for KPI 1)		2023 (%)	National (%)
Assessment of vision		70.8%	57%
Assessment of lying / standing blood pressure		37.5%	42%
Assessment of lying / standing blood pressure not possible		0%	13%
Medication review		83.3%	78%
Screening for delirium		20.8%	52%
Assessment of mobility		95.8%	92%
Assessment of continence		91.7%	84%
Post fall management (see KPI dashboard for KPI 2, 3 & 4)			
Proportion of patients check for injury where injury is suspected		64.7%	53%
Proportion with analgesia given within 30 minutes of the injury		37.5%	26%
Proportion with severe harm attributed to the fall		12.5%	68%
Proportion where a hot debrief/swarm huddle was done		37.5%	40%
Proportion of patients for hot debrief / swarm huddle was done within the same shift		25%	24%
Proportion where an after action review / structured debrief was done		41.7%	61%
Proportion where an after action review / structured debrief was done within 5 working days		4.2%	33%

Action Plan 2023

HDUHB to be prepared for the 2025 NAIF Expansion

Share new requirements with In-patient Falls Group

Identify process for capturing additional information required on each site

Identify process for reporting addittional cases onto NAIF on each site

Monitor compliance with new requirements through In-patient falls group

Ensure that all patients who have a femoral fracture receive analgesia within 30 minutes

Review and update Falls Scrutiny / Assurance template to capture administration times of analgsia

Monitor compliance through NAIF and Falls Audit tool and report back to QSESC

Ensure older adult inpatients are enabled to be as active as possible

Deconditioning work programmes to include falls prevention

Staff to attend the new falls training programme to increase awareness of promiting independence and preventing falls

Ensure that there are robust governance processes in place to understand when post falls checks fail to identify a fall related injury

Maintain regular assurance and scrutiny of all falls resulting in harm through monthly site meetings, Directorate QSE and QSESC meetings

Montior compliance through 6monthly Falls Audits

Ensure learning from events and feedback mechanisms are in place to share leaarning where incidents identified

Ensure all older patients are screened for delirium on admission using 4AT and reviewed for changes suggestive of delirium during their admission

Embed the 4AT into all admission assessments for older adults

Ensure that 4AT assessments are updated where clinically suggested or in response to changes suggestive of delirium

Ongoing Actions

Development of Falls Training Programme

Establish SNM Falls Audit – currently being piloted across sites

Improve compliance with lying and standing blood pressures

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, 30 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 April 2025.pdf

2.4 TI Reporting Framework Tracker March 2025.pdf



Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

1. Finance, strategy and planning
2. Performance and outcomes
3. Fragile services
4. Governance
5. Leadership, capability and culture
6. Quality of care

Escalation Domains

ARAC – 15th April 2025

Targeted Intervention Progress Report

Introduction

Key Highlights

- **Governance Structure Transformation -** The Board approved a new Committee structure in January 2025, to be implemented from April 2025, with Clinical Care Groups (CCGs) replacing the directorate-based approach.
- **Positive External Validation -** Structured Assessment 2024 and Internal Audit feedback confirm robust corporate governance arrangements and a mature approach to risk management. Further reinforced by being de-escalated by Welsh Government for Governance and Leadership
- **Self-Assessment Enhancement -** A comprehensive seven-step process has been developed for the 2025/26 maturity matrix assessment, directly addressing prior audit recommendations.
- **Standardised Reporting -** Significant progress in standardising TI reporting across committees, with each committee now focusing on relevant de-escalation criteria.
- **Implementation Challenges -** While governance frameworks are well established, translating these into consistent service delivery improvements remains challenging, particularly in areas like cancer, urgent care, and diagnostics.

Criteria 36 - Effective Oversight and Scrutiny

Reporting Group: TI Coordination Group | **Committee**: ARAC | **Status**: Assure **Executive Lead**: Joanne Wilson

Summary of Current Status

- **Strong Board and Committee Oversight -** Regular reports provided to Board and Committees include IPAR, Risk Register, Quality & Safety Dashboard, Clinical Services Plan updates, and GIRFT reports.
- **Enhanced Committee Focus -** Each committee now focuses on the de-escalation criteria relevant to its remit, particularly within Finance and Performance Committee and Strategy and Planning Committee.
- **Strengthened Governance Model -** The new Clinical Care Group model will implement Integrated Governance Groups (IGGs) meeting fortnightly to examine planning, performance, finance, people, quality, and safety matters.
- **Structured TI Reporting -** Standardised approaches to reporting on TI are now in place across all Health Board committees, with improved summary information for ARAC.

Next Steps/Actions

1. **Clinical Care Group Implementation -** Complete the phased implementation of the CCG model with appropriate support mechanisms from April 2025.
2. **Committee Structure Transition -** Fully implement the new Board Committee structure approved in January 2025.
3. **Embedding Consistent Reporting -** Continue the structured reporting by the six specific TI actions under ARAC's remit, ensuring each action is clearly tracked, monitored, and reported.

Evidence/Assurance - Structured Assessment 2024 - noting the Health Board's openness and transparency in reporting. Board approval of new Committee structure (January 2025 Board meeting). Committee Self-Assessment feedback. Committee reports

Risk - No significant risks identified for this criterion.

Criteria 37 - Board's Duty of Quality in Decision-Making

Reporting Group: TI Coordination Group | **Committee**: ARAC | **Status**: Advise **Executive Lead**: Sharon Daniel

Summary of Current Status

- **Quality Impact Assessment Process -** The Health Board has progressed its approach to the Duty of Quality through the QIA process for all service changes, particularly within the Clinical Services Plan.
- **Evidence-Based Decision Making -** Board consistently examines quality implications when considering service changes, as demonstrated in the November 2024 Board papers.
- **Upcoming Public Consultation -** The planned CSP consultation phase (May-August 2025) will further strengthen quality considerations by gathering patient and stakeholder insights.
- **Scope for Improvement -** While the CSP services have comprehensive clinical data supporting fragility assessments, services outside this scope lack the same oversight.

Next Steps/Actions

1. **Regular CSP Updates -** Continue providing detailed updates on areas of fragility (ongoing).
2. **Complaints & Claims Data Monitoring -** Maintain regular reporting to relevant committees (monthly).
3. **Risk Register Monitoring -** Continue to reflect service fragility and associated mitigations where applicable (ongoing).
4. **Integrated Approach Development -** Develop a more cohesive model integrating workforce pressures, financial assessments, service resilience, and patient accessibility.

Evidence/Assurance - CSP Updates detailing areas of fragility. Complaints & Claims Data regularly reported to committees. Risk Registers reflecting service fragility

Risk - No specific risks identified for this criterion.

Criteria 38 - Programme and Performance Management Structure

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Reporting Group: TI Coordination Group | **Committee**: ARAC | **Status**: Advise **Executive Lead**: Lee Davies

Summary of Current Status

- **Mixed Improvement Picture -** While progress has been noted in financial delivery, limited improvement has been seen in areas such as urgent care, with cancer and diagnostics remaining challenging and reliant on additional resources
- **Welsh Government Feedback -** In January 2025, WG acknowledged positive progress but emphasised the importance of having adequate capacity and capability to deliver the 2025-26 annual plan.
- **Enhanced Accountability Model -** The Clinical Care Group model aims to address delivery challenges by placing accountability closer to clinical teams and creating greater scrutiny, ownership, and transparency.
- **Performance Tracking Framework -** Each service now has clear KPIs linked to TI de-escalation criteria with monthly tracking through the Improving Together framework.

Next Steps/Actions

1. **Establish Formal Escalation Process -** Implement a formal escalation route between the Director of Delivery and the CEO/Deputy CEO for non-engagement (by 28 February 2025). – **Completed** under the revised Escalation Framework for 25/26
2. **Resource Allocation Review -** Prioritise resources to areas most critical for de-escalation, quality, and safety. **By the end of April 2025** (post annual plan approval)
3. **Effectiveness Review -** Complete the Internal Audit review of the effectiveness of the new governance arrangements.

Evidence/Assurance - Welsh Government Feedback (21 January 2025). Welsh Government Feedback (March 2025). Internal Audit review (pending completion). Maturity Matrix (Scheduled for Board in July 2025).

Risk - Delivery Capacity - There is a risk around the ambition of the annual plan and the wider health board resources to ensure delivery, particularly in challenged areas like cancer, diagnostics and urgent

Criteria 39 - Risk Management Arrangements

Reporting Group: TI Coordination Group | **Committee**: ARAC | **Status**: Advise **Executive Lead**: Joanne Wilson

Summary of Current Status

- **Mature Risk Framework -** Risk management arrangements are embedded across the organisation, with robust processes for identifying, recording, and managing risks through the Board Assurance Framework, Corporate Risk Register, and Datix.
- **Board Oversight -** The Board has agreed its risk appetite (Jan 2025) and approach to risk tolerance (Mar 2025), providing a clear framework for determining acceptable risk levels.
- **Implementation Gap -** Despite established processes, challenges remain in ensuring that recorded risks transition smoothly from identification to active mitigation, particularly at the operational level.
- **Operational Governance Improvement -** A new operational governance structure, led by the COO, is expected to be implemented by April 2025 to address inconsistencies in operational risk management.

Next Steps/Actions

1. **Support COO Implementation -** Support the Chief Operating Officer to implement consistent operational governance arrangements by April 2025.
2. **Risk Mitigation Enhancement -** Focus on developing risk management plans with specific deliverables, measurable milestones, and clearly assigned responsibilities.
3. **Operational-Strategic Alignment -** Embed consistent governance practices across all operational functions to ensure a consistent flow of information from front-line risks to Board oversight

Evidence/Assurance - **Structured Assessment 2024** - confirming the Board's mature approach to overseeing strategic and corporate risks. New risk appetite statement and tolerance approach

Risk - No specific risks identified for this criterion. However, it is clear that the implementation of the CCG structure is fundamental across a number of the TI Criteria.

Criteria 40 - Governance and Assurance Systems

Reporting Group: TI Coordination Group | **Committee**: ARAC | **Status**: Advise **Executive Lead**: Lee Davies

Summary of Current Status

- **Established Governance Mechanisms -** New governance arrangements are well established and provide mechanisms for seeking assurance and escalation as required.
- **Performance Challenges -** In areas like cancer, urgent care, and diagnostics, limited improvement or deterioration highlights potential gaps in the effectiveness of programme and performance management oversight (this is likely linked to Criteria 38).
- **Aligned Committee Structure -** Board-approved Committee structure (January 2025) aligns with the six domains of Targeted Intervention, ensuring clear accountability for de-escalation criteria.
- **Early Warning System -** A dashboard of leading indicators has been developed to enable early identification of delivery risks before they manifest in performance metrics.

Next Steps/Actions

1. **Effectiveness Review -** Schedule a comprehensive review of the new governance arrangements for Q2 2025/26, focusing on escalation processes in challenged performance areas.
2. **Resource Alignment -** Ensure teams responsible for delivering key improvements have sufficient capacity and capability to meet ambitious targets.
3. **Performance Monitoring Enhancement -** Strengthen the connection between governance frameworks and actual performance improvement.

Evidence/Assurance - Board approval of Committee structure (January 2025). Audit Scheduled for September 2025. Leading indicators dashboard implementation

Risk - No specific risks identified for this criterion. However, if the actions are not followed, this is likely to lead to a delivery risk.

Criteria 41 – Maturity Matrix Self-Assessment

Reporting Group: TI Coordination Group | **Committee**: ARAC | **Status**: Advise **Executive Lead**: Lee Davies

Summary of Current Status

- **Prior Self-Assessment -** The Health Board completed a self-assessment against the governance maturity matrix in Q4 of 2023-24, providing a realistic view of governance maturity. This will allow the Health Board to take a view around how much we have progressed in the last 12 months.
- **Enhanced Assessment Process -** A comprehensive seven-step process has been developed for the 2025/26 assessment, running from March to July 2025, including stakeholder engagement, WG feedback integration, and formal Board approval.
- **Continuous Improvement Approach -** Regular reassessments of governance maturity are conducted throughout the year to adapt to emerging challenges and priorities.
- **Welsh Government Feedback Incorporation -** The next assessment will address WG feedback from January/March 2025 and the 2025-26 annual plan feedback, thus ensuring a 360 view across all stakeholders.

Next Steps/Actions

1. **Complete Annual Plan -** Finalise the annual plan for 2025-26 by April 2025, setting the stage for the subsequent maturity assessment. – Completed
2. **Evidence Gathering -** Begin the comprehensive review of internal documents, operational plans, and strategy alignment (March-April 2025). **– Commenced 80% completed**
3. **Stakeholder Engagement -** Implement the sequential stakeholder engagement process beginning with Clinical, Operational, and Corporate teams (May 2025).
4. **Board Approval -** Present the completed maturity assessment to the Board for formal approval (31 July 2025).

Evidence/Assurance - Maturity Matrix from Q4 2023-24. Detailed seven-step process for 2025/26 assessment. Welsh Government feedback (January, March and Annual Plan likely to be May 25)

Risk - No specific risks identified for this criterion.

ARAC's Visibility across Targeted Intervention

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Why this approach?

ARAC needs better visibility of key "Alert" criteria but does not require a deep review of all 56 items.

Key proposal

1. Focus on "Alert" - Present only criteria at "Alert" status, grouped by the committee responsible.
2. Brief explanations on request - If ARAC needs more detail, a short update can be provided for any "Alert" criterion.
3. Regular summaries - ARAC will receive an "Alert" summary at agreed intervals, ensuring consistent oversight of the most urgent issues.

Outcome

- ARAC gains a high-level understanding of major risks.
- Committees continue to handle detailed scrutiny of each criterion.

Alert Criteria by Committee

Sustainable Resources Committee (SRC) – Finance and Performance Committee

- Criterion 3: Annual plan with Board approval showing a substantial financial improvement trajectory that meets or exceeds the target control total. – this criteria is likely to be satisfied now and subject to agreement may move to advise?

ARAC's Visibility across Targeted intervention

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Strategic Development and Operational Delivery Committee (SDODC) – Strategy and Planning Committee

- **Criterion 4:** Submission of an acceptable annual plan in line with the current planning framework. This criterion is likely to be satisfied now and subject to agreement may move to advise?
- **Criterion 8:** Delivery of annual plan commitments, especially ministerial priorities. This needs to be addressed in Q1 around de-risking a number of key areas in the plan, so remains at alert.
- **Criterion 13:** Maintain 60% Single Cancer Pathway (SCP) performance for three consecutive months. Remains at alert, subject to February and March performance.
- **Criterion 17:** Achieve a 15% reduction in follow-ups delayed by 100%, for three consecutive months, then maintain for three more.
- **Criterion 18:** Ensure 65% of R1 ophthalmology patients are seen within or no more than 25% over their target date, sustained for three months. Set out in the annual plan, however, need more concrete plans with milestones and deliverables
- **Criterion 24:** Reduce ambulance handovers over one hour by 11% for three consecutive months, then maintain for another three. This is the biggest risk in terms of the Health Board achieving de-escalation, the current plans do not achieve the 680 1- hour ambulance handover TI expectation.
- **Criterion 25:** Continue progress toward no more than 7% of patients waiting over 12 hours at each site and across the Health Board. As with criterion 24 this remains extremely challenged in 25/26
- **Criterion 26:** Ensure median time from ED arrival to assessment by a clinical decision maker is no more than 60 minutes. Same as Criterion 24 and 25.
- **Criterion 27:** Achieve a 5% continuous reduction in delayed care pathways for three consecutive months, then maintain for a further three. The Annual Plan does have a trajectory to achieve this criterion. However, the latest performance data suggests this will be a challenge unless there is a material step change in the current DPOCs (linked to six goals)

ARAC's Visibility across Targeted intervention

Quality, Safety and Experience Committee (QSEC)

- Criterion 34: Demonstrate that all external recommendations (Royal Colleges, HIW, etc.) are discharged, verified, or scheduled under the longer-term improvement plan. This criterion is now likely to be de-escalated to advise, given the significant improvement in this area.
- Criterion 52: Provide an effective response to external reports, leading to sustainable improvements. This criterion is also likely to be stepped down to advise as set out in the QESC slides.

People, Organisational Development and Culture Committee (PODCC)

- Criterion 45: Develop a sustainable workforce and review workforce/clinician job plans annually to meet the annual plan requirements. This will be reviewed in April 25 as the annual plan and recent audit shows high compliance 87% (Job Planning) audit, so it is likely this will move to Assure.

Conclusion

Conclusion & Next Steps

- **Governance Framework Implementation -** The Health Board is making significant progress in strengthening governance through the implementation of the new Committee structure and Clinical Care Group model from April 2025.

- **Consistent Operational Governance -** A key focus remains on establishing consistent operational governance arrangements, particularly in supporting the COO to implement standardised approaches across all operational teams.

- **Effectiveness Evaluation -** A comprehensive review of the new governance arrangements is planned for Q2 2025/26 to assess whether they are delivering the intended improvements in performance, particularly in challenged areas.

- **Maturity Assessment -** The enhanced seven-step process for the 2025/26 maturity matrix assessment will provide a robust evaluation of governance arrangements, with Board approval scheduled for July 2025.

- **Capacity and Capability Focus -** In line with Welsh Government feedback, ensuring adequate capacity and capability to deliver the ambitious annual plan remains a priority, requiring careful resource allocation and prioritisation. Furthermore, this is consistent with the need to de-risk a number of areas in Q1, such as UEC and the identification and work up of all savings to achieve the £19m recurrent requirement

Criteria	Action	Status	Executive Lead	Summary of Current Status	Lead Executive Response (if applicable)	Documented Plan and Dates for Delivery (Evidence)	Actions Outstanding	Evidence and Assurance	Risk
36	Effective oversight and scrutiny of current service provision consistently being provided by the Board and the appropriate Committee as demonstrated by Committee and Board papers.	Assure	Joanne Wilson	Regular reports provided to Board and Committees include IPAR, Risk Register, Q&S Dashboard, Clinical Services Plan Updates, Deep Dive reports on specific issues, updates on GIRFT reports. Furthermore, the Targeted Intervention (TI) pack undergoes thorough scrutiny at committee level, with robust and regular discussions across relevant committees. Significant progress has been made to ensure that each committee focuses on the de-escalation criteria relevant to its remit, particularly within the Sustainable Resources Committee (or as amended to the Finance and Performance Committee) and the Strategic Development and Operational Delivery Committee (or as amended to the Strategy and Planning Committee). From the Draft Internal Audit Report 2024/25 (Objective 1, Key Findings on Governance & Reporting Arrangements): Following feedback from independent members at ARAC meetings, further actions regarding summary information on the assurance of scrutiny and monitoring of TI progress of other committees be provided in future escalation reports to ARAC and the TI governance arrangement of QSEC require addressing have been addressed (see Feb25 TI update to ARAC). Standardised reporting on TI taking place across the Health Board's committees. The new Clinical Care Group (CCG) model planned for implementation in April 2025 aims to further strengthen governance through Integrated Governance Groups (IGGs) that will meet fortnightly to examine planning, performance, Finance, people, quality, health and safety matters. This represents a planned transition from our current directorate-based approach, with preparatory work underway to ensure smooth implementation. While this transition represents a significant organisational change that will require time to fully embed, it is designed to provide greater cohesion across related clinical services and strengthen local ownership of care pathways while maintaining robust Health Board-wide oversight. A phased implementation approach with appropriate support mechanisms will be critical to its success.	Positive feedback has been received by AW in Structured Assessment 2024 regarding the Health Board's openness and transparency in its reporting. The Board approved a new Committee structure at its meeting on 30 January 2025, with implementation planned from April 2025.	Board Committee Structure - Jan25 Board 1. Structuring reports by the six specific TI actions under ARAC's remit, ensuring that each action is clearly tracked, monitored, and reported. In addition, summary assurance from other committees will also to be provided – (complete) 2. Highlighting any variance or potential non-compliance promptly. Where there is any indication that performance, quality, or governance arrangements do not align with TI criteria, ARAC will be duly notified so that corrective measures can be enacted swiftly and robust oversight can be maintained. (complete) 3. The approach to QESC follows the same reporting and assurance framework as other committees. Where criteria fall within QESC's remit, regular updates will be submitted, detailing progress, evidence-based outcomes, assurance ratings, and any further actions required. This consistent process ensures that each committee, QESC included, receives transparent and comprehensive updates on the organisation's performance against TI requirements (February 2025) (complete)	Committee reporting in Dec/Jan25	Structured Assessment 2025 Committee Self Assessment feedback Committee reports	N/A
37	Evidence of Board considering the Duty of Quality to inform their decision making and evaluating their compliance with the Duty.	Advise	Sharon Daniel	While there is clinical data supporting fragility within the CSP's scope, including complaints, claims, and cost implications, services outside this scope lack the same comprehensive oversight. A more cohesive model—integrating workforce pressures, financial assessments, service resilience, and patient accessibility—would help frame the Board's understanding and response to fragile services more effectively. This remains a priority to ensure alignment across all fragile pathways, especially in light of emerging configuration challenges. The Board has progressed its approach to the Duty of Quality through the Quality Impact Assessment (QIA) process for all service changes, particularly within the Clinical Services Plan. Evidence shows that the Board consistently examines quality implications when considering service changes, as demonstrated in the November 2024 Board papers where options for nine clinical services under the CSP were evaluated with explicit quality considerations. The planned consultation phase (May-August 2025) will further strengthen this by gathering patient and stakeholder insights on quality impacts. However, we recognise the need for a more consistent approach across all services, especially those outside the CSP scope. The newly implemented Clinical Care Group structure will support this by embedding quality oversight at service level through bi-weekly governance meetings from April 2025.		1. CSP Updates, detailing areas of fragility. (On Track -on-going) 2. Complaints & Claims Data, regularly reported to relevant committees (On-Track - monthy) 3. Risk Registers where applicable, reflecting service fragility and associated mitigations. (On-Track - on-going)			No risk identified
38	Effective programme and performance management structure is in place which defines objectives of the improvement work has plans which show how the work is delivered and what barriers could impact on delivery of outcomes; structures have effective open and transparent reporting with effective Board oversight and a clear performance and delivery framework that drives improvement.	Advise	Lee Davies	Recent governance improvements have provided a strong foundation, with clear objectives defined across various programmes. However, translating these objectives into consistent delivery remains a challenge. While progress has been noted in financial delivery, limited improvement has been seen in areas such as cancer, urgent care, and diagnostics. In some cases, deterioration has highlighted gaps in the effectiveness of the performance and programme delivery framework. Welsh Government Feedback (21 January 2025) Welsh Government acknowledged our positive progress in meeting 2024–25 objectives but emphasised the importance of having adequate capacity and capability to deliver our 2025–26 annual plan. They underlined the need for sufficient organisational planning and oversight, given the scale and complexity of upcoming programmes. The planned introduction of the Clinical Care Group model from April 2025 aims to address previous delivery challenges by placing accountability closer to clinical teams and creating greater scrutiny, ownership and transparency. Each CCG will be led by a senior "triumvirate" spanning managerial, medical, and nursing roles, with collective accountability for service quality, performance, workforce, and financial outcomes. To address the performance gaps noted by Welsh Government (particularly in cancer, urgent care, and diagnostics), each service now has clear key performance indicators linked to TI de-escalation criteria with monthly performance tracking through the Improving Together framework. However, it is recognised that delivering against these ambitious trajectories will require appropriate resources and capacity, which presents an ongoing challenge given the current financial constraints. The allocation of resources will need to be agreed and prioritised to areas most critical for de-escalation, quality and safety , but ongoing assessment of capacity to deliver will be essential. A key consideration for the successful implementation of this structure will be ensuring teams have the necessary resources, training and transitional support to adapt to new ways of working while maintaining operational delivery during this period of change. However, there is inevitably a risk around the ambition of the annual plan and the wider health board resources to ensure delivery.	A review of the effectiveness of the new governance arrangements will be undertaken by Internal Audit, expected to be completed in March 25	**Action - Formal Escalation Process for Non-Engagement -** To address the incomplete plans and limited engagement in certain programmes, a formal escalation route between the Programme Director of Targeted Intervention and the CEO/Deputy CEO will be established. This process ensures that any directorate or service failing to provide complete, timely plans will be escalated for support and accountability. **Target Implementation Date: 28 February 2025.**			No risk identified
39	Risk management arrangements are in place for identifying, recording managing risks across the organisation. Board is sighted on key risks and areas of concern on a regular basis and is able to offer constructive scrutiny on performance and effective oversight and scrutiny of fragile services provided by QSEC and Board.	Advise	Joanne Wilson	Risk management arrangements are embedded across the organisation, with robust processes for identifying, recording, and managing risks. This framework is built on a well-established set of tools, such as the Board Assurance Framwork, Corporate Risk Register and Datix, complemented by structured directorate escalation meetings. These meetings cover six key risk areas, ensuring a comprehensive assessment of performance variations and emerging challenges. This systematic approach aims to promote a proactive culture of risk identification, where issues can be identified and addressed early. The Board have agreed its risk appetite (Jan25) and approach to risk tolerance (Mar25). The Board is consistently sighted on key risks and areas of concern through well-defined reporting lines, including the Quality, Safety, and Experience Committee (QSEC), the Targeted Intervention (TI) Coordination Group, and the Audit and Risk Assurance Committee (ARAC). These governance structures allow the Board to engage in constructive scrutiny of performance and risk, providing effective oversight, especially in the management of fragile and high-risk services. This approach allows the Board to fulfil its role not only in terms of monitoring but also in challenging and supporting the development of mitigation strategies. Despite these established processes, challenges remain in ensuring that recorded risks transition smoothly from identification to active mitigation. It has been observed that while risks are being systematically recorded, there is sometimes a lack of capacity to manage the risks and the actionable plans tied to these risks. This gap can be addressed by focusing on the development of risk management plans that contain specific deliverables , measurable milestones, and clearly assigned responsibilities (subject to capacity) that are linked to the Health Board's agreed objectives. Strengthening these aspects will enhance the link between risk identification and tangible mitigation outcomes, promoting a more cohesive approach to risk management across the Health Board. The implementation of the Clinical Care Group model from April 2025 aims to further enhance risk management by integrating risk identification and management at service level. Each CCG's fortnightly Integrated Governance Group meetings are designed to ensure emerging risks are identified and addressed promptly, with clear escalation routes to the Integrated Quality, Finance & Performance Delivery Group where needed. This is intended to address the previously identified gap between risk identification and active mitigation, creating more responsive risk management closer to service delivery. The Board's newly approved risk appetite statement (January 2025) and risk tolerance approach (March 2025) provide a clear framework for determining acceptable risk levels, ensuring consistency in risk assessment and management across the organisation. Operational oversight has recently been improved through internal escalation processes that help identify operational issues and risks in a timely manner. However, governance arrangements at the operational level remain inconsistent, particularly across the Operations Directorate. The inconsistencies identified are currently being addressed through the introduction of a new operational governance structure. This revised structure, expected to be implemented by April 2025, will be led by the Chief Operating Officer, whose support will be crucial to ensure consistent application and monitoring across all operational teams. The objective is to align operational governance standards with the mature corporate governance practices already demonstrated by the Health Board, thus promoting a unified standard of governance across all tiers of the organisation. Risk Management is also included in the new standardised operational governance arrangements which are also expected to be implemented in April 2025. The corporate governance arrangements within the Health Board are mature and robust, a conclusion consistently reinforced through structured assessments. These assessments highlight that strategic and corporate risks are well-monitored, and there is a continuous effort to ensure alignment between strategic intentions and operational actions. However, to support future governance resilience, it will be crucial to focus on embedding consistent governance practices across all operational functions. This will ensure a consistent flow of information, from front-line operational risks to strategic oversight by the Board, thereby enhancing the Health Board's capacity to manage both immediate and long-term challenges.	Mature and robust corporate governance arrangements in place, with further work to develop consistent governance arrangements in the Operations Directorate	Support the Chief Operating Officer to implement consistent operational governance arrangements (Apr25)	Support the Chief Operating Officer to implement consistent operational governance arrangements - (Apr25)	Structured Assessment 2024 - the Board continues to have a mature approach to overseeing strategic and corporate risks and risk management arrangements.	N/A
40	Clear governance and assurance systems in place with performance (quality resource activity/outcomes) issues escalated appropriately through clear structures and processes.	Advise	Lee Davies	As above, the new governance arrangements are now well established and provide the mechanisms for seeking assurance and escalating as required. A review is required of the effectiveness of these mechanisms as, in areas like cancer, urgent care, and diagnostics, we've observed limited improvement but in some cases, a deterioration, highlighting potential gaps in the effectiveness of our programme and performance management. Although the structure defines objectives, the framework is not yet supporting the level of oversight required to ensure consistent delivery against these objectives. The new governance arrangements are now well-established, with the Board approved Committee structure (January 2025) being implemented from April 2025. This structure aligns with the six domains of Targeted Intervention, ensuring clear accountability for de-escalation criteria. The Clinical Care Group governance model aims to further strengthen this by creating consistent operational governance through standardised Integrated Governance Groups, addressing the previously identified inconsistencies in operational governance. To evaluate effectiveness, a comprehensive review of the new governance arrangements is scheduled for Q2 2025/26, with a particular focus on whether escalation processes are functioning effectively in areas like cancer, urgent care and diagnostics where performance challenges persist. A dashboard of leading indicators has been developed to enable early identification of delivery risks before they manifest in performance metrics. Successful implementation of these governance arrangements will require careful attention to resource allocation, ensuring that teams responsible for delivering key improvements have sufficient capacity and capability to meet the ambitious targets set in the Annual Plan. This remains a challenge in the current financial environment but is essential to the effectiveness of the governance framework.	As above				No risk identified

41	Self-assessment against an agreed governance maturity matrix with evidence the agreed level.	Advise	Lee Davies	The Health Board undertook a self-assessment against an agreed governance maturity matrix in Q4 of 2023-24, providing a realistic view of the organisation's current position regarding governance maturity. This assessment has been crucial, particularly given the broader context of the annual plan recovery work undertaken during the summer of 2023 and the strategic preparations for the 2024-25 planning cycle. It offered a critical lens through which governance practices were evaluated, enabling an honest appraisal of strengths and areas needing enhancement. The maturity matrix framework provided clear insights, which have informed the Health Board's subsequent approach to improving its governance maturity. The assessment did not exist in isolation; rather, it has become a key reference point for ongoing organisational improvements. It has ensured that governance practices are continuously reassessed, with findings feeding into the decision-making processes to strengthen governance structures, align roles and responsibilities, and provide a clear direction for ongoing enhancement activities. In a manner similar to the Health Board's handling of the 56 de-escalation criteria under the Targeted Intervention (TI) framework, the maturity matrix serves as both a strategic and operational tool that reinforces decision-making processes. These processes ensure that both strategic and operational planning governance arrangements are not only reactive but also proactive, with an emphasis on anticipating challenges, promoting best practices, and ensuring alignment across critical areas of focus. The maturity matrix is thus integral to the Health Board's structured approach to organisational improvement, helping to drive alignment between strategic goals and operational practices. For the 2025/26 maturity matrix assessment, a significantly enhanced seven-step process has been developed, running from March to August 2025. This comprehensive approach includes: 1. Initial evidence gathering (March-April) - A thorough review of internal documents, operational plans, strategy alignment, and previous assessments to ensure robust evidence across all nine maturity domains. 2. Sequential stakeholder engagement (May) - Beginning with Clinical, Operational and Corporate teams (12-13 May), followed by Executive assessment (14 May), ensuring multiple perspectives are captured. 3. Integration of Welsh Government feedback (May-June) - Incorporating formal WG responses to the Annual Plan and all TI correspondence throughout 24/25 to ensure alignment with external expectations. 4. Consolidation (June) - Reassessment based on integrated feedback with detailed narrative justifications and evidence for each maturity score. 5. Committee scrutiny (June-July) - Formal review by the Strategy and Planning Committee (1 July) with recommendations for Board consideration. 6. Board approval (31 July) - Submission for formal approval with comprehensive documentation of Board feedback. 7. Submission to Welsh Government (Early August) - Final submission with full supporting evidence. This structured approach directly addresses prior audit recommendations regarding evidence usage and Board oversight while ensuring the maturity assessment reflects not just planning processes but broader organisational capabilities. Regular reassessments of governance maturity are conducted throughout the year to adapt to emerging challenges and priorities. This continuous assessment cycle allows the Health Board to remain agile, capable of responding to both internal and external pressures, while still maintaining alignment with its strategic objectives. By leveraging the insights gained through the maturity matrix and aligning them with the strategic priorities identified in the 2025-26 annual plan, the Health Board aims to ensure that its governance arrangements not only meet current needs but are also future-ready. The next maturity matrix reassessment will take place following the completion of the 2025-26 annual plan. This reassessment will help to ensure that planning practices remain relevant and aligned with the evolving needs of the organisation. Furthermore, this will service as an improvement process ensures that governance structures are not static but evolve in tandem with the changing operational landscape and strategic ambitions of the Health Board.	A further assessment will be made following the completion of the annual for 2025-26 (April 25)				N/A

2.5

10:05, 0 Mins

2.5 - All Wales NHS Audit Committee Chairs' Meeting Update

Rhodri Evans (Hywel Dda UHB - Independent Member)

Meeting cancelled

For information

2.6

10:05, 5 Mins

2.6 - Standing Orders, Standing Financial Instructions and Scheme of Delegation

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

For approval

Attachments

2.6 Revised Standing Orders ARAC April 2025.pdf

2.6 Appendix 1 - LHB Model Standing Orders Reservation and Delegation of Po~.pdf

2.6 Appendix 2 - Master SoD Revised for ARAC Review 070425.pdf

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	15 April 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Revised Model Standing Orders
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Director of Corporate Governance/Board Secretary
SWYDDOG ADRODD: REPORTING OFFICER:	Charlotte Wilmshurst, Assistant Director of Assurance and Risk

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Local Health Boards, NHS Trusts and Special Health Authorities (Constitution, Membership and Procedures) (Miscellaneous Amendments) (Wales) Regulations 2024 came into force on the 20 January 2025.

These Regulations amended the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009, The Public Health Wales National Health Service Trust (Membership and Procedure) Regulations 2009, The National Health Service Trusts (Membership and Procedure) Regulations 1990 and The Health Education and Improvement Wales Regulations 2017.

These amendments have necessitated revisions to the Model Standing Orders (SO) for Local Health Boards, NHS Trusts in Wales and Special Health Authorities. In line with this, Hywel Dda University Health Board's (HDdUHB's) SOs have been reviewed and updated to account for these, and these are presented to the Audit and Risk Assurance Committee for comment, prior to recommending their onward submission for approval to the Board on 29 May 2025.

Cefndir / Background

HDdUHB's SOs were last approved by Board in May 2024; however, these have been further updated following receipt of a letter received on 30 January 2025 from the Cabinet Secretary for Health and Social Care regarding amendments required to the Standing Orders.

The Local Health Boards, NHS Trusts and Special Health Authorities (Constitution, Membership and Procedures) (Miscellaneous Amendments) (Wales) Regulations 2024 came into force on the 20 January 2025. These Regulations amended the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009, The Public Health Wales National Health Service Trust (Membership and Procedure) Regulations 2009, The National Health Service Trusts (Membership and Procedure) Regulations 1990 and The Health Education and Improvement Wales Regulations 2017.

The purpose of these amendments is to ensure consistency relating to:

i. The eligibility requirements for the chair, vice-chair and non-officer members/non-executive directors of the Board.
ii. The provisions relating to the appointment of officer members to boards of Local Health Boards.
iii. The arrangements for appointing the Trade Union Member to a board of Local Health Boards.
iv. The timescales for the publication of board and committee agendas and papers.
Considering these amendments, it is necessary to make revisions to the Model Standing Orders and Reservation and Delegation of Powers for Local Health Boards, NHS Trusts and Special Health Authorities using the Welsh Ministers power of direction in accordance with Section 12(3), Section 19(1) and Section 23(1) of the National Health Service (Wales) Act 2006

Asesiad / Assessment

Standing Orders

A review has been undertaken of the Model SOs and SFIs for Health Boards, NHS Trusts and Special Health Authorities. These amendments supersede those issued previously in WHC/2024/019. A new Welsh Circular, WHC (2025) 007 has been issued to confirm this.

HDdUHB's SOs have been reviewed and updated (Appendix 1), with changes made shown in red/strikethrough text. The key areas to note are highlighted below:

1. **Eligibility requirements**

No amendments.

2. **Appointment of officer members**

Section B – The Local Health Board: Membership of the Local Health Board

1.1.1 The membership of the LHB shall be no more than 24 members comprising the Chair, Vice Chair, non-officer members (appointed by the Minister for Health and Social Services), Associate Members, the Chief Executive (appointed by the Board with the involvement of the Chief Executive, NHS Wales) and officer members ~~(appointed by the Board)~~. (appointed by Non-Executive Members of the Board and the Chief Executive).

Section B – The Local Health Board: Officer Members [to be known as Executive Directors]

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

3. **Appointment of the Trade Union Member to Local Health Boards**

Section B – The Local Health Board: Non-Officer Members [to be known as Independent Members]

1.1.4 A total of 9, appointed by the Minister for Health and Social Services, including: an elected member of a local authority whose area falls within the LHB area; a current member or employee of a Third Sector organisation within the LHB area; a nominated trade union official; a person who holds a post in a University that is related to health; and five other Independent Members who together have experience and expertise in legal; finance; estates; Information Technology; and community knowledge and understanding.

4. **Publication of Board agendas and papers**

Section B – Meetings: Notifying and equipping Board members

7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least ~~10 calendar days~~ 5 clear days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

Section B – Meetings: Notifying the public and others

7.4.7 Except for meetings called in accordance with Standing Order 7.3, at least 10 calendar days before each meeting of the Board a public notice of the time and place of the meeting, ~~and the public part of the agenda~~, shall be displayed bilingually (in English and Welsh):

- On the LHB's website~~, together with the papers supporting the public part of the Agenda;~~ as well as
- Through other methods of communication as set out in the LHB's communication strategy.

7.4.8 When providing notification of the forthcoming meeting, the LHB shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc. The agenda and papers will be made available to the public at least 5 clear days before each meeting of the Board.

Schedule 1
No amendments.

Schedule 2.1 - Model Standing Financial Instructions for Local Health Boards

No changes have been made to HDdUHB's Standing Financial Instructions; however, following the introduction of the Procurement Act 2023, the model SFIs are in the process of being updated and will be issued in due course.

Schedule 3 - Board and Committee Arrangements

The three new Committees constituted from 1 April 2025 have been added:

- Digital, Data and Innovation Committee
- Finance and Performance Committee
- Strategy and Planning Committee

The two Committees that were disestablished on 31 March 2025 have been removed:

- Sustainable Resources Committee
- Strategic Development and Operational Delivery Committee

Schedule 4 – Joint Committee Arrangements
No amendments

Schedule 5 – Advisory Group Terms of Reference and Operating Arrangements
No amendments

Corporate Scheme of Delegation
The Health Board's current Corporate Scheme of Delegation was approved by Board on 28 November 2024.

As part of this year's annual review, separate work has been undertaken on an Operational Scheme of Delegation which has exposed a number of necessary changes to make within the Corporate Scheme of Delegation.

The revised Corporate Scheme of Delegation has been shared with Executive Directors, identifying these revisions and also the revisions made in line with changes agreed and approved at Remuneration and Terms of Service Committee meetings throughout the year.

The revised version of the Corporate Scheme of Delegation was shared at Executive Team on 26 March 2025 and in subsequent e-mails following this for final agreement, and the Scheme of Delegation attached represents the 2025 revised version for Audit and Risk Assurance Committee's review.

The revised document is attached as Appendix 2, and for ease the main changes have been extracted below:

Section	What has changed?	Rationale?
Throughout	Standardisation of Health Board Officer titles given the introduction of the Health Board's new operational arrangements including Clinical Care Groups and Clinical Service Groups Removal of reference to OJEU thresholds Reference to 'Serious Adverse Incidents' amended to 'incidents meeting criteria for nationally reporting to NHS Executive' with the inclusion of those categories that require reporting i.e. severe, catastrophic, etc	Standardisation of titles required following the introduction of the Health Board's new operational arrangements including Clinical Care Groups and Clinical Service Groups. OJEU thresholds no longer relevant – replaced with 'relevant EC Directives'. Terminology updated.
STANDING ORDERS	**WORKING IN PARTNERSHIP** **Working in Partnership** (Row 30) Identification and engagement with all key partners and regular review of effectiveness	Addition of Director of Public Health in the Operational Responsibility column as the Health Board lead for Partnerships) alongside the Director of Primary Care, Community Strategy and Long Term Care. Removal of the Director of Strategy & Planning in the Operational Responsibility column given their responsibility for ARCH, the Mid Wales Collaborative and Llais are covered elsewhere in the Corporate Scheme of Delegation.
STANDING FINANCIAL INSTRUCTIONS (SFI)	**CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS**	Delegated Responsibility transferred from the Chief Operating Officer to the Director

	15.1.1f Capital Plan (Row 219) f) Ensure that any 3rd party use of NHS estate is properly controlled, reimbursed and reported. This will include ensuring that appropriate security, insurance and indemnity arrangements are in place and that there is a written agreement as to each party's responsibilities and liabilities	of Allied Health Professions & Health Science. Operational responsibility transferred from the Director of Estates, Facilities & Capital Management to the Head of Property Performance	
STANDING FINANCIAL INSTRUCTIONS (SFI)	**CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS** **15.1.3 Capital Plan** (Row 220) The Board must approve a three year Capital Plan, and an annual Capital Programme, as set out in the Integrated Medium Term Plan and Budgetary Control chapters of these SFI	Identification of Head of Capital Planning in the Operational Responsibility column	
STANDING FINANCIAL INSTRUCTIONS (SFI)	**CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS** **15.6.1 Asset Registers** (Row 227) Maintenance of asset registers (on advice from Director of Strategy & Planning and Director of Finance)	Operational responsibility broadened to include 'Asset Owners'	
SCHEME OF DELEGATION FROM OTHER	**QUALITY, SAFETY AND EXPERIENCE** **Management of Incident Reporting & Investigation** (Row 309) j) Reporting of incidents in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)	Delegated responsibility transferred from the Chief Operating Officer to the Director of Allied Health Professions and Health Science given their lead for Health & Safety, with operational responsibility transferred from the Director of Estates, Facilities & Capital Management to the Head of Health, Safety & Security	

SCHEME OF DELEGATION FROM OTHER	**QUALITY, SAFETY AND EXPERIENCE** **Management of the Clinical Audit Function** (Row 319) a) Coordination and participation in national audits and development of a Hywel Dda Clinical Audit Plan	Delegated responsibility transferred from the Director of Nursing, Quality & Patient Experience to the Medical Director (as agreed at RTSC on 02.04.25) with operational responsibility transferred from the Assistant Director of Quality & Service Improvement to the Clinical Audit Manager	
SCHEME OF DELEGATION FROM OTHER	**QUALITY, SAFETY AND EXPERIENCE** **HM Coroner** (Row 328) a) Maintaining relationship and ensuring appropriate response to requests for information	New entry – previously a gap. Delegated responsibility attributed to the Director of Nursing, Quality & Patient Experience with operational responsibility attributed to the Assistant Director (Legal & Patient Support)	
SCHEME OF DELEGATION FROM OTHER	**QUALITY, SAFETY AND EXPERIENCE** **HM Coroner** (Row 329) b) Sending response to HM Coroner	New entry – previously a gap. Delegated responsibility and operational responsibility attributed to the Chief Executive	
SCHEME OF DELEGATION FROM OTHER	**COMMISSIONING** **Commissioning (including Primary Care Services)** (Rows 357–360; 368-369; 371) c) Maintaining a register of commissioning contracts d) Ensuring every commissioning contract has a lead manager responsible for ensuring that contract delivers activity, quality and finance e) Agreement of annual contract with existing providers and within existing budgets - NHS, third sector, independent or private f) Agreement of contract variations l) Ensuring there is a contracting framework in place which sets out expectations around what will be included in	Delegated and operational responsibility potentially to transfer from the Director of Strategy & Planning to the Director of Finance (alongside the Director of Primary Care, Community Strategy & Long Term Care). TBA prior to May 2025 Board.	

	documentation and approach to management including meetings m) Ensuring that contracts have appropriate documentation in place including key performance metrics relating to activity, targets, quality and finance and that regular performance monitoring meetings take place o) Authorisation of invoices against contracts (within budget) excluding NHS Long Term Agreements (LTAs)		
SCHEME OF DELEGATION FROM OTHER	**COMMISSIONING** **Commissioning (including Primary Care Services)** (Row 366) j) Agreement of changes to contracts where this would place a cost pressure on the organisation which would have a significant impact on the delivery of outcomes	New entry – previously a gap identified through work on the Operational SoD. Delegated responsibility and operational responsibility attributed to both the Director of Strategy & Planning and the Director of Finance	
SCHEME OF DELEGATION FROM OTHER	**COMMISSIONING** **Commissioning of Continuing Healthcare and Funded Nursing Care (**Row 376) c) Authorising of invoices against agreed packages of care ~~outside panel~~	Delegated Matter broadened (and standard terminology updated).	
SCHEME OF DELEGATION FROM OTHER	**OPERATIONAL** **Operational Delivery of:** (Row 397) f) Primary Care	New entry – previously a gap. Delegated responsibility attributed to the Director of Primary Care, Community Strategy and Long Term Care with operational responsibility attributed to the Primary Care Clinical Care Group Service Director	
SCHEME OF DELEGATION FROM OTHER	**OPERATIONAL** **Operational Delivery of:** (Row 398) g) Estates & Facilities	New entry – previously a gap. Delegated responsibility attributed to the Estates & Facilities Group Service Director with	

		operational responsibility attributed to the Estates & Facilities Group Service Director	
SCHEME OF DELEGATION FROM OTHER	**OPERATIONAL** **Operational Delivery of:** (Row 403) l) WGH Creche	Operational responsibility transferred from the Director of Estates, Facilities & Capital Management to the Women & Family Health Clinical Service Group General Manager	
SCHEME OF DELEGATION FROM OTHER	**OPERATIONAL** **Medical Records:** (Row 419) Responsibility for Medical Records Directorate	New entry – previously a gap. Delegated and operational responsibility transferred from the Chief Operating Officer to the Director of Finance	
SCHEME OF DELEGATION FROM OTHER	**OPERATIONAL** **Operational quality and safety and effectiveness** (Row 473) a) Implementing Hospital Patient Environment audits	Operational responsibility transferred from the Director of Estates, Facilities & Capital Management to the Service Director, Estates & Facilities Group	
SCHEME OF DELEGATION FROM OTHER	**OPERATIONAL** **Estates** (Row 489) f) Delivery of Capital Estates Projects	Added the Director of Allied Health Professions and Health Science alongside the Director of Strategy & Planning for delegated responsibility given the new split of roles, and added in the Head of Operations alongside the Director of Estates, Facilities & Capital Management (to replace with new job title) for operational responsibility	
SCHEME OF DELEGATION FROM OTHER	**CORPORATE** **Legal Advice** (Row 530) b) Authority to seek legal advice – all issues	Added in Director of Workforce & OD to the Delegated Responsibility column to reflect the seeking of legal advice for workforce matters (and added in the	

		Assistant Director of People Management to the Operational Responsibility column)
SCHEME OF DELEGATION FROM OTHER	**CORPORATE** **Committee Lead** (Row 573) g) Finance and Performance Committee	Change of Committee title from the Sustainable Resources Committee to the Finance and Performance Committee
SCHEME OF DELEGATION FROM OTHER	**CORPORATE** **Committee Lead** (Row 576) j) Strategy and Planning Strategic Development and Operational Delivery Committee	Change of Committee title from the Strategic Development and Operational Delivery Committee to the Strategy and Planning Committee
SCHEME OF DELEGATION FROM OTHER	**CORPORATE** **Committee Lead** (Row 577) k) Digital, Data and Innovation Committee	Additional Committee (Digital, Data and Innovation Committee) to reflect new Committee structure
LEGISLATION COMPLIANCE	**Health & Safety** (Row 628) Fire & Rescue Services Act 2005 & Regulatory Reform (Fire Safety) Order 2005	Transfer of delegated responsibility from the Chief Operating Officer to the Director of Allied Health Professions and Health Science (as agreed at RTSC on 02.04.25)

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to:

- **CONSIDER** the required amendments made to HDdUHB's Standing Orders in light of WG amendments to the Model Standing Orders.
- **REVIEW** HDdUHB's revised Scheme of Delegation.
- **RECOMMEND** the revised version of HDdUHB Standing Orders and Scheme of Delegation to the Board on 29 May 2025 for approval.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.10 The Committee will be responsible for reviewing the 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
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Model Standing Orders and Standing Financial Instructions
Rhestr Termau: Glossary of Terms:	Included 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:	Director of Corporate Governance/Board Secretary

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Robust governance arrangements underpinning financial management contribute towards internal control and value for money being achieved.
Ansawdd / Gofal Claf: Quality / Patient Care:	Where applicable, included within the report
Gweithlu: Workforce:	Where applicable, included within the report
Risg: Risk:	A sound system of internal control ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed.
Cyfreithiol: Legal:	Model SOs are issued by Welsh Ministers to Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Health Boards in Wales must agree SOs for the regulation of their proceedings and business. SOs are designed to translate the statutory requirements set out in the Local Health Boards (Constitution, Membership and Procedures (Wales) Regulations 2009 (S.I 2009/779 W.67)) into day to day operating practice, and, together with the adoption of a Scheme of Decisions reserved to the Boar; a Scheme of Delegations to officers and others; and SFIs, they provide a regulatory framework for the business conduct of the Health Board.
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	No direct impacts
Cydraddoldeb: Equality:	The Model SOs and SFIs have been subject to an Equality Impact Assessment as part of the NHS Reform Programme, and the revised SO's were subject to an in house EqIA screening in September 2012, the outcome of which indicated no negative impacts in relation to the Health Board's duties under the Equality Act 2010. A summary report was produced to this effect. The March 2014 revisions have been scrutinised with no negative impacts identified; therefore, no amendments will be made to the report produced in 2012. The most recent amendments outlined above and attached have been subject to an EqIA Screening, and there is no evidence at this stage of potential adverse impact in relation to equality, diversity or human rights. Should any issues arise at any stage following implementation of the revised SOs, a full EqIA will be undertaken as appropriate.

Model Standing Orders

Reservation and Delegation of Powers

For Local Health Boards

Foreword

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

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

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

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

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

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Section A – Introduction

Statutory Framework

i) The Hywel Dda University Local Health Board (the LHB) is a statutory body that was established on 1 June 2009 and became operational on the 1 October 2009 under **The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 (S.I. 2009/778)**, "the Establishment Order".

ii) The principal place of business of the LHB is – Corporate Offices, Ystwyth Building, St David's Park, Carmarthen, SA31 3BB.

iii) All business shall be conducted in the name of Hywel Dda University LHB, and all funds received in trust shall be held in the name of the LHB as a corporate Trustee.

iv) LHBs are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how LHBs are governed and their functions.

v) Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Welsh Ministers have made **the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779)** ("The Constitution Regulations") which set out the constitution and membership arrangements of LHBs, which includes a requirement for LHBs to make SOs for the regulation of its proceedings and business including provision for the Boards suspension. Sections 12 and 13 of the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on LHBs and to give directions about how they exercise those functions. LHBs must act in accordance with those directions. Most of the LHB's statutory functions are set out in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009 (S.I. 2009/1511).**

vi) **The National Health Service Joint Commissioning Committee (Wales) Directions 2024 (WG24-06)** provide that the seven LHBs in Wales will establish a joint committee to exercise the functions of planning, securing and commissioning:

(a) specialised services for –
    (i) cancer and blood disorders,

(ii) cardiac conditions,
(iii) mental health and vulnerable groups,
(iv) neurosciences, and
(v) women and children,

(b) services where there is agreement between the Local Health Boards that they should be arranged on a regional and national basis,
(c) emergency medical services,
(d) non-emergency patient transport services,
(e) emergency medical retrieval and transfer services,
(f) NHS 111 services,
(g) sexual assault referral centres, and
(h) other services as directed by the Welsh Ministers.

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

viii) In addition to directions the Welsh Ministers may from time to time issue guidance which LHBs must take into account when exercising any function. However in some cases the relevant function may be contained in other legislation. In exercising their powers LHBs must be clear about the statutory basis for exercising such powers.

ix) As a statutory body, the LHB has specified powers to contract in its own name and to act as a corporate trustee. The LHB also has statutory powers under sections 194 and 195 of the NHS (Wales) Act 2006 to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

x) The **National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993)** have effect as made under section 33 of the NHS (Wales) Act 2006 enable LHBs, NHS Trusts and Local Authorities to enter into any partnership arrangements to exercise certain NHS functions and health-related functions as specified in the Regulations. The arrangement can only be made if it is likely to lead to an improvement in the way in which NHS functions and health-related functions are exercised, and the partners have consulted jointly with all affected parties, and the arrangements fulfil the objectives set out in the Area Plan developed in accordance with the **Social Services and Well-being (Wales) Act 2014 (2014).**

xi) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions. NHS bodies includes the NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trusts and, for the purpose of this duty, also

includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.

xii) Section 82 of the NHS Act 2006 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

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

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

xiv) **The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1) (**the 2020 Act) makes provision for:

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

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

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

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

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

xv) The **Well-being of Future Generations (Wales) Act 2015** also places duties on LHBs and some Trusts in Wales. Sustainable development in the context of the Act means the process of improving economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

xvi) The Welsh Language (Wales) Measure 2011 makes provision with regards to the development of standards of conduct relating to the Welsh language. These standards replace the requirement for a Welsh Language Scheme previously provided for by Section 5 of the Welsh Language Act 1993. The Welsh Language Standards (No.7) Regulations 2018 (2018/411) came into force on the 29 June 2018 and specifies standards in relation to the conduct of Local Health Boards. The Local Health Board will ensure that it has arrangements in place to meet those standards which the Welsh Language Commissioner has required by way of a compliance notice under section 44 of the 2011 Measure.

xvii) LHBs are also bound by any other statutes and legal provisions which govern the way they do business. The powers of LHBs established under statute shall be exercised by LHBs meeting in public session, except as otherwise provided by these SOs.

NHS Framework

xviii) In addition to the statutory requirements set out above, LHBs must carry out all business in a manner that enables them to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that are expected at all levels of the service, locally and nationally.

xix) Adoption of the principles will better equip LHBs to take a balanced, holistic view of their organisations and their capacity to deliver high quality, safe healthcare services for all its citizens within the NHS framework set nationally.

xx) The overarching NHS governance and accountability framework incorporates these SOs; the Schedules of Reservation and Delegation of Powers; SFIs together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework*; the Health and Care Quality Standards 2023, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

* The NHS Wales Values and Standards of Behaviour Framework can be

accessed via the following link: https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/living-public-service-values/values-and-standards-of-behaviour-framework/

xxi) The Welsh Ministers, reflecting their constitutional obligations and legal duties under the **Well-being of Future Generations (Wales) Act 2015,** have stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.

xxii) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/. Directions or guidance on specific aspects of LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Local Health Board Framework

xxiii) Schedule 2 provides details of the key documents that, together with these SOs, make up the LHB's governance and accountability framework. These documents must be read in conjunction with these SOs and will have the same effect as if the details within them were incorporated within the SOs themselves. The Standing Financial Instructions form Schedule 2.1 of these SOs.

xxiv) LHBs will from time to time agree and approve policy statements which apply to the LHB's Board members and/or all or specific groups of staff employed by Hywel Dda University LHB and others. The decisions to approve these policies will be recorded in an appropriate Board minute and, where appropriate, will also be considered to be an integral part of the LHB's SOs and SFIs. Details of the LHB's key policy statements are also included in Schedule 2.

xxv) LHBs shall ensure that an official is designated to undertake the role of the Director of Corporate Governance/Board Secretary (the role of which is set out in paragraph xxxiii below).

xxvi) For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance – SOs 1.1.2 refers.

Applying Standing Orders

xxvii) The SOs of the LHB (together with SFIs and the Values and Standards of

Behaviour Framework (Standards of Behaviour Policy), will, as far as they are applicable, also apply to meetings of any formal Committees established by the LHB, including any Advisory Groups, sub-Committees, joint-Committees and joint sub-Committees. These SOs may be amended or adapted for the Committees as appropriate, with the approval of the Board. *Further details on committees may be found in Schedule 3 of these SOs and further details on joint-Committees may be found in Schedule* 4.

xxviii) Full details of any non-compliance with these SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Director of Corporate Governance/Board Secretary, who will ask the Audit and Risk Assurance Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and LHB officers have a duty to report any non-compliance to the Director of Corporate Governance/Board Secretary as soon as they are aware of any circumstance that has not previously been reported.

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

Variation and amendment of Standing Orders

xxx) Although these SOs are subject to regular, annual review by the LHB, there may, exceptionally, be an occasion where it is necessary to vary or amend the SOs during the year. In these circumstances, the Director of Corporate Governance/Board Secretary shall advise the Board of the implications of any decision to vary or amend SOs, and such a decision may only be made if:

- The variation or amendment is in accordance with regulation 15 of the Constitution Regulations and does not contravene a statutory provision or direction made by the Welsh Ministers;
- The proposed variation or amendment has been considered and approved by the Audit and Risk Assurance Committee and is the subject of a formal report to the Board; and
- A notice of motion under Standing Order 7.5.14 has been given.

Interpretation

xxxi) During any Board meeting where there is doubt as to the applicability or interpretation of the SOs, the Chair of the LHB shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair shall take appropriate advice from the Director of Corporate Governance/Board Secretary and, where appropriate the Chief Executive or the Director of Finance (in the case of SFIs).

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

The role of the Director of Corporate Governance/Board Secretary

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

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

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

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

Section B – Standing Orders

1. THE LOCAL HEALTH BOARD

1.0.1 The LHB's principal role is to ensure the effective planning and delivery of the local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for its citizens, and in a manner that promotes human rights.

1.0.2 The LHB was established by the **Local Health Boards (Establishment and Dissolution) (Wales) Order 2009** (S.I. 2009/778) and most of its functions are contained in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009** (S.I. 2009/1511). The LHB must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.

1.0.3 To fulfil this role, the LHB will work with all its partners and stakeholders in the best interests of its population.

1.1 Membership of the Local Health Board

1.1.1 The membership of the LHB shall be no more than 24 members comprising the Chair, Vice Chair, non-officer members (appointed by the Minister for Health and Social Services), Associate Members, the Chief Executive (appointed by the Board with the involvement of the Chief Executive, NHS Wales) and officer members ~~(appointed by the Board)~~ (appointed by Non-Executive Members of the Board and the Chief Executive).

1.1.2 For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members (which will include the Chair) shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance. Officer and non-officer members shall have full voting rights. Associate Members do not have voting rights.

Officer Members [to be known as Executive Directors]

1.1.3 A total of 9 (including the Chief Executive), ~~appointed by the Board,~~ appointed in accordance with the Constitution, Membership and Procedures Regulations, whose responsibilities include the following areas: Medical; Finance; Nursing; Primary Care and Community and Mental Health Services; Strategic and Operational Planning; Workforce and Organisational Development; Public Health; Therapies and Health

Science. Executive Directors may have other responsibilities as determined by the Board and set out in the scheme of delegation to officers.

Non Officer Members [to be known as Independent Members]

1.1.4 A total of 9, appointed by the Minister for Health and Social Services, including: an elected member of a local authority whose area falls within the LHB area; a current member or employee of a Third Sector organisation within the LHB area; a nominated trade union official; a person who holds a post in a University that is related to health; and five other Independent Members who together have experience and expertise in legal; finance; estates; Information Technology; and community knowledge and understanding.

1.1.5 In addition to the eligibility, disqualification, suspension and removal provisions contained within the Constitution Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of more than one NHS body in Wales.

Associate Members

1.1.6 A total of 4 associate members may be appointed to the Board. They will attend Board meetings on ex-officio basis, but will not have any voting rights.

1.1.7 No more than three Associate Members may be appointed by the Minister for Health and Social Services. This may include:

- Director of Social Services (nominated by local authorities in the LHB area)
- Chair of the Stakeholder Reference Group
- Chair of the Healthcare Professionals' Forum

1.1.8 The Board may appoint an additional Associate Member to assist in carrying out its functions, subject to the agreement of the Minister for Health and Social Services.

Use of the term 'Independent Members'

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

- Chair
- Vice Chair
- Non Officer Members

unless otherwise stated.

1.2 Joint Directors

1.2.1 Where a post of Executive Director of the LHB is shared between more than one person because of their being appointed jointly to a post:

i) Either or both persons may attend and take part in Board meetings;
ii) If both are present at a meeting they shall cast one vote if they agree;
iii) In the case of disagreement no vote shall be cast; and
iv) The presence of both or one person will count as one person in relation to the quorum.

1.3 Tenure of Board members

1.3.1 Independent Members and Associate Members appointed by the Minister for Health and Social Services shall be appointed for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. These members can be reappointed but may not hold office as a member or associate member for the same Board for a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

1.3.2 Any Associate Member appointed by the Board will be for a period of up to one year. An Associate member may be re-appointed if necessary or expedient for the performance of the LHBs functions. If re-appointed they may not hold office as an Associate Member for the same Board for a total period of more than four years. Time served includes time as a Ministerial appointment (if relevant) which need not be consecutive and will still be counted towards the total period even where there is a break in the term. An Independent or Associate Member appointed by the Minister for Health and Social Services who has already served the maximum 8 years as a Ministerial appointment to the same Board will not be eligible for appointment by the Board as an Associate Member.

1.3.3 Executive Directors' tenure of office as Board members will be determined by their contract of appointment.

1.3.4 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are applicable, as specified in Schedule 2 of the Constitution Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Chair will advise the Minister in writing of any such cases immediately.

1.3.5 The LHB will require Board members to confirm in writing their continued eligibility on an annual basis.

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

Role

1.4.1 The principal role of the LHB is set out in SO 1.0.1. The Board's main role is to add value to the organisation through the exercise of strong leadership and control, including:

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

Responsibilities

1.4.2 The Board will function as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

1.4.3 Independent Members who are appointed to bring a particular perspective, skill or area of expertise to the Board must do so in a balanced manner, ensuring that any opinion expressed is objective and based upon the best interests of the health service. Similarly, Board members must not place an over reliance on those individual members with specialist expertise to cover specific aspects of Board business, and must be prepared to scrutinise and ask questions about any contribution that may be made by that member.

1.4.4 LHBs shall issue an indemnity to any Chair and Independent Member in the following terms: "A Board [or Committee] member, who has acted honestly and in good faith, will not have to meet out of their personal resources any personal liability which is incurred in the execution of their Board function. Such cover excludes the reckless or those who have acted in bad faith".

1.4.5 Associate Members, whilst not sharing corporate responsibility for the decisions of the Board, are nevertheless required to act in a corporate manner at all times, as are their fellow Board members who have voting rights.

1.4.6 All Board members must comply with their terms of appointment. They must equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes, engaging fully in Board activities and promoting the LHB within the communities it serves.

1.4.7 **The Chair** – The Chair is responsible for the effective operation of the Board, chairing Board meetings when present and ensuring that all Board business is conducted in accordance with these SOs. The Chair may have

certain specific powers delegated by the Board and set out in the Scheme of Delegation.

1.4.8 The Chair shall work in close harmony with the Chief Executive and, supported by the Director of Corporate Governance/Board Secretary, shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

1.4.9 **The Vice-Chair** – The Vice-Chair shall deputise for the Chair in their absence for any reason and will do so until either the existing chair resumes their duties or a new chair is appointed.

1.4.10 In addition to their corporate role across the breadth of the Board's responsibilities, the Vice-Chair has a specific brief to oversee the LHB's performance in the planning, delivery and evaluation of primary care, community health and mental health services ensuring a balanced care model to meet the needs of the population within the LHB's area.

1.4.11 **Chief Executive** – The Chief Executive is responsible for the overall performance of the executive functions of the LHB. They are the appointed Accountable Officer for the LHB and shall be responsible for meeting all the responsibilities of that role, as set out in their Accountable Officer Memorandum.

1.4.12 **Lead roles for Board members** – The Chair will ensure that individual Board members are designated as lead roles or "champions" as required by the Welsh Ministers or as set out in any statutory or other guidance. Any such role must be clearly defined and must operate in accordance with the requirements set by the LHB, the Welsh Ministers or others. In particular, no operational responsibilities will be placed upon any Independent Member fulfilling such a role. The identification of a Board member in this way shall not make them more vulnerable to individual criticism, nor does it remove the corporate responsibility of the other Board members for that particular aspect of Board business.

2. RESERVATION AND DELEGATION OF LHB FUNCTIONS

2.0.1 Subject to any directions that may be given by the Welsh Ministers, the Board shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the LHB may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Board must set out clearly the terms and conditions upon which any delegation is being made.

2.0.2 The Board's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

i) Schedule of matters reserved to the Board;
ii) Scheme of delegation to committees and others; and
iii) Scheme of delegation to officers.

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

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

2.1 Chair's action on urgent matters

2.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Director of Corporate Governance/Board Secretary as appropriate, may deal with the matter on behalf of the Board - after first consulting with at least two other Independent Members. The Director of Corporate Governance/Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

2.1.2 Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

2.2 Delegation of Board functions

2.2.1 The Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board' within the Model Standing Orders (see paragraph 2.0.2.(i)) to Committees and others, setting any conditions and restrictions it considers necessary and following any directions or regulations given by the Welsh Ministers. These functions may be carried out:

i) By a Committee, sub-Committee or officer of the LHB (or of another LHB or Trust); or
ii) By another LHB; NHS Trust; Strategic Health Authority or Primary Care Trust in England; Special Health Authority; or
iii) Jointly with one or more bodies including local authorities through a joint-Committee, sub-Committee or joint sub-Committee.

2.2.2 The Board may agree and formally approve the delegation of specific executive powers to be exercised by Committees, sub-Committees, joint-Committees or joint sub-Committees which it has formally constituted.

2.3 Delegation to officers

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

2.3.2 This must be considered and approved by the Board (subject to any amendment agreed during the discussion). The Chief Executive may periodically propose amendments to the Scheme of Delegation to Officers and any such amendments must also be considered and approved by the Board.

2.3.3 Individual Executive Directors are in turn responsible for delegation within their own directorates/departments/localities in accordance with the framework established by the Chief Executive and agreed by the Board.

3. COMMITTEES

3.1 LHB Committees

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

Use of the term 'Committee'

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

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

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

3.2 Joint Committees

3.2.1 The Board may, and where directed by the Welsh Ministers must, together with one or more LHBs or NHS Trusts or the local authorities operating

within the LHB's area, appoint joint-Committees or joint sub-Committees. These may consist wholly or partly of the LHB's Board members or Board members of other health service bodies or of persons who are not LHB Board members or Board members of other health service bodies. Any such appointments must be made in accordance with the Board's defined requirements on membership (including definition of member roles, powers and terms and conditions of appointment) and any directions given by the Welsh Ministers.

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

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

- The National Health Service Wales Joint Commissioning Committee (JCC)

Joint Committee Standing Orders, terms of reference and operating arrangements

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

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

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

3.3 Sub-Committees

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

3.4 Committees established by the LHB

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

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

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

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

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

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

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

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

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

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

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

3.5 Other Committees

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

3.6 Confidentiality

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

3.7 Reporting activity to the Board

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

4. NHS WALES SHARED SERVICES PARTNERSHIP

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

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

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

4.0.3 The Director of Shared Services will be designated as Accountable Officer for Shared Services.

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

4.0.5 The Shared Services Committee is to be known as the Shared Services Partnership Committee for operational purposes.

5. ADVISORY GROUPS

5.0.1 The LHB has a statutory duty to take account of representations made by persons and organisations who represent the interests of the communities it serves, its officers and healthcare professionals. To help discharge this duty, the Board may and where directed by the Welsh Ministers must, appoint Advisory Groups to the LHB to provide advice to the Board in the exercise of its functions.

5.0.2 The LHB's Advisory Groups include a Stakeholder Reference Group, Healthcare Professionals' Forum and Local Partnership Forum. *The membership and terms of reference for these groups are set out in Schedule 5.*

5.0.3 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board shall, wherever possible, require its Advisory Groups to hold meetings in public unless there are specific, valid reasons for not doing so.

5.1 Terms of reference and operating arrangements

5.1.1 The Board must formally approve terms of reference and operating arrangements for the Advisory Groups. These must establish the governance arrangements and ways of working, setting out, as a minimum:

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

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

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

5.2 Support to the Advisory Groups

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

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

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

5.3 Confidentiality

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

5.4 Advice and feedback

5.4.1 The LHB may specifically request advice and feedback from the Advisory Groups on any aspect of its business, and they may also offer advice and feedback even if not specifically requested by the LHB. The Groups may provide advice to the Board:

- At Board meetings, through the SRG and HPF Chair's participation as Associate Members;
- In written advice;
- In any other form specified by the Board.

5.5 Reporting activity

5.5.1 The Board shall ensure that the Chairs of all Advisory Groups report formally, regularly and on a timely basis to the Board on their activities. Advisory Group Chairs shall bring to the Board's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.5.2 Each Advisory Group shall also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

5.5.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

5.6 THE STAKEHOLDER REFERENCE GROUP (SRG)

Role

5.6.1 The SRG's role is to provide independent advice on any aspect of LHB business. This may include:

- Early engagement and involvement in the determination of the LHB's overall strategic direction;
- Provision of advice on specific service proposals prior to formal consultation; as well as
- Feedback on the impact of the LHB's operations on the communities it serves.

5.6.2 The SRG provides a forum to facilitate full engagement and active debate

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

5.6.3 The SRG's role is distinctive from that of Llais, who have a statutory role in representing the interests of patients and the public in their areas. The SRG shall represent those stakeholders who have an interest in, and whose own role and activities may be impacted by the decisions of the LHB. Membership may include community partners, provider organisations, special interest and other groups operating within the LHBs area.

5.6.4 It does not cover those stakeholders whose interests are represented within the remit of other Advisory Groups established by the LHB, e.g., the Healthcare Professionals' Forum and Local Partnership Forum.

5.6.5 In addition to the provisions above the Board must set out, the relationships and accountabilities with others, such as the Regional Partnership Board.

5.7 Relationship with the Board

5.7.1 The SRG's main link with the Board is through the SRG Chair's membership of the Board as an Associate Member.

5.7.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings. The SRG's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.

5.7.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the SRG.

5.7.4 The Board's Chair shall put in place arrangements to meet with the SRG Chair on a regular basis to discuss the SRG's activities and operation.

5.8 Relationship between the SRG and others

5.8.1 The Board must ensure that the SRG's advice represents a balanced, co-ordinated stakeholder perspective from across the local communities served by the LHB. The SRG shall:

- Ensure effective links and relationships with other advisory groups, local and community partnerships and other key stakeholders who do not form part of the SRG membership;
- Ensure its role, responsibilities and activities are known and understood by others; and
- Take care to avoid unnecessary duplication of activity with other bodies/groups with an interest in the planning and provision of NHS

services, e.g., Regional Partnership Boards.

5.9 Working with Llais

5.9.1 The SRG shall make arrangements to ensure designated Llais members receive the SRG's papers and are invited to attend SRG meetings.

5.9.2 The SRG shall work together with Llais within the area covered by the LHB to engage and involve those within the local communities served whose views may not otherwise be heard.

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

5.10 THE HEALTHCARE PROFESSIONALS' FORUM (HPF)

Role

5.10.1 The HPF's role is to provide a balanced, multi-disciplinary view of healthcare professional issues to advise the Board on local strategy and delivery. Its role does not include consideration of healthcare professional terms and conditions of service.

5.10.2 The HPF shall facilitate engagement and debate amongst the wide range of clinical interests within the LHB's area of activity, with the aim of reaching and presenting a cohesive and balanced healthcare professional perspective to inform the LHB's decision making.

5.11 Terms of reference and operating arrangements

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

5.12 Relationship with the Board

5.12.1 The HPF's main link with the Board is through the HPF Chair's membership of the Board as an Associate Member.

5.12.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings. The HPF's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.

5.12.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the HPF.

5.12.4 The Board's Chair shall put in place arrangements to meet with the HPF Chair on a regular basis to discuss the HPF's activities and operation.

5.13 Rights of Access to the LHB Board for Professional Groups

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

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

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

5.14 Relationship with the National Professional Advisory Group

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

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

5.15 THE LOCAL PARTNERSHIP FORUM (LPF)

Role

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

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

5.16 Relationship with the Board and others

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

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

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

5.16.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the LPF's staff representative members.

5.16.4 The Board's Chair shall put in place arrangements to meet with the LPG's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

5.16.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

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

6. WORKING IN PARTNERSHIP

6.0.1 The LHB shall work constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for its citizens. This will be delivered in in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers, e.g., the development of population assessments and area plans.

6.0.2 The Chair shall ensure that the Board has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the LHB through:

- The LHB's own structures and operating arrangements, e.g., Advisory Groups; and
- The involvement (at very local and community wide levels) in partnerships and community groups – such as Regional Partnership and Public Service Boards – of Board members and LHB officers with delegated authority to represent the LHB and, as appropriate, take decisions on its behalf.

6.0.3 The Social Services and Well-Being (Wales) Act 2014 sets out duties for working in partnership with local authorities complementing existing duties under section 82 of the NHS Act 2006 (duty to cooperate with local authorities) and sections 10 (arrangements with other bodies) and 38 (duty to make services available to enable the discharge of local authority functions) of the NHS (Wales) Act 2006. This includes "Partnership Arrangements" established under the direction of Regional Partnership Boards and under which the LHB may carry out any of the specified functions on behalf of the partnership body and may established pooled funds for specified purposes. An advice note on partnership working –

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

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

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

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

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

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

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

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

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

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

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

- The planning of the provision of its healthcare services;
- The development and consideration of proposals for service change and the way in which those services are provided;
- The Board's decisions affecting the operation of those healthcare services that it has responsibility for; and

- Engaging, formally consulting and working jointly within the LHB's area on any proposals for substantial development or change of the services it is responsible for, in line with the Guidance on Changes to Health Services in Wales 2023.

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

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

Relationship with the Board

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

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

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

7. MEETINGS

7.1 Putting Citizens first

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

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

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

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

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

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

7.2 Annual Plan of Board Business

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

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

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

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

Annual General Meeting (AGM)

7.2.5 The LHB must hold an AGM in public no later than the 31 July each year [Note: no later than 30 September 2023 for year 2023/2024]. At least 10 calendar days prior to the meeting a public notice of the intention to hold the meeting, the time and place of the meeting, and the agenda, shall be displayed bilingually (in English and Welsh) on the LHB's website.

The notice shall state that:

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

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

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

7.3 Calling Meetings

7.3.1 In addition to the planned meetings agreed by the Board, the Chair may call a meeting of the Board at any time. Individual Board members may also request that the Chair call a meeting provided that at least one third of the whole number of Board members, support such a request.

7.3.2 If the Chair does not call a meeting within seven days after receiving such a request from Board members, then those Board members may themselves call a meeting.

7.4 Preparing for Meetings

Setting the agenda

7.4.1 The Chair, in consultation with the Chief Executive and Director of Corporate Governance/Board Secretary, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Board business; any standing items agreed by the Board; any applicable items received from the Board's Committees and Advisory Groups; and the priorities facing the LHB. The Chair must ensure that all relevant matters are brought before the Board on a timely basis.

7.4.2 Any Board member may request that a matter is placed on the Agenda by writing to the Chair, copied to the Director of Corporate Governance/Board Secretary, at least 12 calendar days before the meeting. The request must set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of board business.

Notifying and equipping Board members

7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least ~~10 calendar days~~ 5 clear days before a formal Board

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

7.4.4 No papers will be included for consideration and decision by the Board unless the Chair is satisfied (subject to advice from the Director of Corporate Governance/Board Secretary, as appropriate) that the information contained within it is sufficient to enable the Board to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Board, and the outcome of that assessment shall accompany the report to the Board to enable the Board to make an informed decision.

7.4.5 In the event that at least half of the Board members do not receive the Agenda and papers for the meeting as set out above, the Chair must consider whether or not the Board would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

7.4.6 In the case of a meeting called by Board members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

7.4.7 Except for meetings called in accordance with Standing Order 6.3, at least 10 calendar days before each meeting of the Board a public notice of the time and place of the meeting, ~~and the public part of the agenda~~ shall be displayed bilingually (in English and Welsh):

- On the LHB's website, ~~together with the papers supporting the public part of the Agenda;~~ as well as
- Through other methods of communication as set out in the LHB's communication strategy.

7.4.8 When providing notification of the forthcoming meeting, the LHB shall set out when and how the agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc. The agenda and papers will be made available to the public at least 5 clear days before each meeting of the Board.

7.5 Conducting Board Meetings

Admission of the public, the press and other observers

7.5.1 The LHB shall encourage attendance at its formal Board meetings by the public and members of the press as well as LHB officers or representatives from organisations who have an interest in LHB business. The venue for such meetings shall be appropriate to facilitate easy access for attendees and translation services; and shall have appropriate facilities to maximise accessibility.

7.5.2 The Board and its committees shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance/Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Board shall resolve:

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

7.5.3 In these circumstances, when the Board is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Board in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Board meeting held in public session.

7.5.4 The Director of Corporate Governance/Board Secretary, on behalf of the Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

7.5.5 In encouraging entry to formal Board Meetings from members of the public and others, the Board shall make clear that attendees are welcomed as observers. The Chair shall take all necessary steps to ensure that the Board's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

7.5.6 Unless the Board has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Board, its Committees and Advisory Groups

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

Chairing Board Meetings

7.5.8 The Chair of the LHB will preside at any meeting of the Board unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and Vice-Chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.

7.5.9 The Chair must ensure that the meeting is handled in a manner that enables the Board to reach effective decisions on the matters before it. This includes ensuring that Board members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the Board must have access to appropriate advice on the conduct of the meeting through the attendance of the nominated Director of Corporate Governance/Board Secretary. The Chair has the final say on any matter relating to the conduct of Board business.

Quorum

7.5.10 At least six Board members, at least three of whom are Executive Directors and three are Independent Members, must be present to allow any formal business to take place at a Board meeting.

7.5.11 If the Chief Executive or an Executive Director is unable to attend a Board meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, Board members' voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Board member in their own right, e.g., a person deputising for the Chief Executive will usually be an Executive Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

7.5.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Board member

disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes.

Dealing with motions

7.5.13 In the normal course of Board business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Board member may put forward a motion proposing that a formal review of that service area is undertaken by a Committee of the Board. The Director of Corporate Governance/Board Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Board unless moved by a Board member and seconded by another Board member (including the Chair).

7.5.14 **Proposing a formal notice of motion –** Any Board member wishing to propose a motion must notify the Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Chair has determined that the proposed motion is relevant to the Board's business, the matter shall be included on the Agenda, or, where an emergency motion has been proposed, the Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

7.5.15 The Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Board business.

7.5.16 **Amendments -** Any Board member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Board alongside the motion.

7.5.17 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e., the substantive motion.

7.5.18 **Motions under discussion –** When a motion is under discussion, any Board member may propose that:

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned and the meeting proceed to

the next item of business;

- A Board member may not be heard further;
- The Board decides upon the motion before them;
- An ad hoc Committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

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

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

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

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

Voting

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

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

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

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

7.6 Record of Proceedings

7.6.1 A record of the proceedings of formal Board meetings (and any other meetings of the board where the Board members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Board member attendance (including the Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the Board, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

7.6.2 Agreed minutes shall be circulated in accordance with Board members' wishes, and, where providing a record of a formal Board meeting shall be made available to the public both on the LHB's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act 2018, the General Data Protection Regulation 2018, and the LHB's Communication Strategy and Welsh language requirements.

7.7 Confidentiality

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

8. VALUES AND STANDARDS OF BEHAVIOUR

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

8.1 Declaring and recording Board members' interests

8.1.1 ***Declaration of interests –*** It is a requirement that all Board members

must declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Board member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Board's business. Board members must be familiar with the Values and Standards of Behaviour Framework (Standards of Behaviour Policy), and their statutory duties under the Constitution Regulations. Board members must notify the Chair and Director of Corporate Governance/Board Secretary of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Board members.

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

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

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

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

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

8.2 Dealing with Members' interests during Board meetings

8.2.1 The Chair, advised by the Director of Corporate Governance/Board Secretary, must ensure that the Board's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Board members must demonstrate, through their actions, that their contribution to the Board's decision making is based upon the best interests of the LHB and the NHS in Wales.

8.2.2 Where individual Board members identify an interest in relation to any aspect of Board business set out in the Board's meeting agenda, that member must declare an interest at the start of the Board meeting. Board members should seek advice from the Chair, through the Director of Corporate Governance/Board Secretary before the start of the Board meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Board minutes.

8.2.3 It is the responsibility of the Chair, on behalf of the Board, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions made by the Welsh Ministers. The range of possible actions may include determination that:

i) The declaration is formally noted and recorded, but that the Board member should participate fully in the Board's discussion and decision, including voting. This may be appropriate, for example where the Board is considering matters of strategy relating to a particular aspect of healthcare and an Independent Member is a healthcare professional whose profession may be affected by that strategy determined by the Board;
ii) The declaration is formally noted and recorded, and the Board member participates fully in the Board's discussion, but takes no part in the Board's decision;
iii) The declaration is formally noted and recorded, and the Board member takes no part in the Board discussion or decision;
iv) The declaration is formally noted and recorded, and the Board member is excluded for that part of the meeting when the matter is being discussed. A Board member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Board.

8.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Board member is compatible with an identified conflict of interest.

8.2.5 Where the Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice Chair, on behalf of the Board.

8.2.6 In all cases the decision of the Chair (or the Vice Chair in the case of an

interest declared by the Chair) is binding on all Board members. The Chair should take advice from the Director of Corporate Governance/Board Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

8.2.7 ***Members with pecuniary (financial) interests –*** Where a Board member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the Board, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Board may determine that the Board member concerned shall be excluded from that part of the meeting.

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

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

8.3 Dealing with officers' interests

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

8.4 Reviewing how Interests are handled

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

8.5 Dealing with offers of gifts[2] , hospitality and sponsorship

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[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.
[2] The term gift refers also to any reward or benefit.

8.5.1 The Values and Standards of Behaviour Framework (Standards of Behaviour Policy) approved by the Board prohibits Board members and LHB officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

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

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

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the LHB;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the LHB; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it should always be declined.

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

8.6 Sponsorship

8.6.1 In addition gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

8.6.2 All sponsorship must be approved prior to acceptance in accordance with the **Values and Standards of Behaviour Framework** (Standards of Behaviour Policy) and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

8.7 Register of Gifts, Hospitality and Sponsorship

8.7.1 The Director of Corporate Governance/Board Secretary, on behalf of the Chair, will maintain a register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Board members. Executive Directors will adopt a similar mechanism in relation to LHB officers working within their Directorates.

8.7.2 Every Board member and LHB officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship, including those offers that have been refused. The Director of Corporate Governance/Board Secretary, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship are kept under active review, taking appropriate action where necessary.

8.7.3 When determining what should be included in the Register with regard to gifts and hospitality, individuals shall apply the following principles, subject to the considerations in Standing Order 8.5.3:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value, e.g., seasonal items such as diaries/calendars would not usually need to be recorded.
- **Hospitality:** Only significant hospitality offered or received should

be recorded. Occasional offers of 'modest and proportionate[3]' hospitality need not be included in the Register.

8.7.4 Board members and LHB officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- Acceptance would further the aims of the LHB ;
- The level of hospitality is reasonable in the circumstances;
- It has been openly offered; and,
- It could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

8.7.5 The Director of Corporate Governance/Board Secretary will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the LHB to be submitted to the Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the Board upon the adequacy of the LHB's arrangements for dealing with offers of gifts, hospitality and sponsorship.

9. SIGNING AND SEALING DOCUMENTS

9.0.1 The common seal of the LHB is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board.

9.0.2 Where it is decided that a document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised independent Member) and the Chief Executive (or another authorised individual) both of whom must witness the seal.

9.1. Register of Sealing

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

9.2 Signature of Documents

9.2.1 Where a signature is required for any document connected with legal

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

proceedings involving the LHB, it shall be signed by the Chief Executive, except where the Board has authorised another person or has been otherwise directed to allow or require another person to provide a signature.

9.2.2 The Chief Executive or nominated officers may be authorised by the Board to sign on behalf of the LHB any agreement or other document (not required to be executed as a deed) where the subject matter has been approved either by the Board or a Committee to which the Board has delegated appropriate authority.

9.3 Custody of Seal

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

10. GAINING ASSURANCE ON THE CONDUCT OF LHB BUSINESS

10.0.1 The Board shall set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of LHB business, its governance and the effective management of the organisation's risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

10.0.2 The Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit Committee (or equivalent).

10.0.3 Assurances in respect of the services provided by the NHS Wales Shared Services Partnership shall primarily be achieved by the reports of the Director of Shared Services to the Shared Services Partnership Committee, and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the Director of Shared Services. The Director of Shared Services and the Shared Services Partnership Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the LHB.

10.0.4 Assurances in respect of the functions discharged by the National Health Services Wales Joint Commissioning Committee (the JCC) shall be achieved by the reports of the JCC Chair, and reported back by the Chief Executive. Reference should be made to paragraph 3.2 above regarding the governance arrangements which should be agreed for the Joint Committees.

10.0.5 Arrangements for seeking and providing assurance in respect of any other services provided on behalf of or in association with the LHB shall be clearly identified and reflected within the practice of the organisation and within the relevant agreements.

10.1 The role of Internal Audit in providing independent internal assurance

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

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

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

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

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

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

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

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

10.3 External Assurance

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

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

10.3.3 The Board shall keep under review and ensure that, where appropriate, the LHB implements any recommendations relevant to its business made by the Welsh Government's Audit Committee, the Senedd Cymru/Welsh Parliament's Public Accounts Committee and other appropriate bodies.

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

11. DEMONSTRATING ACCOUNTABILITY

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

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

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

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

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

12. REVIEW OF STANDING ORDERS

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

12.0.2 These SOs shall be reviewed annually by the Audit and Risk Assurance

Committee, which shall report any proposed amendments to the Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SOs, including the appropriate impact assessments.

Schedule 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

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

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

Introduction

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

i) A Committee, e.g., Quality and Safety Committee;

ii) A sub-Committee, e.g., a locality based Quality and Safety Committee taking forward matters within a defined area. Any such delegation would, subject to the Board's authority, usually be via a main Committee of the Board;

iii) A joint-Committee or joint sub-Committee, e.g., with other LHBs established to take forward matters relating to specialist services; and

iv) Officers of the LHB (who may, subject to the Board's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

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

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

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

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

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

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

- ***Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in SOs or SFIs***

- ***The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management***

- ***Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility***

- ***The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development***

- ***The Board must take appropriate action to assure itself that all matters delegated are effectively carried out***

- ***The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes***

- ***Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others***

- ***The Board may delegate authority to act, but retains overall responsibility and accountability***

- ***When delegating powers, the Board will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.***

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

The Board

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

The Chief Executive

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

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

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

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

The Director of Corporate Governance/Board Secretary

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

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

The Audit and Risk Assurance[4] Committee

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

Individuals to who powers have been delegated

Individuals will be personally responsible for:

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

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

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

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

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

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

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

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

accessed via the following hyperlink to LHB's website:

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

SCHEDULE OF MATTERS RESERVED TO THE BOARD[5]

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

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

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

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

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

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

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

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

DELEGATION OF POWERS TO COMMITTEES AND OTHERS[6]

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

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

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

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

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

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

[6] As defined in Standing Orders

SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OFFICERS

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

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

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

Schedule 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

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

LHB framework

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

- ***SFIs*** *(see Schedule 2.1 below) – available via the following hyperlink to the LHB's website):*
  Standing Orders and Standing Financial Instructions - Hywel Dda University Health Board (nhs.wales)

- ***Values and Standards of Behaviour Framework***
  Our values – Hywel Dda University Health Board (nhs.wales)

- ***Standards of Behaviour Policy*** – available via the following hyperlink to the LHB's website:
  hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/policies/standards-of-behaviour-policy/

- ***Risk and Assurance Framework***
  hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/policies/risk-management-framework/

- ***Key policy documents –*** available via the following hyperlink to the LHB's website:
  Policies and written control documents - Hywel Dda University Health Board (nhs.wales)

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

These documents may be accessed by contacting the Corporate Goverance Team, corporate Offices, Ystwyth Building, St David's Park, Carmarthen, SA31 3BB.

NHS Wales framework

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

Schedule 2.1

MODEL STANDING FINANCIAL INSTRUCTIONS FOR LOCAL HEALTH BOARDS

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

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

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

Schedule 3

BOARD COMMITTEE ARRANGEMENTS

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

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

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

Board committees - Hywel Dda University Health Board (nhs.wales)

Schedule 4

JOINT COMMITTEE ARRANGEMENTS

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

Available via the following hyperlinks:

- Schedule 4.1 – National Health Service Wales Joint Commissioning Committee

  Standing Orders - NHS Wales Joint Commissioning Committee

  Standing Financial Instructions - NHS Wales Joint Commissioning Committee

Schedule 5

ADVISORY GROUPS

Terms of Reference and Operating Arrangements

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

Schedule 5.1 – Stakeholder Reference Group
Schedule 5.2 – Health Professionals Forum
Schedule 5.3 – Local Partnership Forum

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

Advisory groups - Hywel Dda University Health Board (nhs.wales)

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM FOR CHIEF EXECUTIVES OF LOCAL HEALTH BOARDS						
SOURCE	**REF**	**SECTION HEADER**	**SUB HEADER**		**DELEGATED TO**	**OPERATIONAL RESPONSIBILITY**
ACCOUNTABLE OFFICER MEMORANDUM	Section 3a	Section 3	N/A	Responsibility for:- a) The overall organisation, management and staffing of the LHB and its arrangements related to quality and safety of care as well as matters of finance, together with any other aspect relevant to the conduct of the LHB's business in pursuance of the strategic direction set by the LHB's Board, and in accordance with its statutory responsibilities; i) ensuring that all items of expenditure, including payments to staff, fall within the legal powers of the Board; ii) acting within the scheme of delegations and ensuring that you comply with guidance on classes of payment that you should authorise personally.	Chief Executive	N/A
ACCOUNTABLE OFFICER MEMORANDUM	Section 3b	Section 3b	N/A	b) Ensuring that in delegating functions to officers you are satisfied of their ongoing capacity and capability to deliver on those functions, facilitating access to the information they need, ongoing training and development, as well as professional or specialist advice where appropriate.	Chief Executive	N/A
ACCOUNTABLE OFFICER MEMORANDUM	Section 3c	Section 3c	N/A	c) Prudent and economical administration, for the avoidance of waste and extravagance, and for the efficient and effective use of all resources	Chief Executive	N/A
ACCOUNTABLE OFFICER MEMORANDUM	Section 3d	Section 3	N/A	d) Ensuring that the assets for which you are responsible are properly safeguarded, particularly: i) information, including systems for maintaining the trust of patients and the public by ensuring that the LHB will store, share and use information, including their personal information safely, and securely; and ii) land, buildings or other property (including stores and equipment)	Chief Executive	N/A
ACCOUNTABLE OFFICER MEMORANDUM	Section 3e	Section 3	N/A	e) Ensuring that, in the consideration of policy proposals relating to the expenditure or income for which you have responsibility, all relevant financial considerations (including any issues of propriety, regularity or value for money) are taken into account	Chief Executive	N/A
ACCOUNTABLE OFFICER MEMORANDUM	Section 3f	Section 3	N/A	f) Ensuring that risks to the achievement of the LHB's objectives and fulfilment of its statutory responsibilities are identified, that their significance is assessed, and that a sound system of internal control is in place to manage them; i) implementing an appropriate framework of assurance covering all aspects of LHB business, ensuring that research and evaluation work is planned so that strategic objectives and spending programmes for which you have responsibility are routinely evaluated to assess their effectiveness and value for money; ii) ensuring, as a key source of your internal assurance, that you establish arrangements for internal audit in accordance with the International Standards for the professional practice of Internal Audit as adopted by the NHS in Wales, Welsh Government and HM Treasury, and ensuring that appropriate action is taken in response to reports produced by Internal Audit.	Chief Executive	N/A
ACCOUNTABLE OFFICER MEMORANDUM	Section 3g	Section 3	N/A	g) Ensuring that there are appropriate arrangements to counter fraud and that procedures for dealing with suspected cases of fraud are complied with	Chief Executive	N/A
ACCOUNTABLE OFFICER MEMORANDUM	Section 3h	Section 3	N/A	h) Ensuring that the LHB co-operates fully with external auditors, regulators and inspectors - including the Wales Audit Office (WAO), Healthcare Inspectorate Wales (HIW), and the Care and Social Services Inspectorate Wales (CSSIW), and ensuring that appropriate action is taken in response to any reports produced by such bodies	Chief Executive	N/A
ACCOUNTABLE OFFICER MEMORANDUM	Section 3i	Section 3	N/A	i) Signing the LHB's accounts and, in doing so, accepting personal responsibility for their proper presentation fully supported by sound financial procedures and records, and in accordance with the LHB Accounts Directions issued by Welsh Ministers, ensuring that losses or special payments are properly identified and handled in accordance with defined requirements	Chief Executive	N/A

ACCOUNTABLE OFFICER MEMORANDUM	Section 4	Section 4	N/A	In regard to the planning, designing, developing and securing the delivery of safe, high quality primary, community, in hospital care services and, specialised and tertiary services for the citizens within the geographical areas covered by the LHB:- i) Ensure the LHB carries out these responsibilities in a way that fulfils its duty to ensure the quality and safety of healthcare and the proper stewardship of public money. ii) Take account of your corporate responsibilities and accountability to the LHB Board of which you are a member.	Chief Executive	N/A
ACCOUNTABLE OFFICER MEMORANDUM	Section 5	Section 5	N/A	Ensure compliance with the principles set out within Managing Welsh Public Money and the framework and standards of good governance set for the NHS in Wales (as embodied within the Welsh Government's Citizen Centred Governance Principles and reflected within the contents of the NHS Wales Governance e-manual) i) Assist the Chair in ensuring that his/her establishment and implementation of the LHB's governance framework accords with these standards and principles.	Chief Executive	N/A
ACCOUNTABLE OFFICER MEMORANDUM	Section 6	Section 6	N/A	Work in partnership with other organisations to achieve its strategic aims and objectives. i) Ensure that the wider impact of the activities for which you are responsible are properly identified and, where appropriate, taken into account in determining the governance and accountability arrangements overseeing such work ii) Ensure that the governance arrangements are formally recorded and that you put in place appropriate arrangements to provide you with assurance on those areas for which you are accountable.	Chief Executive	N/A
ACCOUNTABLE OFFICER MEMORANDUM	Section 7	Section 7	N/A	Take joint responsibility for the delivery of a service through joint arrangements that involve the pooling of budgets. Such arrangements may be handled under a specific statutory authority, e.g., Section 33 of the National Health Service (Wales) Act 2006. - Where you and another Accountable Officer or Officers take joint responsibility, ensure that that there is absolute clarity on all aspects of the service for which you are responsible and accountable. Specifically, you must set down, in a formal agreement, the governance and financial accounting arrangements, including audit and assurance requirements, in accordance with any requirements determined by the Welsh Government.	Chief Executive	N/A
ACCOUNTABLE OFFICER MEMORANDUM	Section 8	Section 8	N/A	Ensure that where your LHB contracts with a third party for the provision of goods or services it does so in accordance with all relevant legislation together with any requirements determined by the Welsh Government. i) Ensure that appropriate systems are in place to provide assurance that such funds are allocated in accordance with the terms of the contract and are not misappropriated.	Chief Executive	N/A
ACCOUNTABLE OFFICER MEMORANDUM	Section 9	Section 9	N/A	Responsibility to see that appropriate advice is tendered to the Board on all matters of financial propriety, regularity and value for money, and more broadly on all considerations of prudent and economic administration, efficiency and effectiveness	Chief Executive	N/A
ACCOUNTABLE OFFICER MEMORANDUM	Section 10	Section 10	N/A	If the Board or the Chair is contemplating a course of action which you consider would infringe the requirements of propriety, regularity or value for money, set out in writing to the Chair and the Board your objection to the proposal, the reason for your objection and your duty to inform NHS Wales Chief Executive and the external auditors if your advice is overruled. Wherever possible, the NHS Wales Chief Executive should be informed before the Board takes its decision. If it is not possible, due to the urgency of the situation, to notify the NHS Wales Chief Executive beforehand, and if the Board decides nonetheless to proceed against advice, a written instruction to take the action in question must be sought. The request for the instruction and the instruction itself should be communicated to the NHS Wales Chief Executive and to the external auditors without undue delay, and before the decision is implemented, so that any necessary intervene with the Board can be taken and Welsh Ministers informed.	Chief Executive	N/A
ACCOUNTABLE OFFICER MEMORANDUM	Section 11	Section 11	N/A	The Chief Executive should be generally available for consultation and that in any temporary period of unavailability, e.g., due to illness, or during normal periods of annual leave, responsibility should be delegated to a senior officer of the LHB	Deputy Chief Executive	N/A

ACCOUNTABLE OFFICER MEMORANDUM	Section 12	Section 12	N/A	Should it becomes clear that the Chief Executive is so incapacitated that they are unable to discharge these responsibilities over a period of four weeks or more, the NHS Wales Chief Executive should be notified so that an Acting Accountable Officer can be designated pending the Chief Executive's return. The same applies if, exceptionally, an absence of more than four weeks is planned during which the Chief Executive cannot be contacted.	Deputy Chief Executive	N/A
ACCOUNTABLE OFFICER MEMORANDUM	Section 14	Section 14	N/A	Responsibility for the Budgets assigned and to be held to account for the exercise of the responsibilities as Accountable Officer directly	Chief Executive	N/A
ACCOUNTABLE OFFICER MEMORANDUM	Section 16	Section 16	N/A	May be required to attend Public Accounts Committee with NHS Wales Chief Executive about matters relevant to the proper stewardship of funds within the NHS in Wales. i) May be required to appear before the Public Accounts Committee separately depending on the matter under consideration.	Chief Executive	N/A
STANDING ORDERS	xxvii & xxviii	GENERAL	Applying Standing Orders	Non Compliance and Variation of Standing Order	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary
STANDING ORDERS	xxxi	GENERAL	Applying Standing Orders	Final interpretation of Standing Orders	Chair	Director of Corporate Governance/Board Secretary and where appropriate the Director of Finance (for SFIs)
STANDING ORDERS	xxxiii	GENERAL	The role of the Board Secretary	Responsibility for providing advice to the Board on all aspects of governance/committee services	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary
STANDING ORDERS	2.1	RESERVATION AND DELEGATION OF LHB FUNCTIONS	Chair's Action on Urgent Matters	Use of Chair's Action and onward reporting to Board	Chair	Director of Corporate Governance/Board Secretary
STANDING ORDERS	2.3.1	RESERVATION AND DELEGATION OF LHB FUNCTIONS	Delegation To Officers	Compilation of Scheme of Delegation for functions delegated to Chief Executive for consideration and approval by the Board	Chief Executive	Director of Corporate Governance/Board Secretary
STANDING ORDERS	2.3.1	RESERVATION AND DELEGATION OF LHB FUNCTIONS	Delegation To Officers	Delegation of functions within Directorates/departments/localities in line with the framework established by the Chief Executive and agreed by the Board	Executive Directors/Directors	Executive Directors/Directors
STANDING ORDERS	6	WORKING IN PARTNERSHIP	Working In Partnership	Identification and engagement with all key partners and regular review of effectiveness	Chair	Director of Public Health and Director of Primary Care, Community Strategy and Long Term Care ~~and Director of Strategy and Planning~~
STANDING ORDERS	7.2	MEETINGS	Annual Plan of Board Business	Development of the Annual Plan of Board Business	Chair	Director of Corporate Governance/Board Secretary
STANDING ORDERS	7.3	MEETINGS	Calling Meetings	Call meetings of the Board	Chair	Director of Corporate Governance/Board Secretary
STANDING ORDERS	7.4	MEETINGS	Preparing for Meetings	Preparation of Board meetings	Chair	Director of Corporate Governance/Board Secretary
STANDING ORDERS	7.5	MEETINGS	Conducting Board Meetings	Report decisions made & review HB business conducted in private session	Chair	Director of Corporate Governance/Board Secretary
STANDING ORDERS	7.5	MEETINGS	Conducting Board Meetings	Chair all HB Meetings & associated responsibilities	Chair (or Vice Chair in Chair's Absence)	Chair (or Vice Chair in Chair's Absence)
STANDING ORDERS	7.6	MEETINGS	Record of Proceedings	A record of proceedings of Board Meetings	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary

STANDING ORDERS	8.1	VALUES AND STANDARDS OF BEHAVIOUR	Declaring and recording Board members' interests	Establishment, maintenance and annual review of a Register of Interests declared by all Board Members	Chief Executive	Director of Corporate Governance/Board Secretary
STANDING ORDERS	8.3	VALUES AND STANDARDS OF BEHAVIOUR	Dealing with officers' interests	Establishment, maintenance and annual review of a Register of Interests for relevant LHB Officers	Chief Executive	Director of Corporate Governance/Board Secretary
STANDING ORDERS	8.7	VALUES AND STANDARDS OF BEHAVIOUR	Register of Gifts, Hospitality and Sponsorship	Establishment, maintenance and annual review of a Register of Gifts, Hospitality, Sponsorship and Honoraria for Board Members and LHB Officers	Chair and Chief Executive	Director of Corporate Governance/Board Secretary
STANDING ORDERS	9.1	SIGNING AND SEALING DOCUMENTS	Register of Sealing	Establishment, maintenance and bi-annual reporting of a Register of Sealings	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary
STANDING ORDERS	9.2	SIGNING AND SEALING DOCUMENTS	Signature of Documents	Signing and sealing of legal documents such as transfers of land, lease agreements and other important/key contracts on behalf of the Board	Chief Executive	Director of Corporate Governance/Board Secretary
STANDING ORDERS	9.2.1	SIGNING AND SEALING DOCUMENTS	Signature of Documents	Signing any agreement or other document (not required to be executed as a deed) on behalf of the Board where the subject matter has been approved either by the Board or a Committee to which the Board, as per the authority delegated within the Financial Scheme of Delegation	Chief Executive	Nominated Officers (as per financial scheme of delegation)
STANDING ORDERS	9.3	SIGNING AND SEALING DOCUMENTS	Custody of Seal	Safe custody of Seal in a secure place	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary
STANDING FINANCIAL INSTRUCTIONS (SFI)	1.1.3	INTRODUCTION	General	Approval of all financial procedures	Director of Finance, through Sustainable Resources Committee	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	1.1.4	INTRODUCTION	General	Provision of advice in regard to the interpretation/applications of SFIs	Director of Finance	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	1.2.1	INTRODUCTION	General	Report non-compliance with SFIs for consideration by Audit Committee (to formally consider the matter and make proposals to the Board on any action taken)	Director of Finance	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	1.3	INTRODUCTION	General	Ensure the LHB meets its statutory obligation to perform its functions within the available financial resources	Chief Executive	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	2.2.1	RESPONSIBILITIES AND DELEGATION	The Board	Accountability for overall Financial Control	Chief Executive and Director of Finance	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	2.2.2	RESPONSIBILITIES AND DELEGATION	The Board	Overall responsibility for ensuring that financial obligations and targets are met and overall responsibility for the system of internal control	Chief Executive	Chief Executive
STANDING FINANCIAL INSTRUCTIONS (SFI)	2.2.3	RESPONSIBILITIES AND DELEGATION	The Board	To ensure that Board Members and LHB Officers, and new appointees are notified of and understand their responsibilities within the SFIs	Chief Executive	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	2.3.1	RESPONSIBILITIES AND DELEGATION	The Board	a) Implementing Financial Policies and coordinating any corrective action necessary to further these policies	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	2.3.1	RESPONSIBILITIES AND DELEGATION	The Board	b) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems are incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	2.3.1	RESPONSIBILITIES AND DELEGATION	The Board	c) Ensuring that sufficient records are maintained to show and explain the LHB's transactions in order to disclose, with reasonable accuracy, the financial position of the LHB at any time	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	2.3.1	RESPONSIBILITIES AND DELEGATION	The Board	d) The provision of financial advise to other Board members and LHB officers, and LHB committees and Advisory Groups	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	2.3.1	RESPONSIBILITIES AND DELEGATION	The Board	e) the design, implementation and supervision of systems of internal financial control and,	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	2.3.1	RESPONSIBILITIES AND DELEGATION	The Board	f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the LHB may require for the purpose of carrying out its statutory duties	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	2.3.2	RESPONSIBILITIES AND DELEGATION	The Board	Ensuring an ongoing training and communication programme is in place to affect these SFIs	Director of Finance	Deputy Director of Finance

STANDING FINANCIAL INSTRUCTIONS (SFI)	2.4.1	RESPONSIBILITIES AND DELEGATION	The Board	Responsible for security of LHB's property, avoiding loss, exercising economy, efficiency, and sustainability in the use of resources & conforming with Sos, SFIs, financial procedures and Scheme of Delegation	All Board Members, LHB Officers, LHB Committees and Advisory Groups	All Board Members, LHB Officers, LHB Committees and Advisory Groups
STANDING FINANCIAL INSTRUCTIONS (SFI)	2.5.1	RESPONSIBILITIES AND DELEGATION	The Board	Ensure any contractor or employee of a contractor who is empowered by the LHB to commit the LHB to expenditure or who is authorised to obtain income are made aware of these SFIs and their requirement to comply	Chief Executive	All Executive Directors/Directors
STANDING FINANCIAL INSTRUCTIONS (SFI)	3.1.1	AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT	Audit Committee	Establishment of an Audit Committee with clearly defined terms of reference. Detailed terms of reference and operating arrangements for the Audit Committee are set out in Schedule 3 to the SOs. This committee will follow the guidance set out in the NHS Wales Audit Committee Handbook.	Chief Executive	Director of Corporate Governance/Board Secretary
STANDING FINANCIAL INSTRUCTIONS (SFI)	3.2.1a	AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT	Chief Executive	a) Ensuring arrangements are in place to review, evaluate and report on the effectiveness of internal financial control including establishment of an IA function	Chief Executive	Director of Finance and Director of Corporate Governance/Board Secretary
STANDING FINANCIAL INSTRUCTIONS (SFI)	3.2.1b	AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT	Chief Executive	b) Ensuring that the Internal Audit function meets the Public Sector Internal Audit Standards and provides sufficient independent and objective assurance to the Audit Committee and the Accountable Officer	Chief Executive	Director of Corporate Governance/Board Secretary
STANDING FINANCIAL INSTRUCTIONS (SFI)	3.2.1c	AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT	Chief Executive	c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;	Chief Executive	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	3.2.1d	AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT	Chief Executive	d) Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover: • a clear opinion on the effectiveness of internal control in accordance with the requirements of the Public Sector Internal Audit Standards major internal financial control weaknesses discovered, • progress on the implementation of Internal Audit recommendations, • progress against plan over the previous year, • a strategic audit plan covering the coming three years, and • a detailed plan for the coming year	Chief Executive	Head of Internal Audit/Director of Corporate Governance/Board Secretary
STANDING FINANCIAL INSTRUCTIONS (SFI)	3.3.1	AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT	Internal Audit	Ensure there is an internal audit function that operates in accordance with the standards and framework set for the provision of Internal Audit in the NHS in Wales.	Chief Executive	Director of Corporate Governance/Board Secretary
STANDING FINANCIAL INSTRUCTIONS (SFI)	3.4.1	AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT	External Audit	Ensure that there is a cost effective external audit service	Audit and Risk Assurance Committee	Director of Finance and Director of Corporate Governance/Board Secretary
STANDING FINANCIAL INSTRUCTIONS (SFI)	3.4. 2	AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT	External Audit	Invite External Audit representative to attend every Audit Committee	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary
STANDING FINANCIAL INSTRUCTIONS (SFI)	3.4.4	AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT	External Audit	Formally consider and review the External Audit Strategy	Audit and Risk Assurance Committee	Director of Finance and Director of Corporate Governance/Board Secretary
STANDING FINANCIAL INSTRUCTIONS (SFI)	3.4.5	AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT	External Audit	Review the External Audit Annual Plan and the associated fees, and consider any material changes to the annual audit plan	Audit and Risk Assurance Committee	Director of Finance and Director of Corporate Governance/Board Secretary
STANDING FINANCIAL INSTRUCTIONS (SFI)	3.5.1	AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT	Fraud and Corruption	Monitor & ensure compliance with Directions issued by Welsh Ministers on fraud and corruption	Chief Executive and Director of Finance	Local Counter Fraud Specialist

STANDING FINANCIAL INSTRUCTIONS (SFI)	3.5.2	AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT	Fraud and Corruption	Nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the NHS Counter Fraud and Corruption Manual and guidance	Chief Executive	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	3.5.4	AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT	Fraud and Corruption	Provide a written report to the Director of Finance and Audit Committee, at least annually, on counter fraud work within the LHB	Director of Finance	Local Counter Fraud Specialist
STANDING FINANCIAL INSTRUCTIONS (SFI)	3.5.5	AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT	Fraud and Corruption	Participate in the annual National Fraud Initiative. It must provide the necessary data for the mandatory element of the initiative by the due dates.	Director of Finance	Local Counter Fraud Specialist
STANDING FINANCIAL INSTRUCTIONS (SFI)	3.5.5	AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT	Fraud and Corruption	The Audit Committee should consider the LHB's participation in additional dataset matching in order to support the detection of fraud across the whole public sector	Director of Finance	Local Counter Fraud Specialist
STANDING FINANCIAL INSTRUCTIONS (SFI)	3.6.1	AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT	Security Management	Monitor and ensure compliance with Directions issued by the Welsh Ministers on NHS security management	Chief Executive	Director of Allied Health Professions and Health Science
STANDING FINANCIAL INSTRUCTIONS (SFI)	3.6.2	AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT	Security Management	Overall responsibility for controlling and coordinating security	Chief Executive	Director of Allied Health Professions and Health Science, and Chief Operating Officer
STANDING FINANCIAL INSTRUCTIONS (SFI)	4.2.4a	FINANCIAL DUTIES	First Financial Duty – The Breakeven Duty	a) Prior to the start of each financial year submit to the Board for approval a report showing the total allocations received, assumed in-year adjustments and their proposed distribution including any sums to be held in reserve;	Director of Finance	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	4.2.4b	FINANCIAL DUTIES	First Financial Duty – The Breakeven Duty	b) Ensure that any ring-fenced or non-discretionary allocations are disbursed in accordance with Welsh Ministers' requirements;	Director of Finance	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	4.2.4c	FINANCIAL DUTIES	First Financial Duty – The Breakeven Duty	c) Periodically review any assumed in-year allocations to ensure that these are reasonable and realistic;	Director of Finance	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	4.2.4d	FINANCIAL DUTIES	First Financial Duty – The Breakeven Duty	d) Regularly update the Board on significant changes to the initial allocation and the application of such funds	Director of Finance	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	4.2.5	FINANCIAL DUTIES	First Financial Duty – The Breakeven Duty	Ensure the LHB meets its First Financial Duty	Chief Executive	Chief Executive
STANDING FINANCIAL INSTRUCTIONS (SFI)	4.3.7-& 4.3.9	FINANCIAL DUTIES	Second Financial Duty – The Planning Duty	To develop and submit to the Board, on an annual basis, the rolling 3 year Integrated Medium Term Plan (IMTP). The Board approved Integrated Medium Term Plan will be submitted to Welsh Government, for approval by the Minister, in line with the requirements set out in the NHS Planning Framework	Chief Executive	Director of Strategy and Planning
STANDING FINANCIAL INSTRUCTIONS (SFI)	5.1.1	FINANCIAL MANAGEMENT AND BUDGETARY CONTROL	Budget Setting	Prepare and submit budgets for approval and delegation by the Board	Chief Executive	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	5.2.1	FINANCIAL MANAGEMENT AND BUDGETARY CONTROL	Budgetary Delegation	Delegate, via the Director of Finance, the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Regulations made in accordance with section 33 of the National Health Service (Wales) Act 2006 (c. 42). This delegation must be in writing, in the form of a letter of accountability, and be accompanied by a clear definition.	Chief Executive	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	5.2.2	FINANCIAL MANAGEMENT AND BUDGETARY CONTROL	Budgetary Delegation	The budgetary total of virement limit set by the Board must not be exceeded.	Chief Executive, Director of Finance, Budget Holders	Chief Executive, Director of Finance, Budget Holders

STANDING FINANCIAL INSTRUCTIONS (SFI)	5.2.3	FINANCIAL MANAGEMENT AND BUDGETARY CONTROL	Budgetary Delegation	Ensure budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement	Director of Finance	All budget holders
STANDING FINANCIAL INSTRUCTIONS (SFI)	5.2.4	FINANCIAL MANAGEMENT AND BUDGETARY CONTROL	Budgetary Delegation	Ensure non-recurring budgets are not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance	All budget holders	All budget holders
STANDING FINANCIAL INSTRUCTIONS (SFI)	5.2.5	FINANCIAL MANAGEMENT AND BUDGETARY CONTROL	Budgetary Delegation	Provide information as required by the Director of Finance to enable budgets to be compiled and managed appropriately.	Executive Directors/Directors	All budget holders
STANDING FINANCIAL INSTRUCTIONS (SFI)	5.2.6	FINANCIAL MANAGEMENT AND BUDGETARY CONTROL	Budgetary Delegation	Sign up to their allocated budgets at the commencement of the financial year	All budget holders	All budget holders
STANDING FINANCIAL INSTRUCTIONS (SFI)	5.2.7	FINANCIAL MANAGEMENT AND BUDGETARY CONTROL	Budgetary Delegation	Ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist budget holders managing their budgets successfully	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	5.3.1	FINANCIAL MANAGEMENT AND BUDGETARY CONTROL	Financial Management and Budgetary Control	Monitor financial performance against budget and plans and report the current and forecast position, and financial risks, on a monthly basis and at every Board meeting. Any significant variances should be reported to LHB Board as soon as they come to light and the Board shall be advised on any recommendations and action to be taken in respect of such variances.	Director of Finance	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	5.3.2	FINANCIAL MANAGEMENT AND BUDGETARY CONTROL	Financial Management and Budgetary Control	Devise and maintain systems of financial management, performance reporting and budgetary control as per SFI 5.3.2 i.e. Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	5.3.3	FINANCIAL MANAGEMENT AND BUDGETARY CONTROL	Financial Management and Budgetary Control	Establish project management controls and financial reporting systems to ensure these objectives are met. Reporting requirements to Welsh Government will be set out in the approval letter provided post Ministerial approval.	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	5.3.4	FINANCIAL MANAGEMENT AND BUDGETARY CONTROL	Financial Management and Budgetary Control	Ensure that: a) Any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Chief Executive subject to the Board's scheme of delegation	All budget holders	All budget holders
STANDING FINANCIAL INSTRUCTIONS (SFI)	5.3.4	FINANCIAL MANAGEMENT AND BUDGETARY CONTROL	Financial Management and Budgetary Control	b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement	All budget holders	All budget holders
STANDING FINANCIAL INSTRUCTIONS (SFI)	5.3.4	FINANCIAL MANAGEMENT AND BUDGETARY CONTROL	Financial Management and Budgetary Control	c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.	All budget holders	All budget holders
STANDING FINANCIAL INSTRUCTIONS (SFI)	5.3.5	FINANCIAL MANAGEMENT AND BUDGETARY CONTROL	Financial Management and Budgetary Control	Responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the requirements of the Medium Term Financial Plans and (SFI 9.1)	Chief Executive	All budget holders
STANDING FINANCIAL INSTRUCTIONS (SFI)	5.5.1	FINANCIAL MANAGEMENT AND BUDGETARY CONTROL	Reporting to Welsh Government - Monitoring Returns	Responsible for ensuring that the appropriate monitoring returns are submitted to the Welsh Ministers in accordance with published guidance and timescales	Chief Executive	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	6.2	ANNUAL ACCOUNTS AND REPORTS	Annual Accounts and Reports	Sign the accounts on behalf of the LHB	Chair and Chief Executive	Chair and Chief Executive and Director of Finance

STANDING FINANCIAL INSTRUCTIONS (SFI)	6.2a	ANNUAL ACCOUNTS AND REPORTS	Annual Accounts and Reports	Signing of the: a) Annual Governance Statement	Chief Executive	Chief Executive
STANDING FINANCIAL INSTRUCTIONS (SFI)	6.3	ANNUAL ACCOUNTS AND REPORTS	Annual Accounts and Reports	Ensuring that financial reports and returns are prepared in accordance with the accounting policies, guidance and timetable determined by the Welsh Ministers, as per Welsh Government's Manual for Accounts, and consistent with Financial Reporting Manual (FReM) and International Financial Reporting Standards	Director of Finance	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	6.5	ANNUAL ACCOUNTS AND REPORTS	Annual Accounts and Reports	Signing of the: c) Accountability Report	Chief Executive	Chief Executive
STANDING FINANCIAL INSTRUCTIONS (SFI)	7.1.1	BANKING ARRANGEMENTS	General & Bank Accounts	Responsible for managing the LHB's banking arrangements and for advising the Board on the provision of banking services and operation of accounts	Director of Finance	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	7.1.2	BANKING ARRANGEMENTS	General & Bank Accounts	Approval of banking arrangements	Board	N/A
STANDING FINANCIAL INSTRUCTIONS (SFI)	7.3.1	BANKING ARRANGEMENTS	Banking Procedures	Prepare detailed instructions on the operation of bank accounts	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	7.3.2	BANKING ARRANGEMENTS	Banking Procedures	Advise the LHB's bankers in writing of the conditions under which each account will be operated	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	7.3.3	BANKING ARRANGEMENTS	Banking Procedures	Approve security procedures for any payable orders issued without a hand-written signature e.g. automatically printed. All Payable Orders shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	7.4.1	BANKING ARRANGEMENTS	Review	Review the banking arrangements of the LHB at regular intervals to ensure they reflect best practice, that they are efficient and effective and represent best value for money. The results of the review should be reported to the Audit Committee	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	8.1.1a	CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS	General	Responsible for: a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	8.1.1b	CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS	General	Responsible for: b) Ordering and securely controlling any such stationery ensuring all cash related stationery treated as controlled stationery with management responsibility given to a duly designated employee	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	8.1.1c	CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS	General	Responsible for: c) Provision of adequate facilities and systems for officers whose duties include collecting and holding cash	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	8.1.1d	CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS	General	Responsible for: d) Establishing systems and procedures for handling cash and negotiable securities on behalf of the LHB	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	8.1.1e	CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS	General	Responsible for: e) Ensuring effective control systems are in place for the use of payment cards	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	8.1.1f	CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS	General	Responsible for: f) Ensuring that there are adequate control systems in place to minimise the risk of cash/card misappropriation.	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	9.2.1	INCOME, FEES AND CHARGES	Income Systems	Design and maintain procedures to ensure compliance with systems for the proper recording, invoicing, and collection and coding of all monies due	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	9.2.2	INCOME, FEES AND CHARGES	Income Systems	Ensure that systems are in place for the prompt banking of all monies received.	Director of Finance	Deputy Director of Finance

STANDING FINANCIAL INSTRUCTIONS (SFI)	9.3.1	INCOME, FEES AND CHARGES	Fees and Charges	Responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Welsh Ministers or by Statute	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	9.3.2	INCOME, FEES AND CHARGES	Fees and Charges	Inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions	All Officers	All Officers
STANDING FINANCIAL INSTRUCTIONS (SFI)	9.4.3	INCOME, FEES AND CHARGES	Income Due and Debt Recovery	Responsible for recovering income due and for ensuring debt recovery procedures are in place to secure early payment and minimise bad debt risk on all outstanding debts.	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	9.4.6	INCOME, FEES AND CHARGES	Income Due and Debt Recovery	Responsible for ensuring the Welsh Ministers' guidance on disputed debt arbitration is strictly adhered to.	Chief Executive and Director of Finance	Chief Executive and Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.1.1	NON-PAY EXPENDITURE	Scheme of Delegation, Non Pay Expenditure Limits and Accountability	Approval of the non-pay expenditure and operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the LHB's scheme of delegation	Chief Executive	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.1.2.	NON-PAY EXPENDITURE	Scheme of Delegation, Non Pay Expenditure Limits and Accountability	Set out in the operational scheme of delegation and authorisation: a)The list of managers who are authorised to place requisitions for the supply of goods and services; and b)The maximum level of each requisition and the system for authorisation above that level	Chief Executive	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.2.1a	NON-PAY EXPENDITURE	The Director of Finance's responsibilities	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and SFIs and regularly reviewed;	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.2.1b	NON-PAY EXPENDITURE	The Director of Finance's responsibilities	b) Prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services;	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.2.1c	NON-PAY EXPENDITURE	The Director of Finance's responsibilities	c) Ensure systems are in place for the prompt payment of all properly authorised accounts and claims;	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.2.1d	NON-PAY EXPENDITURE	The Director of Finance's responsibilities	d) Ensure systems are in place for providing a system of verification, recording and payment of all amounts payable.	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.2.1e	NON-PAY EXPENDITURE	The Director of Finance's responsibilities	e) Ensure systems are in place for ensuring that payment for goods and services is only made once the goods and services are received.	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.2.1f	NON-PAY EXPENDITURE	The Director of Finance's responsibilities	f) Responsible for ensuring compliance with the Public Sector payment policy ensuring that a minimum of 95 percent of creditors are paid within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.6.1	NON-PAY EXPENDITURE	Prepayments	Approval of proposed prepayment arrangements	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.6.2	NON-PAY EXPENDITURE	Prepayments	Ensure that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered	All Budget Holders	All Budget Holders
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.7.1	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Sustainable Procurement	Adopt a Sustainable Development Strategy consistent with the NHS Wales Sustainable Development Strategy	Director of Finance	Assistant Director of Finance - Financial Planning & Statutory Reporting
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.7.2	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Sustainable Procurement	Benchmark its performance in sustainable procurement and produce annual action plans for improvement through its use of the Sustainable Procurement Assessment Framework (SPAF)	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.7.2	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Sustainable Procurement	For all contracts over £25,000, the LHB shall take account of social, economic and environmental issues when making procurement decisions using the Sustainable Risk Assessment Template (SRA)	Director of Finance	Director of Finance

STANDING FINANCIAL INSTRUCTIONS (SFI)	11.7.5	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Sustainable Procurement	The LHB is required to consider the Welsh Government Guidance on Ethical Procurement and the new Code of Practice on ethical employment in supply chains which commits public, private and third sector organisations to a set of actions that tackle illegal and unfair employment practices including blacklisting, modern slavery and living wage.	Chief Executive	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.8.1 11.7.6	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Sustainable Procurement	The LHB shall make use of the tools developed by Value Wales in implementing the principles of the WBFGA 2015. The LHB shall benchmark its performance against the WBFGA 2015. For all contracts over £25,000, the LHB shall take account of social, economic and environmental issues when making procurement decisions using the Sustainable Risk Assessment Template (SRA).	Director of Finance	NWSSP/Head of Procurement
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.9.1	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Planning Procurement	Ensure that the LHB has procedures that set out: a)Requirements and exceptions to formal competitive tendering requirements; b)Tendering processes including post tender discussions; c)Requirements and exceptions to obtaining quotations; d)Evaluation and scoring methodologies; and e)Approval of firms for providing goods and services	Director of Finance	Director of Finance/NWSSP
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.9.2	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Planning Procurement	Depending on the value of the procurement, a process of planning the procurement must be undertaken with the Procurement Services and appropriate representative from the service and other appropriate stakeholders. The purpose of a planning phase is to determine: • the likely financial value of the procurement, including whole life cost • the likely 'route to market' which will consider the legislative and policy framework set out above. • the availability of funding to be able to award a contract following a successful procurement process. • that the procurement follows current legislative and policy frameworks including Value Based Procurement	Director of Finance	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.11.1a	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	a) Quotations up to £5,000 (at the discretion of Director of Finance	Director of Finance	All Budget Holders
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.11.1b	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	b) Obtaining minimum of 3 written quotations for goods/services of value between £5,000 and £25,000	Director of Finance	All Budget Holders
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.11.1c	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	c) Authorise and record where the required number of quotations is not available (Note 3.5, Scd 1, SFIs)	Director of Finance	All Budget Holders
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.11.1d	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	d) Formally authorise and record single quotations and report to Audit Committee (Note 3.6, Scd 1, SFIs)	Director of Finance	Director of Finance and NWSSP/Head of Procurement
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.11.1e	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	Competitive Tenders – Total value of contract its entire period: e) Obtaining a minimum of 4 written competitive tenders for goods/services of value between £25,000 and relevant ~~the OJEU~~ thresholds (in compliance with relevant ~~EC~~ Directives as appropriate)	Director of Finance	Budget Holders/NWSSP (Procurement)
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.11.1f	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	f) Obtaining a minimum of 5 written competitive tenders for goods/services of a value in excess of relevant ~~OJEU~~ threshold (in compliance with relevant ~~EC~~ Directives as appropriate)	Chief Executive and Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.11.1g	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	g) Authorise acceptance of lower number of tenderers based on receipt of a full report detailing the reasons (note 5.3 Scd 1,SFIs)	Chief Executive and Director of Finance	Deputy Director of Finance

STANDING FINANCIAL INSTRUCTIONS (SFI)	11.11.1h	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	h) Establish all firms on the tender list are financially sound and professionally competent through a pre-qualification/financial vetting process (note 5.1 Scd 1,SFIs)	Director of Finance	NWSSP (Procurement)
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.11.1i	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	i) Receipt and custody of tenders prior to opening (note 8.3, Scd 1, SFIs)	Director of Finance	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.11.1j	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	j) Decide if late tenders should be considered (paper based procurement only) (note 8.3, Scd 1, SFIs)	Director of Finance	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.11.1l	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	l) Maintain Tender Register in a secure place (note 9.3, Scd 1, SFIs)	Director of Finance	PA to Chief Executive
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.11.1m	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	m) Evaluation of tenders in a robust and fair manner (note 10.2, Sch1, SFIs)	Chief Executive	Chief Executive or nominated project group or other
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.11.1n	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	n) Extending contracts on a single occasion provided that it does not exceed 50% of original value of the contract to a maximum of £75,000. Contract extensions must be reported to Audit and Risk Assurance Committee (note 10.8, Sch 1,SFIs)	Chief Executive	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.11.1o	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	o)Approve Single Tender Actions & report to Audit and Risk Assurance Committee (note 4.2 Schedule 1, SFIs)	Chief Executive and Director of Finance	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.12.1	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Designing Competitions	Nominate officer who shall oversee and manage each contract on behalf of the LHB so as to ensure that these implicit obligations in SFIs are met	Chief Executive	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.13.1	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Single Quotation Application or Single Tender Application	In exceptional circumstances, there may be a need to secure goods/services/works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character as required in SFI 11.13.1	Chief Executive	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.19	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	No Purchase Order, No Pay	Ensure compliance with the 'No Purchase Order, No Pay' policy, the All Wales policy which was introduced to ensure that Procure to Pay continues to provide world-class services on a 'Once for Wales' basis.	Chief Executive	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.20.2	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Official Orders	Authorise who may use and be issued with official orders	Chief Executive	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	12.1.1	HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES	Healthcare Agreements	Responsible for ensuring the LHB enters into suitable Health Care Agreements (or Individual Patient Commissioning Agreements, where appropriate) for its provision of health care services	Chief Executive	Director of Strategy and Planning (Medical Director for IPCAs)
STANDING FINANCIAL INSTRUCTIONS (SFI)	12.3.1	HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES	Healthcare Agreements	Ensure that regular reports are provided to the Board detailing performance and associated financial implications of all health care agreements	Chief Executive	Director of Finance

STANDING FINANCIAL INSTRUCTIONS (SFI)	13.2.2	GRANT FUNDING	Policies and procedures	Ultimately responsible for ensuring that the LHB's grant and procurement procedures: • Are kept up to date; • Conform to statutory requirements; • Adhere to guidance issued by the Welsh Ministers; • Are consistent with the principles of sustainable development; and • Are strictly followed by all Executive Directors, Independent Members and staff within the organisation	Chief Executive	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.1.1	PAY EXPENDITURE	Remuneration and Terms of Service Committee	Establish a Remuneration and Terms of Service Committee	Board	Director of Corporate Governance/Board Secretary
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.1.2	PAY EXPENDITURE	Remuneration and Terms of Service Committee	The Committee shall report in writing to the Board the basis for its recommendations.	Remuneration & Terms of Service Committee	Director of Workforce & OD and Director of Corporate Governance/Board Secretary
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.1.3	PAY EXPENDITURE	Remuneration and Terms of Service Committee	Present to the Board for approval, proposals for the setting of remuneration and terms of service for employees and officers not covered by the Committee	Chief Executive	Director of Workforce & OD
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.2.1	PAY EXPENDITURE	Funded Establishment	Approval of any variation of funded establishment of any department	Chief Executive	All Executive Directors/Directors
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1	PAY EXPENDITURE	Staff Appointments	Authorisation of engagement, re-engagement, re-engagement of employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside of their approved budget and funded establishment	Chief Executive	All Executive Directors/Directors
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1a	PAY EXPENDITURE	Staff Appointments	a) Authority to fill funded posts within the establishment with permanent staff	All Budget Holders	All Budget Holders
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1b	PAY EXPENDITURE	Staff Appointments	b) Authority to appoint staff to posts not on the formal establishment	Executive Directors/Directors	Executive Directors/Directors
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1c	PAY EXPENDITURE	Staff Appointments	c) Additional increments – the granting of additional increments to staff within budgets (subject to the rules of Agenda for Change)	Director of Workforce & OD	~~Deputy Director of Workforce & OD~~ Assistant Director of People Management
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1d	PAY EXPENDITURE	Staff Appointments	d) Applications for re-grading (in line with the agreed policy on Agenda for Change and in accordance with all Wales Terms and Conditions).	Director of Workforce & OD	~~Assistant Director of Workforce & OD (Resourcing & Utilisation)~~ Assistant Director of People Management
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1e	PAY EXPENDITURE	Staff Appointments	e) Authority to complete standing data forms affecting pay, new starters, variations and leavers	Line Managers and Heads of Service	Line Managers and Heads of Service
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1f	PAY EXPENDITURE	Staff Appointments	f) Authority to authorise overtime	Heads of Service/General Managers	Heads of Service/General Managers
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1g	PAY EXPENDITURE	Staff Appointments	g) Authority to authorise travel and subsistence expenses (within 3 months of incurring expenditure)	Line Managers and Heads of Service	Line Managers and Heads of Service
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1h(i)	PAY EXPENDITURE	Staff Appointments	h) Authority to book Bank or Agency Staff for (i) Consultants and Middle Grades	Chief Operating Officer	Executive Directors/Directors/ Directors for Corporate Departments/Clinical Care Group Service Directors/Clinical Service Groups General Managers/General Managers for Operational Directorate

STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1h(ii)	PAY EXPENDITURE	Staff Appointments	h) Authority to book Bank or Agency Staff for (ii) Nursing Staff	Chief Operating Officer	Executive Directors/Directors/ Directors for Corporate Departments/Clinical Care Group Service Directors/Clinical Service Groups General Managers/General Managers for Operational Directorate
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1h(iii)	PAY EXPENDITURE	Staff Appointments	h) Authority to book Bank or Agency Staff for (iii) All other Staff	Chief Operating Officer	~~Directorate Management Team~~ Executive Directors/Directors/Directors for Corporate Departments/Clinical Care Group Service Directors/Clinical Service Groups General Managers/General Managers for Operational Directorate
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1i(i)	PAY EXPENDITURE	Staff Appointments	i) Annual Leave approval	Line Managers	Line Managers
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1i(ii)	PAY EXPENDITURE	Staff Appointments	(ii) Annual leave approval to carry forward in exceptional circumstances 5 days	Executive Director/Director or nominated deputy (via Line Manager)	Executive Director/Director or nominated deputy (via Line Manager)
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1i(iii)	PAY EXPENDITURE	Staff Appointments	(iii) Approval of Special Leave (including compassionate, carers and leave without pay (in line with All Wales Special Leave Policy)	Line Managers	Line Managers
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1j	PAY EXPENDITURE	Staff Appointments	j) Approval of leave without pay	Line Managers	Line Managers
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1k(i-iii)	PAY EXPENDITURE	Staff Appointments	k) Approval of Medical and Dental Staff Leave of Absence (i) Doctors below Consultant Grade a) Annual Leave b) Study Leave (ii) Consultant Staff a) Annual Leave b) Study Leave (iii) Clinical Directors a) Annual Leave b) Study Leave	Line Managers	Line Managers
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1k(iv)	PAY EXPENDITURE	Staff Appointments	(iv)Medical Director a) Annual Leave b) Study Leave	Chief Executive	Chief Executive
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1l	PAY EXPENDITURE	Staff Appointments	l) Approval of time off in lieu	Line Managers/~~Service Delivery Managers~~	Line Managers/~~Service Delivery Managers~~
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1m	PAY EXPENDITURE	Staff Appointments	m) Approval of maternity, paternity and adoption leave in line with LHB Policy	Line Managers and Workforce & OD Manager	Line Managers and Workforce & OD Manager
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1n	PAY EXPENDITURE	Staff Appointments	n) Approval of sick leave – return to work on phased basis to assist with recovery in line with All Wales Sickness Policy	Line Managers	Line Managers
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1o	PAY EXPENDITURE	Staff Appointments	o) Approval of extension of sick leave on full or half pay - Directors	Remuneration & Terms of Service Committee	Director of Workforce & OD
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1p	PAY EXPENDITURE	Staff Appointments	p) Approval of extension of sick leave on full or half pay – Other staff	Director of Workforce & OD	Director of Workforce & OD
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1q(i)	PAY EXPENDITURE	Staff Appointments	q) Study leave & Conferences (i) In-house learning & development programmes	Line Managers	Line Managers

STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1q(ii)	PAY EXPENDITURE	Staff Appointments	q) Study leave & Conferences (ii) Applications for higher award	Line Managers, Care Group Director/General Manager Professional Head & Executive led Panel	Line Managers, Care Group Director/General Manager Professional Head & Executive led Panel
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1r(i)	PAY EXPENDITURE	Staff Appointments	r) Approval of relocation costs (i) Chief Executive & Directors	Remuneration & Terms of Service Committee	Director of Workforce & OD
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1r(ii)	PAY EXPENDITURE	Staff Appointments	r) Approval of relocation costs (ii) Medical and Dental Staff	Director of Workforce & OD (as per Relocation Expenses Policy)	~~Director of Workforce & OD~~ Assistant Director of People Management
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1r(iii)	PAY EXPENDITURE	Staff Appointments	r) Approval of relocation costs (iii) Other Staff groups	Director of Workforce & OD (as per Relocation Expenses Policy)	~~Director of Workforce & OD~~ Assistant Director of People Management
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1s(i)	PAY EXPENDITURE	Staff Appointments	s) Approval of lease cars (i) Chief Executive	Chair	Chair
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1s(ii)	PAY EXPENDITURE	Staff Appointments	s) Approval of lease cars (ii) Directors	Chief Executive	Chief Executive
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1s(iii)	PAY EXPENDITURE	Staff Appointments	s) Approval of lease cars (iii) Other Staff groups	Budget Holders	Budget Holders/NWSSP (Procurement)
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1t(i)	PAY EXPENDITURE	Staff Appointments	t) Approval of mobile phones (i) Chief Executive	Chair	Chair
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1t(ii)	PAY EXPENDITURE	Staff Appointments	t) Approval of mobile phones (ii) Directors	Chief Executive	Chief Executive
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.3.1t(iii)	PAY EXPENDITURE	Staff Appointments	t) Approval of mobile phones (iii) Other Staff groups	~~Line Managers~~ Budget Holders	~~Line Managers~~ Budget Holders
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.4.1	PAY EXPENDITURE	Staff Appointments	Present to the Board for approval, procedures for the determination of commencing pay rates, conditions of service, etc, for employees in accordance with pay, terms and conditions set out in Agenda for Change and other pay review bodies	Chief Executive	Director of Workforce & OD
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.5.1	PAY EXPENDITURE	Payroll	The Director of Workforce and Organisational Development, has responsibility for securing an efficient, well-controlled payroll service from NHS Wales Shared Services Partnership that: a) pays the correct staff with the correct amount, b) all payments are supported by properly authorised documentation.	Director of Workforce & OD	~~Deputy Director of Workforce & OD~~ Assistant Director of People Management
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.5.2a	PAY EXPENDITURE	Payroll	Responsible for: a) Securing the provision of an efficient, value for money payroll service	Director of Workforce & OD	~~Deputy Director of Workforce & OD~~ Assistant Director of People Management
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.5.2b	PAY EXPENDITURE	Payroll	Responsible for: b) Specifying timetables for submission of properly authorised time records and other notifications	Director of Workforce & OD	NWSSP
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.5.2c	PAY EXPENDITURE	Payroll	Responsible for: c) The final determination of pay and allowances including verification that the rate of pay and relevant conditions of service are in accordance with current	Director of Workforce & OD	NWSSP
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.5.2d	PAY EXPENDITURE	Payroll	Responsible for: d) Agreeing the timing and method of payment with the payroll service	Director of Workforce & OD	~~Deputy Director of Workforce & OD~~ Assistant Director of People Management
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.5.2e	PAY EXPENDITURE	Payroll	Responsible for: e) Authorising the release of payroll data where in accordance with the provisions of the Data Protection Act 1998 (C.29); Director of Workforce & OD Head of Information Governance	Director of Workforce & OD	Head of Information Governance

STANDING FINANCIAL INSTRUCTIONS (SFI)	14.5.2f	PAY EXPENDITURE	Payroll	Responsible for: f) Verification and documentation of data	Director of Workforce & OD	NWSSP
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.5.2g	PAY EXPENDITURE	Payroll	Responsible for: g) The timetable for receipt and preparation of payroll data and the payment of employees and allowances	Director of Workforce & OD	NWSSP
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.5.2h	PAY EXPENDITURE	Payroll	Responsible for: h) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay	Director of Workforce & OD	NWSSP
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.5.2i	PAY EXPENDITURE	Payroll	Responsible for: i) Security and confidentiality of payroll information	Director of Workforce & OD	NWSSP
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.5.2j	PAY EXPENDITURE	Payroll	Responsible for: j) Checks to be applied to completed payroll before and after payment	Director of Workforce & OD	NWSSP
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.5.2k	PAY EXPENDITURE	Payroll	Responsible for: k) A system to ensure the recovery from those leaving the employment of the LHB of sums of money and property due by them to the LHB	Director of Workforce & OD	NWSSP
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.5.3a	PAY EXPENDITURE	Payroll	a) Ensuring that any arrangements for a payroll service from NHS Wales Shared Services Partnership (NWSSP) is supported by appropriate Service Level Agreements, contract terms and conditions, adequate internal controls and audit review procedures	Chief Executive	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.5.3b	PAY EXPENDITURE	Payroll	b) Ensuring a sound system of internal control and audit review of any internally provided payroll service	Chief Executive	Director of Workforce & OD
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.5.3c	PAY EXPENDITURE	Payroll	c)Maintenance and/or the authorisation of regular and independent reconciliation of pay control accounts	Chief Executive	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.5.4	PAY EXPENDITURE	Payroll	Submitting time records, and other notifications in accordance with agreed timetables, completing time records and other notifications in accordance with the contract of Service Level Agreements, and submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement.	Line Managers	Line Managers
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.6.1	PAY EXPENDITURE	Contracts of Employment	Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation, and dealing with variations to, or termination of, contracts of employment	Director of Workforce & OD	NWSSP
STANDING FINANCIAL INSTRUCTIONS (SFI)	15.1.1a	CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS	Capital Plan	a) Ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans	Chief Executive	Director of Strategy and Planning
STANDING FINANCIAL INSTRUCTIONS (SFI)	15.1.1b	CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS	Capital Plan	b) Responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost	Chief Executive	Senior Responsible Owner for each capital scheme
STANDING FINANCIAL INSTRUCTIONS (SFI)	15.1.1c	CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS	Capital Plan	c) Ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received	Chief Executive	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	15.1.1d	CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS	Capital Plan	d) Ensure that an annual capital programme is adopted by the Board prior to the commencement of the financial year	Director of Strategy and Planning	Director of Strategy and Planning
STANDING FINANCIAL INSTRUCTIONS (SFI)	15.1.1e	CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS	Capital Plan	e) Ensure the availability of resources to finance all revenue consequences of the investment, including capital charges	Chief Executive	Director of Strategy and Planning

STANDING FINANCIAL INSTRUCTIONS (SFI)	15.1.1f	CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS	Capital Plan	f) Ensure that any 3rd party use of NHS estate is properly controlled, reimbursed and reported. This will include ensuring that appropriate security, insurance and indemnity arrangements are in place and that there is a written agreement as to each party's responsibilities and liabilities	~~Chief Operating Officer/Director of Strategy and Planning~~ Director of Allied Health Professions & Health Science	~~Director of Estates, Facilities & Capital Management~~ Head of Property Performance
STANDING FINANCIAL INSTRUCTIONS (SFI)	15.1.3	CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS	Capital Plan	The Board must approve a three year Capital Plan, and an annual Capital Programme, as set out in the Integrated Medium Term Plan and Budgetary Control chapters of these SFI	Director of Strategy and Planning	~~Director of Strategy and Planning~~ Head of Capital Planning
STANDING FINANCIAL INSTRUCTIONS (SFI)	15.2.1	CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS	Capital Investment Decisions	A business case is produced in line with Welsh Ministers' guidance for the development of business cases as set out in: a)NHS Wales Infrastructure Investment Guidance (Welsh Health Circular WHC (2018) 043) https://gov.wales/nhs-wales-infrastructure-investment-guidance b) Better business cases: investment decision-making framework https://gov.wales/better-business-cases-investment-decision-making-framework	Director of Strategy and Planning	Senior Responsible Owner for each capital scheme
STANDING FINANCIAL INSTRUCTIONS (SFI)	15.4.5a	CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS	Capital Procedures and Responsibilities	Issue to the manager responsible for any capital scheme: a) Specific authority to commit expenditure	Director of Strategy and Planning	Senior Responsible Owner for each capital scheme
STANDING FINANCIAL INSTRUCTIONS (SFI)	15.4.5b	CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS	Capital Procedures and Responsibilities	Issue to the manager responsible for any capital scheme: b) Authority to proceed to tender	Director of Strategy and Planning	Senior Responsible Owner for each capital scheme
STANDING FINANCIAL INSTRUCTIONS (SFI)	15.4.5c	CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS	Capital Procedures and Responsibilities	Issue to the manager responsible for any capital scheme: c) Approval to accept a successful tender	Director of Strategy and Planning	Senior Responsible Owner for each capital scheme
STANDING FINANCIAL INSTRUCTIONS (SFI)	15.4.6	CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS	Capital Procedures and Responsibilities	Issue a scheme of delegation for capital investment management in accordance with the Welsh Ministers' guidance and the LHB's SOs	Chief Executive	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	15.4.7	CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS	Capital Procedures and Responsibilities	Issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.	Director of Finance	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	15.6.1	CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS	Asset Registers	Maintenance of asset registers (on advice from Director of Strategy & Planning and Director of Finance)	Chief Executive	~~Director of Strategy & Planning and Director of Finance~~ Asset Owners
STANDING FINANCIAL INSTRUCTIONS (SFI)	15.6.5	CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS	Asset Registers	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers	Director of Finance	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	15.7.1	CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS	Security of Assets	Overall control of fixed assets	Director of Finance	Director of Finance

STANDING FINANCIAL INSTRUCTIONS (SFI)	15.7.2	CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS	Security of Assets	Approval of fixed asset control procedures	Director of Finance	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	15.7.3	CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS	Security of Assets	All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance	Director of Finance	Budget Holders/NWSSP (Procurement)
STANDING FINANCIAL INSTRUCTIONS (SFI)	SFI 16.2.1a	STORES AND RECEIPT OF GOODS	Control of Stores, Stocktaking, condemnations and disposal	a) Delegate overall responsibility for control of stores (subject to Director of Finance). Further delegation for the day-to-day responsibility subject to delegation being entered in a record available to the Director of Finance	Chief Executive	Chief Operating Officer
STANDING FINANCIAL INSTRUCTIONS (SFI)	SFI 16.2.1b	STORES AND RECEIPT OF GOODS	Control of Stores, Stocktaking, condemnations and disposal	b) Responsible for systems of control over stores and receipt of goods	Director of Finance	Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	SFI 16.2.1c	STORES AND RECEIPT OF GOODS	Control of Stores, Stocktaking, condemnations and disposal	c) Responsible for the control of pharmaceutical stocks	Director of Primary Care, Community Strategy and Long Term Care	Head of Medicines Management
STANDING FINANCIAL INSTRUCTIONS (SFI)	SFI 16.2.1d	STORES AND RECEIPT OF GOODS	Control of Stores, Stocktaking, condemnations and disposal	d) Responsible for the control of fuel, oil and coal stocks	Chief Operating Officer	Service Director, Estates & Facilities Group ~~Director of Estates, Facilities & Capital Management~~
STANDING FINANCIAL INSTRUCTIONS (SFI)	16.2.2	STORES AND RECEIPT OF GOODS	Control of Stores, Stocktaking, condemnations and disposal	Security arrangements and custody of keys	Chief Operating Officer/ Director of Primary Care, Community Strategy and Long Term Care	Designated Manager /Pharmaceutical Manager
STANDING FINANCIAL INSTRUCTIONS (SFI)	16.2.3	STORES AND RECEIPT OF GOODS	Control of Stores, Stocktaking, condemnations and disposal	Set out procedures and systems to regulate the stores	Director of Finance	Chief Operating Officer
STANDING FINANCIAL INSTRUCTIONS (SFI)	16.2.4	STORES AND RECEIPT OF GOODS	Control of Stores, Stocktaking, condemnations and disposal	Agree stocktaking arrangements	Director of Finance	Designated Manager /Pharmaceutical Manager
STANDING FINANCIAL INSTRUCTIONS (SFI)	16.2.5	STORES AND RECEIPT OF GOODS	Control of Stores, Stocktaking, condemnations and disposal	Approve alternative arrangements where a complete system of stores control is not justified	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	16.2.6	STORES AND RECEIPT OF GOODS	Control of Stores, Stocktaking, condemnations and disposal	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	16.2.6	STORES AND RECEIPT OF GOODS	Control of Stores, Stocktaking, condemnations and disposal	Approve system for slow moving and obsolete stock, and report to Director of Finance evidence of significant overstocking	Designated Manager	Designated Manager
STANDING FINANCIAL INSTRUCTIONS (SFI)	16.3.1	STORES AND RECEIPT OF GOODS	Goods supplied by an NHS supplies agency	Identify persons authorised to requisition and accept goods from NHS Supplies store	Chief Executive	All Budget Holders

STANDING FINANCIAL INSTRUCTIONS (SFI)	17.1.1	DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS	Disposals and Condemnations	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	17.1.2	DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS	Disposals and Condemnations	Advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate, when disposing of LHB asset	Head of Department or authorised deputy	Head of Department or authorised deputy
STANDING FINANCIAL INSTRUCTIONS (SFI)	17.1.3a	DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS	Disposals and Condemnations	a) Condemning and disposal of all unserviceable articles	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	17.1.3b	DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS	Disposals and Condemnations	b) Report evidence of negligence in use to Director of Finance who will take appropriate action	Condemning Officer	Condemning Officer
STANDING FINANCIAL INSTRUCTIONS (SFI)	17.1.4	DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS	Disposals and Condemnations	Take appropriate action on reported evidence of negligence in use	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	17.2.2	DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS	Losses and Special Payments	Prepare procedural instructions on the recording of and accounting for losses and special payments; and ensure that all losses or special payments cases are properly managed in accordance with the guidance set out in the Welsh Government's Manual for Accounts	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	17.2.3	DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS	Losses and Special Payments	Discovery or suspicion of loss of any kind must be reported immediately to Heads of Department who should then inform the Chief Executive and Director of Finance.	All Staff	All Staff
STANDING FINANCIAL INSTRUCTIONS (SFI)	17.2.4a	DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS	Losses and Special Payments	a) Where a criminal offence is suspected, the police must be informed if theft or arson are involved	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	17.2.4b	DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS	Losses and Special Payments	b) Where a fraud or corruption or anomalies which indicate fraud or corruption is suspected the Local Counter Fraud Specialist, NHS Counter Fraud Services Wales and NHS Protect in accordance with Directions issued by Welsh Ministers on fraud and corruption must be informed	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	17.2.5	DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS	Losses and Special Payments	Notify the Audit Committee, Auditor General's representative and the fraud liaison officer within the Welsh Government's Department for Health, Social Services and Children of all frauds	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	17.2.6	DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS	Losses and Special Payments	Notify the Audit Committee and Auditor General's representative of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial)	Director of Finance	Deputy Director of Finance

STANDING FINANCIAL INSTRUCTIONS (SFI)	17.2.7	DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS	Losses and Special Payments	Take any necessary steps to safeguard the LHB's interests in bankruptcies and company liquidations	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	17.2.8	DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS	Losses and Special Payments	Maintain losses and special payments register	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	17.2.9	DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS	Losses and Special Payments	Approve the writing-off of losses or the making of special payments within delegated limits determined by the Welsh Ministers and as set out in Schedule 3 of the SOs	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	17.2.10	DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS	Losses and Special Payments	Consider whether any insurance claim can be made from the Welsh Risk Pool or from other commercial insurance arrangements for any loss	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	17.2.13	DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS	Losses and Special Payments	Ensure all losses and special payments are reported to the Audit Committee at every meeting	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	18.1.1	DIGITAL, DATA and TECHNOLOGY	Digital Data and Technology Strategy	Develop an IM&T Strategy	Director of Finance	Digital Director
STANDING FINANCIAL INSTRUCTIONS (SFI)	18.1.2	DIGITAL, DATA and TECHNOLOGY	Digital Data and Technology Strategy	Publish and maintain a Freedom of Information (FOI) Publication Scheme	Director of Corporate Governance/Board Secretary	Assistant Director of Corporate Legal Services and Public Affairs
STANDING FINANCIAL INSTRUCTIONS (SFI)	18.2.1a	DIGITAL, DATA and TECHNOLOGY	Responsibilities and duties of the responsible Director	a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the LHB's data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 (C.29);	Director of Finance	Digital Director
STANDING FINANCIAL INSTRUCTIONS (SFI)	18.2.1b	DIGITAL, DATA and TECHNOLOGY	Responsibilities and duties of the responsible Director	b) Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;	Director of Finance	Digital Director
STANDING FINANCIAL INSTRUCTIONS (SFI)	18.2.1c	DIGITAL, DATA and TECHNOLOGY	Responsibilities and duties of the responsible Director	c) Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.	Director of Finance	Digital Director
STANDING FINANCIAL INSTRUCTIONS (SFI)	18.2.1d	DIGITAL, DATA and TECHNOLOGY	Responsibilities and duties of the responsible Director	d) Ensure that policies, procedures and training arrangements are in place to ensure compliance with information governance law.	Director of Finance	Digital Director
STANDING FINANCIAL INSTRUCTIONS (SFI)	18.2.1e	DIGITAL, DATA and TECHNOLOGY	Responsibilities and duties of the responsible Director	e) Ensure comprehensive incident reporting.	Director of Finance	Digital Director
STANDING FINANCIAL INSTRUCTIONS (SFI)	18.3.1	DIGITAL, DATA and TECHNOLOGY	Responsibilities and duties of the Director of Finance	Ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation.	Director of Finance	Deputy Director of Finance

STANDING FINANCIAL INSTRUCTIONS (SFI)	18.4.1	DIGITAL, DATA and TECHNOLOGY	Contracts for data and digital services with other health bodies or outside agencies	Ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage.	Director of Finance	Digital Director
STANDING FINANCIAL INSTRUCTIONS (SFI)	18.4.2	DIGITAL, DATA and TECHNOLOGY	Contracts for data and digital services with other health bodies or outside agencies	Where another health organisation or any other agency provides a computer service for financial applications, assurances should be periodically sought to ensure that adequate controls are in operation	Director of Finance	Digital Director
STANDING FINANCIAL INSTRUCTIONS (SFI)	18.5.1	DIGITAL, DATA and TECHNOLOGY	Risk assurance	Ensure that risks to the LHB arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate IT disaster recovery plans.	Director of Finance	Digital Director
STANDING FINANCIAL INSTRUCTIONS (SFI)	19.1.4	PATIENTS' PROPERTY	LHB Responsibility	Inform staff of their responsibilities and duties for the administration of the property of patients	Chief Operating Officer	Departmental/Senior Managers
STANDING FINANCIAL INSTRUCTIONS (SFI)	19.2.1	PATIENTS' PROPERTY	Responsibilities of the Chief Executive	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission	Chief Executive and Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	19.3.1	PATIENTS' PROPERTY	Responsibilities of the Director of Finance	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients	Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	20.1.3	FUNDS HELD ON TRUST (CHARITABLE FUNDS)	Corporate Trustee	Establish a Charitable Funds Committee to ensure that each trust fund which the LHB is responsible for managing is managed appropriately with regard to its purpose and to its requirements	Board	Director of Nursing, Quality & Patient Experience
STANDING FINANCIAL INSTRUCTIONS (SFI)	20.2.2	FUNDS HELD ON TRUST (CHARITABLE FUNDS)	Accountability to Charity Commission and the Welsh Ministers	Take account of the Schedule of Matters Reserved to the Board and the Scheme of Delegation which make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom.	Director of Nursing, Quality & Patient Experience and Director of Finance	Head of Hywel Dda Health Charities and Senior Finance Business Partner
STANDING FINANCIAL INSTRUCTIONS (SFI)	20.2.2a	FUNDS HELD ON TRUST (CHARITABLE FUNDS)	Accountability to Charity Commission and the Welsh Ministers	Expenditure on Charitable Funds and Endowment Funds is delegated subject to the following limits: a) up to £1,000;	Senior Nurse Manager, Service Delivery Manager, Heads of Service or Managers at equivalent level	N/A
STANDING FINANCIAL INSTRUCTIONS (SFI)	20.2.2b	FUNDS HELD ON TRUST (CHARITABLE FUNDS)	Accountability to Charity Commission and the Welsh Ministers	Expenditure on Charitable Funds and Endowment Funds is delegated subject to the following limits: b) £1,001 to £10,000;	Clinical or Service Director, Service General Manager, Head of Nursing or Managers at equivalent level	N/A
STANDING FINANCIAL INSTRUCTIONS (SFI)	20.2.2c	FUNDS HELD ON TRUST (CHARITABLE FUNDS)	Accountability to Charity Commission and the Welsh Ministers	Expenditure on Charitable Funds and Endowment Funds is delegated subject to the following limits: c) £10,001 to £50,000;	Charitable Funds Sub-Committee	N/A
STANDING FINANCIAL INSTRUCTIONS (SFI)	20.2.2d	FUNDS HELD ON TRUST (CHARITABLE FUNDS)	Accountability to Charity Commission and the Welsh Ministers	Expenditure on Charitable Funds and Endowment Funds is delegated subject to the following limits: d) £50,001 to £100,000	Charitable Funds Committee	N/A
STANDING FINANCIAL INSTRUCTIONS (SFI)	20.2.2e	FUNDS HELD ON TRUST (CHARITABLE FUNDS)	Accountability to Charity Commission and the Welsh Ministers	Expenditure on Charitable Funds and Endowment Funds is delegated subject to the following limits: e) Over £100,000	Corporate Trustee	N/A

STANDING FINANCIAL INSTRUCTIONS (SFI)	21.1.1	RETENTION OF RECORDS	Responsibilities of the Chief Executive	Maintain archives for all records required to be retained in accordance with the Welsh Ministers' guidance, the Data Protection Act 1998 (c.29) and the Freedom of Information Act 2000 (c.36)	Chief Executive and Director of Finance	Assistant Director of Corporate Legal Services and Public Affairs (FOI only)
STANDING FINANCIAL INSTRUCTIONS (SFI)	21.1.2	RETENTION OF RECORDS	Responsibilities of the Chief Executive	Records held in archives shall be capable of retrieval by authorised persons	Chief Executive and Chief Operating Officer	Acute records - Acute Records Manager Mental Health records - MHA Administrator Community – Community & Integrated Medicine Clinical Care Group Service Director
STANDING FINANCIAL INSTRUCTIONS (SFI)	21.1.2	RETENTION OF RECORDS	Responsibilities of the Chief Executive	Records held in accordance with regulation shall only be destroyed at the express instigation of the Chief Executive. Details shall be maintained of records so destroyed	Chief Executive and Chief Operating Officer and Director of Finance	Acute records - Acute Records Manager Mental Health records - MHA Administrator Community records – Community & Integrated Medicine Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	CLINICAL LEADERSHIP	Medical Professional Leadership and Engagement	a) Maintain a refreshed clinical leadership model	Medical Director	Medical Director
SCHEME OF DELEGATION FROM OTHER	N/A	CLINICAL LEADERSHIP	Nursing	b) Maintain a refreshed clinical leadership model	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience
SCHEME OF DELEGATION FROM OTHER	N/A	CLINICAL LEADERSHIP	Medical Education	a) Liaison with Deanery and Royal Colleges	Medical Director	Associate Medical Director – Medical Education
SCHEME OF DELEGATION FROM OTHER	N/A	CLINICAL LEADERSHIP	Research & Governance	a) Authorisation of Research projects	Medical Director	Director of Research Innovation and University Partnerships
SCHEME OF DELEGATION FROM OTHER	N/A	CLINICAL LEADERSHIP	Research & Governance	b) Authorisation of sponsorship deals in relation to research projects	Medical Director	Director of Research Innovation and University Partnerships
SCHEME OF DELEGATION FROM OTHER	N/A	CLINICAL LEADERSHIP	Research & Governance	Accountable for the effective set-up, delivery, governance, financial management and strategic leadership of research and development activities	Medical Director	Director of Research Innovation and University Partnerships
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Concerns/ Complaints/ Patient Feedback	Management of Concerns/Complaints/Patient Feedback a) Overall responsibility for ensuring that all complaints are dealt with effectively;	Director of Nursing, Quality & Patient Experience	Assistant Director ~~of Nursing~~ (Legal and Patient Support)
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Concerns/ Complaints/ Patient Feedback	b) Recording, receipt and initial acknowledgement of concern/complaint	Director of Nursing, Quality & Patient Experience	Assistant Director ~~of Nursing~~ (Legal and Patient Support) (supported by Concerns Department)

SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Concerns/ Complaints/ Patient Feedback	c) Grading of concern/complaint	Director of Nursing, Quality & Patient Experience	Assistant Director ~~of Nursing~~ (Legal and Patient Support)
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Concerns/ Complaints/ Patient Feedback	d) Identification of an Investigating Officer	Director of Nursing, Quality & Patient Experience	Dependent on Grade Grades 1-3 – coordinated by Patient Support Services with the Service Lead Grade 4 – Service Clinical Director/General Manager
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Concerns/ Complaints/ Patient Feedback	e) Investigation of complaint	Director of Nursing, Quality & Patient Experience	Grade 1-3 - Complaint Investigation Team with Service Manage~~r rment leadership~~ Grade 4/5 – Complaint Investigation Team with Service Director/General Manager ~~Senior management leadership~~
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Concerns/ Complaints/ Patient Feedback	f) Maintaining regular contact with the complainant with regard to the processing of the concern	Director of Nursing, Quality & Patient Experience	Grades 4 & 5 – Investigation Officer/Patient Support Services
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Concerns/ Complaints/ Patient Feedback	g) Maintaining regular contact with the complainant with regard to the matters raised in the concern	Director of Nursing, Quality & Patient Experience	Patient Support Service with Investigating Officer
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Concerns/ Complaints/ Patient Feedback	h) Preparing final draft response (all Grades of Concern)	Director of Nursing, Quality & Patient Experience	Service (the service is provided with the findings of the investigation by Patient Support Services or Investigating Officer) Assistant Director (Legal and Patient Support) ~~of Patient Experience~~
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Concerns/ Complaints/ Patient Feedback	i) Checking of final draft prior to submission to Chief Executive/Deputy Chief Executive/relevant Clinical ED for signature	~~Assistant~~ Director of Nursing Quality & Patient Experience ~~(Legal and Patient Support)~~	Assistant Director ~~of Nursing~~ (Legal and Patient Support)
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Concerns/ Complaints/ Patient Feedback	j) Final check and sign of response to complainant	Chief Executive	Chief Executive/Deputy Chief Executive/relevant Clinical Executive Director

SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Concerns/ Complaints/ Patient Feedback	k) Sending final response to complainant	Director of Nursing, Quality & Patient Experience	Complaint Investigation Team/Patient Support Service
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Incident Reporting & Investigation	a) Overall responsibility for ensuring that all incidents are dealt with effectively	Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing, Assurance & Safeguarding ~~Quality & Governance~~
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Incident Reporting & Investigation	b) Completion of Incident Form	Staff member involved in incident or in immediate area	Staff member involved in incident or in immediate area
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Incident Reporting & Investigation	c) Initial Investigation of Incident	Manager of staff member/person in charge of area	Manager of staff member/person in charge of area
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Incident Reporting & Investigation	d) Reporting of ~~Serious Adverse~~ incidents meeting criteria for nationally reporting to NHS Executive ~~Welsh Government~~	Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing, Assurance & Safeguarding ~~Quality & Governance~~
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Incident Reporting & Investigation	e) Arranging serious patient safety incident (SI) management meeting	Director of Nursing, Quality & Patient Experience	Nominated Investigation Officer
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Incident Reporting & Investigation	f) Investigation of ~~Serious~~ incidents (severe, catastrophic, or those that meet criteria to report nationally)	Director of Nursing, Quality & Patient Experience	Nominated Investigation Officer
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Incident Reporting & Investigation	g) Preparation of final report (severe, catastrophic, or those that meet criteria to report nationally)	Director of Nursing, Quality & Patient Experience	Nominated Investigation Officer
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Incident Reporting & Investigation	h) Agreement of final report prior to submission to the Director of Nursing, Quality, and Patient Experience	Nominated Investigation Officer	Nominated Investigation Officer
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Incident Reporting & Investigation	i) Sign off of final report and closure of investigation (severe, catastrophic, or those that meet criteria to report nationally)	Director of Nursing, Quality & Patient Experience (Grade 5's only) Chief Operating Officer (other)	Assistant Director of ~~Quality & Governance~~ Nursing Assurance & Safeguarding (Grade 5 only) Operation Team (other)
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Incident Reporting & Investigation	j) Reporting of incidents in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)	~~Chief Operating Officer~~ Director of Allied Health Professions and Health Science	~~Director of Estates, Facilities & Capital Management~~ Head of Health, Safety & Security ~~and Health & Safety Managers~~
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Incident Reporting & Investigation	k) Reporting of breaches under the Ionising Radiation (Medical Exposure) Regulations to Health Inspectorate Wales (HIW)	Director of Allied Health Professions and Health Science	~~Radiology Services~~ Patient Safety & Assurance Manager
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Incident Reporting & Investigation	l) Reporting of Data Protection breaches to Information Commissioners Office (ICO)	Director of Finance	Head of Information Governance
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	N/A	Approval of compensation for staff and patients personal effects, clinical negligence and personal injury (also see SFI 17.2.2)	Director of Finance	Deputy Director of Finance
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	N/A	Submission of 'No Surprises' notifications to Welsh Government	Chief Executive	All Executive Directors/ Directors

SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Improving Patient Experience	Developing a Patient Experience Strategy	Director of Nursing, Quality & Patient Experience	Assistant Director of Patient Experience
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Clinical Governance	Joint responsibility for Clinical Governance (Clinical Directors)	Director of Nursing, Quality & Patient Experience/Medical Director/Director of Allied Health Professions and Health Science	Director of Nursing, Quality & Patient Experience /Medical Director/Director of Allied Health Professions and Health Science
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Patient Safety Alerts	a) Maintaining a record of patient safety alerts and monitoring compliance	Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing Quality & Governance
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Patient Safety Alerts	b) Responding to the requirements of safety alerts and providing assurance/information on the ability to meet requirements	Relevant Heads of Service	Relevant Heads of Service
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Health and Care Standards Assessment	a) Completing assessment and compliance with the standards	Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing Quality & Governance
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of the Clinical Audit Function	a) Coordination and participation in national audits and development of a Hywel Dda Clinical Audit Plan	~~Director of Nursing, Quality & Patient Experience~~ Medical Director	~~Assistant Director of Quality & Service Improvement~~ Clinical Audit Manager
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of the Clinical Audit Function	b) Approval of Hywel Dda Clinical Audit Plan	Quality, Safety & Experience Committee	Quality, Safety & Experience Committee
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Ethics & Clinical Trials	a) Lead for Ethics and the establishment of an Ethics Committee	Medical Director	Committee
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Ethics & Clinical Trials	b) Authorisation of clinical trials	Medical Director	Director of Research Innovation and University Partnerships
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	National Institute of Clinical Excellence (NICE)	a) Maintaining a record of publications and recording compliance	Medical Director	Clinical Effectiveness Co-ordinator
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	National Institute of Clinical Excellence (NICE)	b) Responding to requirements and providing information regarding ability to meet requirements	All Executive Directors/Directors	Directors for Corporate Departments/Clinical Care Group Service Directors/General Managers for Operational Directorate
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	a) Performing the role of the NCEPOD Ambassador and collation and provision of information to contribute to NCEPOD audit findings	Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing for Planned & Specialist Care Clinical Care Group/Heads of Service
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	b) Maintaining record of publications and recording compliance	Medical Director	Head of Effective Clinical Practice and Quality Improvement

SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	c) Responding to requirements and providing information regarding ability to meet requirements	All Executive Directors/Directors	Directors for Corporate Departments/Clinical Care Group Service Directors/General Managers for Operational Directorate
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	HM Coroner	a) Maintaining relationship and ensuring appropriate response to requests for information	Director of Nursing, Quality & Patient Experience	Assistant Director (Legal & Patient Support)
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	HM Coroner	b) Sending response to HM Coroner	Chief Executive	Chief Executive
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Safeguarding of Adults and Children	a) Implementation of policy and procedures	Director of Nursing, Quality & Patient Experience	Head of Safeguarding/Assistant Director of Nursing for Planned & Specialist Care Clinical Care Group/Assistant Director of Nursing for Community & Integrated Medicine Clinical Care Group/Heads of Service/Designated Lead Managers
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Safeguarding of Adults and Children	b) Investigation in accordance with POVA requirements	Director of Nursing, Quality & Patient Experience	Head of Safeguarding
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Safeguarding of Adults and Children	c) Safeguarding supervision	Director of Nursing, Quality & Patient Experience	~~Head of Safeguarding~~ Assistant Director of Nursing Quality & Governance
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Safeguarding – Deprivation of Liberties	a) Supervising Authority	Director of Primary Care, Community Strategy and Long Term Care	Head of Long Term Care
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Safeguarding – Deprivation of Liberties	b) Managing Authority	Chief Operating Officer	Deputy Chief Operating Officer ~~Head of Consent & Mental Capacity~~
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	N/A	Management of Infections, Diseases & Notifiable Outbreaks	Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing Quality & Governance ~~(Nursing Practice)~~
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Coordination of Welsh Risk Pool Assessments	a) A&E Services	Chief Operating Officer	Community and Integrated Medicine Clinical Care Group Service Director ~~General Manager (Unscheduled Care)~~
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Coordination of Welsh Risk Pool Assessments	b) Claims & Complaints	Director of Nursing, Quality & Patient Experience	Assistant Director ~~of Nursing~~ (Legal and Patient Support)
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Coordination of Welsh Risk Pool Assessments	c) Maternity Services	Chief Operating Officer	Planned and Specialist Care Clinical Care Group Service Director/Children, Women and Family Health Clinical Service Group General Manager ~~General Manager (Women's & Children's Services)~~

SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Coordination of Welsh Risk Pool Assessments	d) Surgical Pathway	Chief Operating Officer	Planned and Specialist Care Clinical Care Group Service Director ~~General Manager (Scheduled Care)~~
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Coordination of Welsh Risk Pool Assessments	e) Theatres	Chief Operating Officer	Planned and Specialist Care Clinical Care Group Service Director ~~General Manager (Scheduled Care)~~
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Professional Standards, Revalidation and Regulation – Medical & Dental	a) Deliver in-year requirements for medical revalidation	Medical Director	Associate Medical Director – Professional Standards
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Professional Standards, Revalidation and Regulation – Medical & Dental	b) Referral to General Medical Council (GMC)/General Dental Council (GDC)	Medical Director	Associate Medical Director – Professional Standards
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Professional Standards, Revalidation and Regulation – Medical & Dental	c) Monitoring of registration (GMC/GDC regulatory compliance)	Medical Director	Associate Medical Director – Primary Care & Workforce
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Professional Standards, Revalidation and Regulation – Medical & Dental	d) Referrals to any professional body for any Primary care contractor including Medical and Dental	Director of Primary Care, Community Strategy and Long Term Care	Director of Primary Care, Community Strategy and Long Term Care
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Nurse Development, Revalidation and Practice Standards	a) NMC revalidation process	Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing (Nursing Practice)
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Nurse Development, Revalidation and Practice Standards	b) Referral to Nursing & Midwifery Council (NMC)	Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing (Nursing Practice)
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Nurse Development, Revalidation and Practice Standards	c) Monitoring of registration (NMC regulatory compliance)	Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing (Nursing Practice)
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Professional leadership for Therapies and Health Science	a) Health and Care Professions Council (HCPC) registration, education and standards	Director of Allied Health Professions and Health Science	Assistant Director of Allied Health Professions/Deputy Director of Health Sciences
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Professional leadership for Therapies and Health Science	b) Referral to appropriate Professional Body	Director of Allied Health Professions and Health Science	Assistant Director of Allied Health Professions/Deputy Director of Health Sciences

SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	N/A	Develop a Health & Well-being Strategy & Health Needs Analysis for Hywel Dda population	Director of Public Health	Director of Public Health
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	N/A	Accountable Officer for Controlled Drugs	Medical Director	Head of Medicines Management
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	N/A	Value Based Healthcare	Medical Director/Director of Finance	Director of Research, Innovation and University Partnerships
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	N/A	Community Health Pathways Platform	Medical Director	Medical Director
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	N/A	Development of a Primary Care Strategy	Director of Primary Care, Community Strategy and Long Term Care	Director of Primary Care, Community Strategy and Long Term Care
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	a) Approval to commission new healthcare services from NHS, private, third sector or independent organisations	Director of Strategy and Planning and Director of Primary Care, Community Strategy and Long Term Care or through the Chief Operating Officer	Director of Strategy and Planning and Director of Primary Care, Community Strategy and Long Term Care or through the Chief Operating Officer
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	b) Agreement to provide services and payments in accordance with Medicines Management Incentive Scheme	Director of Primary Care, Community Strategy and Long Term Care	Head of Medicines Management
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	c) Maintaining a register of commissioning contracts	Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care	Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	d) Ensuring every commissioning contract has a lead manager responsible for ensuring that contract delivers activity, quality and finance	Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care	Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	e) Agreement of annual contract with existing providers and within existing budgets - NHS, third sector, independent or private	Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care	Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	f) Agreement of contract variations	Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care	Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	g) Signing contracts of value < £50,000 and contract variations > £25,000	As per Scheme of Delegation and Authorised Limits	N/A

SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	g) Signing contracts of value < £125,000 and contract variations > £50,000	Standing Orders and Standing Financial Instructions - Hywel Dda University Health Board	N/A
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	h) Signing contracts of value < £500,000 and contract variations > £125,000	As per Scheme of Delegation and Authorised Limits	N/A
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	i) Signing of contracts of value >£1,000,000	As per Scheme of Delegation and Authorised Limits	N/A
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	j) Agreement of changes to contracts where this would place a cost pressure on the organisation which cannot be funded within existing budgets	Chief Executive	Chief Executive
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	j) Agreement of changes to contracts where this would place a cost pressure on the organisation which would have a significant impact on the delivery of outcomes	Director of Strategy & Planning/Director of Finance	Director of Strategy & Planning/Director of Finance
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	k) Ensuring there is a commissioning framework in place which sets out expectations around what will be included in documentation and approach to management including meetings	Director of Strategy and Planning and Director of Primary Care, Community Strategy and Long Term Care	Director of Strategy and Planning and Director of Primary Care, Community Strategy and Long Term Care
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	l) Ensuring there is a contracting framework in place which sets out expectations around what will be included in documentation and approach to management including meetings	Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care	Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	m) Ensuring that contracts have appropriate documentation in place including key performance metrics relating to activity, targets, quality and finance and that regular performance monitoring meetings take place	Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care	Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	n) Ensuring that there are regular meetings in place to monitor performance against commissioning contracts, that recovery plans are agreed where there are performance or finance issues and that matters of concern are escalated appropriately	Director of Strategy and Planning, Director of Finance and Director of Primary Care, Community Strategy and Long Term Care	Director of Strategy and Planning, Director of Finance and Director of Primary Care, Community Strategy and Long Term Care
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	o) Authorisation of invoices against contracts (within budget) excluding NHS Long Term Agreements (LTAs)	Director of Strategy and Planning/Director of Finance and Director of Primary Care, Community Strategy and Long Term Care	As per Scheme of Delegation and Authorised Limits
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	p) Authorisation of invoices against NHS LTAs	Director of Finance	As per Scheme of Delegation and Authorised Limits

SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning of Continuing Healthcare and Funded Nursing Care	All above sections in primary care commissioning section apply to this area - these are supplementary	N/A	N/A
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning of Continuing Healthcare and Funded Nursing Care	a) Approving new care packages in line with HB policy and procedures	Director of Primary Care, Community Strategy and Long Term Care	Head of Long Term Care
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning of Continuing Healthcare and Funded Nursing Care	b) Authorising emergency care packages or changes to care packages outside panel	Director of Primary Care, Community Strategy and Long Term Care	Head of Long Term Care
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning of Continuing Healthcare and Funded Nursing Care	c) Authorising of invoices against agreed packages of care ~~outside panel~~	Director of Primary Care, Community Strategy and Long Term Care	Service Director for Community & Integrated Medicine Clinical Care Group for high cost/exceptional packages of care/General Manager for routine packages of care within their delegated budget level
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning of Continuing Healthcare and Funded Nursing Care	d) Authorising CHC retrospective claims including Powys and UHB claims	Director of Primary Care, Community Strategy and Long Term Care	Director of Primary Care, Community Strategy and Long Term Care
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning of Continuing Healthcare and Funded Nursing Care	e) Decision to go to arbitration or take legal action in relation to any commissioning or provider contract	Chief Executive	Director of Primary Care, Community Strategy and Long Term Care
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning of cross border secondary and tertiary services for population	a) Attending NHS Wales Joint Commissioning Committee meetings	Chief Executive	Director of Strategy and Planning
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning of cross border secondary and tertiary services for population	b) Input to NHS Wales Joint Commissioning Committee commissioning decisions and agreement to Joint Commissioning Committee policies	Chief Executive	Director of Strategy and Planning
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning of cross border secondary and tertiary services for population	c) Dissemination of NHS Wales Joint Commissioning Committee commissioning policies throughout the organisation	Chief Executive	Director of Strategy & Planning

SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning of cross border secondary and tertiary services for population	d) Approving and signing the annual contract with the NHS Wales Joint Commissioning Committee as commissioner	Chief Executive	Chief Executive
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning of cross border secondary and tertiary services for population	e) Agreeing contract variations with the NHS Wales Joint Commissioning Committee	Chief Executive	Chief Executive
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning of cross border secondary and tertiary services for population	f) Hywel Dda University Health Board representative on the Joint Commissioning Committee Collaborative Commissioning Leadership Group	Director of Strategy & Planning	Director of Strategy & Planning
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	IPFR Process and Prior Approval (in line with HB policy & Procedures)	a) Screening of IPFR requests submitted by patient/ clinicians	Medical Director	IPFR Manager
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	IPFR Process and Prior Approval (in line with HB policy & Procedures)	b) Chairing of the IPFR Panel	Medical Director	IPFR Manager
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	IPFR Process and Prior Approval (in line with HB policy & Procedures)	c) Decisions on clinically urgent IPFR requests which cannot wait for screening and panel process	Medical Director	IPFR Manager
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	IPFR Process and Prior Approval (in line with HB policy & Procedures)	d) Arrangements for Review panels of IPFR screening process and/or panel decision	Medical Director	IPFR Manager
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	IPFR Process and Prior Approval (in line with HB policy & Procedures)	e) Communication with patient and referring clinician	Medical Director	IPFR Manager/Team
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	N/A	Provision of Low Vision Service for HDdUHB population.	Director of Primary Care, Community Strategy and Long Term Care	Director of Primary Care, Community Strategy and Long Term Care
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	a) Scheduled Care	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~Triumvirates~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	b) Cancer & Oncology	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~Triumvirates~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	c) Children, Women & Family Health	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~Triumvirates~~

SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	d) Community Services	Chief Operating Officer	Community & Integrated Medicine Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	e) Mental Health & Learning Disability Services	Chief Operating Officer	~~Director of~~ Mental Health & Learning Disabilities Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	e) Therapy Services	Chief Operating Officer	Allied Health and Health Sciences Clinical Care Group Service Director ~~Clinical Director of Therapies~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	f) Primary Care	Director of Primary Care, Community Strategy and Long Term Care	Primary Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	g) Estates & Facilities	Director of Allied Health Professions and Health Science	Estates & Facilities Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	h) Delivery on targets as per operation delivery plan	Chief Executive	All Executive Directors/Directors
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	i) Organ Donation	Chief Operating Officer	Chief Operating Officer
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	j) Falls	Director of Nursing, Quality & Patient Experience	Director of Nursing, Quality & Patient Experience
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	k) Deconditioning	Director of Allied Health Professions and Health Science	Director of Allied Health Professions and Health Science
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	l) WGH Creche	Chief Operating Officer	~~Director of Estates, Facilities & Capital Management~~ Women & Family Health Clinical Service Group General Manager
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	m) Out of Hours Service	Director of Primary Care, Community Strategy and Long Term Care	Assistant Director of Primary Care
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	n) Management of School Nursing & Health Visiting Service	Chief Operating Officer	Community & Integrated Medicine Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	o) Establish revised children's partnership arrangements	Director of Public Health	Director of Public Health
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	p) Providing assurance on screening services	Director of Public Health	Consultant in Public Health

SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	q) Management of Substance Misuse Service	Chief Operating Officer	Commissioning Manager – Substance Misuse
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	N/A	Designated Education Clinical Lead Officer (DECLO)	Director of Allied Health Professions and Health Science	Regional DECLO with Powys & SBUHB
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Emergency planning, readiness & resilience (including business continuity)	a) Compliance with Emergency Planning & Major Incidents – Civil Contingencies Act 2004	Director of Public Health	Head of Health Emergency Planning
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Emergency planning, readiness & resilience (including business continuity)	b) Maintaining the organisation's Major Incident Plan	Director of Public Health	Head of Health Emergency Planning
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Emergency planning, readiness & resilience (including business continuity)	c) Ensure all Directorates/Services/Departments have up to date Business Continuity Plans in place	Director of Public Health	Head of Health Emergency Planning
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Emergency planning, readiness & resilience (including business continuity)	Responsibility for oversight of CONTEST (Counter-Terrorism Strategy)	Director of Public Health	Director of Allied Health Professions and Health Science, Director of Nursing, Quality and Patient Experience and the Director of Finance for the sub-parts of CONTEST i.e. PREVENT, PURSUE, PROTECT AND PREPARE
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Health and Safety, Security	a) Compliance with health and safety legislation requirements including control of substances hazardous to health regulations	Director of Allied Health Professions and Health Science	All Executive Directors/Directors, Clinical Care Group Service Directors, Clinical Service Group General Managers, Assistant Director of EFCM, Digital Director, Deputy Chief Operating Officer
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Health and Safety, Security	b) Management of security issues	Director of Allied Health Professions and Health Science	All Executive Directors/Directors, Clinical Care Group Service Directors, Clinical Service Group General Managers, Assistant Director of EFCM, Digital Director, Deputy Chief Operating Officer

SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Health and Safety, Security	c) Responsibility for fire safety management	Director of Allied Health Professions and Health Science	Estates & Facilities Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Health and Safety, Security	Responsibility for Annual Health and Safety Report	Director of Allied Health Professions and Health Science	Director of Allied Health Professions and Health Science
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Additional Learning Needs	Additional Learning Needs (ALN) arrangements	Director of Allied Health Professions and Health Science	Director of Allied Health Professions and Health Science
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Medical Records	Responsibility for Medical Records Directorate	~~Chief Operating Officer~~ Director of Finance	~~Chief Operating Officer~~ Director of Finance
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	a) Physiotherapy Records	Chief Operating Officer	Allied Health & Health Sciences Clinical Care Group Service Director ~~Clinical Director of Therapies~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	b) Occupational Therapy Records	Chief Operating Officer	Allied Health & Health Sciences Clinical Care Group Service Director ~~Clinical Director of Therapies~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	c) Speech and Language Therapy Records	Chief Operating Officer	Allied Health & Health Sciences Clinical Care Group Service Director ~~Clinical Director of Therapies~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	d) Dietetics Records	Chief Operating Officer	Allied Health & Health Sciences Clinical Care Group Service Director ~~Clinical Director of Therapies~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	e) Podiatry Records	Chief Operating Officer	Allied Health & Health Sciences Clinical Care Group Service Director ~~Clinical Director of Therapies~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	f) Orthoptic Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~Lead Orthoptist~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	g) Audiology Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~Head of Audiology~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	h) Cardio Physiologist Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~Head of Cardiophysiology~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	i) Neurophysiology Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~Head of Neurophysiology~~

SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	j) OOH Clinical Service Records	Director of Primary Care, Community Strategy and Long Term Care	Primary Care Clinical Care Group Service Director Assistant Director of Primary Care
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	k) Acute Medical Records	Chief Operating Officer	Health Records Manager
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	l) Community, district nursing and Primary Care Records (not Children's Services)	Chief Operating Officer	Primary Care Clinical Care Group Service Director ~~Care Group Director~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	m) Outpatient service records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~Care Group Director~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	n) Palliative Care Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~Care Group Director~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	o) Nursing Records	Chief Operating Officer	Assistant Director (Operations, Quality and Nursing)
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	p) Mental Capacity Records	Chief Operating Officer	Assistant Director (Operations, Quality and Nursing)
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	q) Specialist Nurse (tissue viability records)	Chief Operating Officer	Assistant Director (Operations, Quality and Nursing)
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	r) Cancer Services Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager - Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	s) Community Paediatric Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager - Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	t) Acute Paediatric and Neonates Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager - Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	u) Community Children's Service Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager - Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	v) Midwifery and Women's health Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager - Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	w) Obstetrics and Gynaecology Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager - Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	x) Pathology Records	Chief Operating Officer	Allied Health & Health Sciences Clinical Care Group Service Director ~~Head of Service - Pathology~~

SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	y) Radiology Records	Chief Operating Officer	Allied Health & Health Sciences Clinical Care Group Service Director Radiology Services Manager
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	z) Cardiology Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	aa) Renal Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ab) General Medicine Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ac) Gastroenterology Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ad) Neurology Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ae) Stroke Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	af) Care of The Elderly	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ag) General surgery, vascular, breast care records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ah) Ophthalmology Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ai) Ear, Nose and Throat Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	aj) Trauma and Orthopaedics Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ak) Plaster Services Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	al) Dermatology Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~

SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	am) Rheumatology Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	an) Theatres Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ao) Day Surgery Unit Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ap) Pre-assessment Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	aq) Endoscopy Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ar) Anaesthetics Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	as) Urology Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	at) Critical Care Records	Chief Operating Officer	Planned & Specialist Care Clinical Care Group Service Director ~~General Manager – Scheduled Care~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	au) Mental Health and Learning Disability Records	Chief Operating Officer	~~Director of~~ Mental Health & Learning Disabilities Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	av) Psychology Records	Chief Operating Officer	Allied Health & Health Sciences Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ax) Mental Health Subject Access Requests	Chief Operating Officer	Mental Health Act Administrator
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	aw) Acute Subject Access Requests	Chief Operating Officer	Acute Records Manager
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ay) Managed Practices records	Director of Primary Care, Community Strategy and Long Term Care	Assistant Director of Primary Care
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	az) Low Vision records	Director of Primary Care, Community Strategy and Long Term Care	Head of Dental and Optometry
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	aaa) Dental services records for specific services and not independent Dental Practices	Director of Primary Care, Community Strategy and Long Term Care	Head of Dental and Optometry

SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational quality and safety and effectiveness	a) Implementing Hospital Patient Environment audits	Chief Operating Officer	~~Director of Estates, Facilities & Capital Management~~ Service Director, Estates & Facilities Group
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational quality and safety and effectiveness	b) Decontamination	Chief Operating Officer	Chief Operating Officer
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational quality and safety and effectiveness	c) Capital equipment renewal & replacement	Chief Operating Officer	Chief Operating Officer
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational quality and safety and effectiveness	d) Electro-Bio Medical Engineering (EBME)	Chief Operating Officer	Chief Operating Officer
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Managed Practices	Delivery of Managed Practices Contacts	Director of Primary Care, Community Strategy and Long Term Care	Director of Primary Care, Community Strategy and Long Term Care
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Managed Practices	Management and service delivery of Health Board Managed Practices (including premises contracts)	Director of Primary Care, Community Strategy and Long Term Care	Director of Primary Care, Community Strategy and Long Term Care
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	N/A	Medicines and Healthcare products Regulatory Agency (MHRA) (linking in with the Medical Director for issues relating to medicines/blood as necessary)	Director of Allied Health Professions & Health Science	Director of Allied Health Professions & Health Science/Medical Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	N/A	Medical Devices	Chief Operating Officer	Deputy Director of Operations
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	N/A	Medicines Management	Director of Primary Care, Community Strategy and Long Term Care	Head of Medicines Management
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	N/A	Development of a medicines optimisation strategy (primary & secondary care)	Director of Primary Care, Community Strategy and Long Term Care	Head of Medicines Management
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	N/A	National Contracts for GMS, Dental, Community Pharmacy and Optometry, including implementation, monitoring, performance management and reporting	Director of Primary Care, Community Strategy and Long Term Care	Assistant Director of Primary Care
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Estates	a) Develop an estates strategy and rationalisation plan	Director of Strategy & Planning	Director of Estates & Facilities ~~& Capital~~ (Operational)
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Estates	b) Compliance with environmental regulations	Director of Allied Health Professions and Health Science	Estates & Facilities Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Estates	c) Management of land, buildings, included leased assets	Director of Allied Health Professions and Health Science	Estates & Facilities Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Estates	d) Authorised holder of deed and controller of property	Director of Allied Health Professions and Health Science	Estates & Facilities Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Estates	e) District Valuer issues and negotiations	Director of Allied Health Professions and Health Science	Estates & Facilities Clinical Care Group Service Director

SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Estates	f) Delivery of Capital Estates Projects	Director of Strategy & Planning and Director of Allied Health Professions & Health Science	Director of Estates, Facilities & Capital Management (replace with new job title) and Head of Operations
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Estates	g) Licences and leases for property	Director of Allied Health Professions and Health Science	Estates & Facilities Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Information Management & Technology Strategy	a) Information Governance (including compliance with the Data Protection Act, Access to Health Records Act and other IG legislation)	Director of Finance (Senior Information Risk Owner)	Head of Information Governance
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Information Management & Technology Strategy	b) Data Protection Officer	Director of Finance	Head of Information Governance
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Information Management & Technology Strategy	c) Senior Information Risk Owner (SIRO)	Director of Finance	Digital Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Information Management & Technology Strategy	d) Caldicott Standards and Action Plan	Medical Director	Deputy Caldicott Guardian /Head of Information Governance
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Information Management & Technology Strategy	e) Development and revision of Information Sharing Protocols	Director of Finance	Head of Information Governance
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Information Management & Technology Strategy	f) IG Training Programme	Director of Finance	Head of Counter Fraud
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Information Management & Technology Strategy	g) Data Quality	Director of Finance	Digital Director & all information Asset Owners
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Information Management & Technology Strategy	h) Management and control of computer systems and facilities to ensure achievement and compliance with national standards and IM&T strategy	Director of Finance	Digital Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Information Management & Technology Strategy	i) Purchases/installation of IT software & hardware	Director of Finance	Digital Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Information Management & Technology Strategy	j) Delivery of specific IT projects	Director of Finance	Digital Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Performance Management & Business Intelligence	a) Review & establish the performance management framework which included meaningful performance measures for the totality of the services for the which the Health Board is responsible	Director of Finance	Head of Performance

SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Performance Management & Business Intelligence	b) Develop the Board Performance Report template on an annual basis, advising on aligning and integrating service, workforce and financial performance matters for sign off by the Strategic Development & Operational Delivery Committee	Director of Finance	Head of Performance
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Performance Management & Business Intelligence	c) Establish Performance Management Office	Director of Finance	Head of Performance
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Performance Management & Business Intelligence	d) Provide assurance on the overall performance and delivery against Health Board plans and objectives	Director of Finance	Head of Performance
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	NHS Shared Services Partnership	a) Attending Joint Committee meetings	Chief Executive	Director of Finance
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	NHS Shared Services Partnership	b) Agreeing actions to be taken where performance is off track	Chief Executive	Director of Finance
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	NHS Shared Services Partnership	c) Ensure robust interface protocols are in place and test efficacy on a planned programme of review	Chief Executive	Director of Finance
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	N/A	To oversee the Health Board's contribution to the NHS Wales Decarbonisation Strategic Delivery Plan	Director of Public Health	Director of Public Health
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	N/A	To oversee the Health Board's contribution for social model for health & well-being	Director of Public Health	Director of Public Health
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	N/A	Responsibility for Biodiversity	Director of Public Health	Director of Public Health
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	N/A	Compliance with Climate Change regulations	Director of Public Health	Director of Public Health
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	N/A	Responsibility for the production of an independent annual report on the health of the population of Hywel Dda University Health Board	Director of Public Health	Director of Public Health
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	N/A	Hywel Dda University Health Board representative on the Area Planning Board	Director of Public Health	Director of Public Health
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Corporate Governance, Assurance Framework & Risk Management	a) Develop Board Risk Appetite Statement	Director of Corporate Governance/Board Secretary	Assistant Director of Assurance and Risk
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Corporate Governance, Assurance Framework & Risk Management	b) Review internal risk management processes	Director of Corporate Governance/Board Secretary	Assistant Director of Assurance & Risk

SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Corporate Governance, Assurance Framework & Risk Management	c) Co-ordination & maintenance of Corporate Risk Register	Director of Corporate Governance/Board Secretary	Assistant Director of Assurance & Risk
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Corporate Governance, Assurance Framework & Risk Management	d) Management & maintenance of Operational (Clinical Care Group/Clinical Service Group/Executive Function) Risk Registers	Executive Directors and Directors	Heads of Departments/Heads of Service/Clinical Care Group Service Directors/Clinical Service Group General Managers
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Corporate Governance, Assurance Framework & Risk Management	e) Development of Board Assurance Framework	Director of Corporate Governance/Board Secretary	Assistant Director of Assurance & Risk
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Corporate Governance, Assurance Framework & Risk Management	f) Implement recommendations from external governance reviews	All Executive Directors and Directors	All Executive Directors and Directors
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Corporate Governance, Assurance Framework & Risk Management	Accountable for compliance with Welsh Health Circulars issued by Welsh Government, Ministerial Directions and Consultations	All Executive Directors and Directors	All Executive Directors and Directors
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Policies & Procedures (written control documents)	a) Maintaining a database of all written control documents	Director of Corporate Governance/Board Secretary	Assistant Director of Corporate Legal Services and Public Affairs
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Policies & Procedures (written control documents)	b) Manage the process for developing and reviewing written control documents	Director of Corporate Governance/Board Secretary	Assistant Director of Corporate Legal Services and Public Affairs
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Policies & Procedures (written control documents)	c) Approval of written control documents	Appropriate committee as per Written Control Document Scheme of Delegation *Owning groups & approving committees - clinical written control documentation	As per Written Control Document Scheme of Delegation *Owning groups & approving committees - clinical written control documentation
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	N/A	Board Secretariat	Director of Corporate Governance/Board Secretary	Assistant Director of Assurance and Risk
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Board Development & Committee Management	a) Establish a process for establishment & abolition of committees and groups	Director of Corporate Governance/Board Secretary	Assistant Director of Assurance and Risk

SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Board Development & Committee Management	b) Establish procedures on the management of committees and groups to ensure consistency and good governance	Director of Corporate Governance/Board Secretary	Assistant Director of Assurance and Risk
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Board Development & Committee Management	c) Board and Committee development	Director of Corporate Governance/Board Secretary	Assistant Director of Assurance and Risk
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	N/A	Regulatory and inspections coordination and assurance	Director of Corporate Governance/Board Secretary	Assistant Director of Assurance & Risk
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Legal Advice	a) Engagement of UHB solicitors	Director of Corporate Governance/Board Secretary Director of Workforce & OD for workforce related matters	Assistant Director of Corporate Legal Services and Public Affairs Assistant Director of People Management for workforce related matters
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Legal Advice	b) Authority to seek legal advice – all issues	Director of Corporate Governance/Board Secretary Director of Workforce & OD for workforce related matters	Assistant Director of Corporate Legal Services and Public Affairs Assistant Director of People Management for workforce related matters
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Legal Advice	Legal partnership functions and regionalisation solution discussions with SBUHB	Director of Corporate Governance/Board Secretary	Assistant Director of Corporate Legal Services and Public Affairs
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Partnership Working	Partnership Working with SBUHB	Chief Executive	Director of Strategy and Planning
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Partnership Working	Health Board link with Llais	Director of Strategy and Planning	Director of Strategy and Planning
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	N/A	Arrangements that appropriate insurance/indemnity is in place (Corporate)	Director of Corporate Governance/Board Secretary	Assistant Director of Corporate Legal Services and Public Affairs
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	N/A	Arrangements that appropriate insurance/indemnity is in place (Nursing and Midwifery)	Director of Nursing, Quality & Patient Experience	Assistant Director ~~of Nursing~~ (Legal and Patient Support)/Assistant Director of Nursing (Professional Standards and Regulation)
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	N/A	Maintenance of the University status of the organisation.	Medical Director	Director for Research & Innovation and University Partnerships
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	N/A	COVID-19 Inquiry	Director of Corporate Governance/Board Secretary	Assistant Director of Corporate Legal Services and Public Affairs
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Freedom of information Act (FOI)	a) Coordinate the collecting of information to prepare FOI responses within statutory deadlines	Director of Corporate Governance/Board Secretary	Assistant Director of Corporate Legal Services and Public Affairs
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Freedom of information Act (FOI)	b) Sign off of Final Responses	Relevant Lead Executive Director or Director	Assistant Director of Corporate Legal Services and Public Affairs

SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Freedom of information Act (FOI)	c) Undertake internal reviews/complaints relating to FOI	Director of Nursing, Quality & Patient Experience	Director of Nursing, Quality & Patient Experience
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Public Engagement	a) Develop and implement public engagement strategy	Communications and Engagement Director	Head of Engagement
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Public Engagement	b) Ensure public participation in service design and decision making	Communications and Engagement Director	Head of Engagement
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Stakeholder Engagement & Management (excluding armed forces)	a) Organising a continuous programme of stakeholder events across Hywel Dda	Communications and Engagement Director	Head of Engagement
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Stakeholder Engagement & Management (excluding armed forces)	b) Supporting services in engaging with staff, patients and the public during service change	Communications and Engagement Director	Head of Engagement
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Stakeholder Engagement & Management (including armed forces)	c) Engaging with armed forces, carers, staff, refugees, asylum seekers and those with sensory impairment	Director of Workforce & OD	Assistant Director of Workforce & OD, Business Support, Strategic Partnerships, Diversity & Inclusion
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Communications	a) External Communications including relationships with press, key stakeholders and the public	Communications and Engagement Director	Assistant Director of Communications ~~and Engagement~~
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Communications	b) Internal communications with staff (Corporate Information)	Communications and Engagement Director	Assistant Director of Communications ~~and Engagement~~
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Communications	c) Developing and maintaining the organisation's external website, staff intranet, social media and e-Communications	Communications and Engagement Director	Assistant Director of Communications ~~and Engagement~~
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Communications	d) Responsibility for the effective implementation, delivery and evaluation of the organisation's Communications and Engagement Strategy	Communications and Engagement Director	Assistant Director of Communications ~~and Engagement~~
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Annual Report	a) Annual Report - Ensure the necessary disclosures on governance and the workings of the Board through the preparation, publication and distribution of the Accountability Report including the Annual Governance Statement	Director of Corporate Governance/Board Secretary	Assistant Director of Assurance and Risk

SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Annual Report	b) Annual Report - Performance Report	Communications and Engagement Director	~~Head~~ Assistant Director of Communications
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Policy Development	a) Accountability for all communications and engagement policies ensuring their application within the organisation and ensuring any joint policies agreed with local partners are also applied consistently amongst key partners, including reference to the Health Board's branding, corporate identity, etc	Communications and Engagement Director	Communications and Engagement Director
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Sponsorship	a) Sponsorship to attend courses and conferences	Executive Directors/Directors/*Clinical Care Group Service/Director/Heads of Service/General Managers*	Individual is responsible for completing Gifts, Hospitality & Sponsorship form
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Sponsorship	b) Sponsorship of HB events	Communications and Engagement Director	Assistant Director of Communications ~~and Engagement~~
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Advertising	a) Relating to recruitment	Director of Workforce & OD	Assistant Director of People Management ~~Workforce & OD (Resourcing &~~
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Advertising	b) Other	Communications and Engagement Director	Assistant Director of Communications ~~and Engagement~~
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Welsh Language	a) Compliance with the Welsh Language Act 1993 and the Welsh Language Standards	Communications and Engagement Director	Welsh Language Service Manager
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Welsh Language	b) Welsh translation services	Communications and Engagement Director	Welsh Language Service Manager
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Welsh Language	c) Welsh Language Strategy and development	Communications and Engagement Director	Welsh Language Service Manager
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Partnership Governance	a) Maintain a partnership governance framework to ensure a consistent approach of working across partners	Director of Public Health	Assistant Director of Workforce & OD, Business Support, Strategic Partnerships, Diversity & Inclusion
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Partnership Governance	b) Performance management and monitoring of outcomes of work delivered through partnerships and other inter-organisational arrangements	Director of Public Health	Assistant Director of Workforce & OD, Business Support, Strategic Partnerships, Diversity & Inclusion
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Partnership Governance	Regional Partnership Board Governance	Director of Primary Care, Community Strategy and Long Term Care	Assistant Director of Primary Care
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Partnership Governance	Public Services Board Governance	Director of Public Health	Director of Public Health

SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	N/A	International Health Partnerships (Working Overseas)	Director of Public Health	Director of Public Health
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	N/A	International Health Partnerships (Volunteering)	Director of Public Health	Director of Public Health
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Equality, Diversity and Human Rights	Compliance with the Equality Act 2010 and Public Sector Equality Duty (2016)	Director of Public Health	Assistant Director of Workforce & OD, Business Support, Strategic Partnerships, Diversity & Inclusion
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Committee Lead	a) Public Board	Chief Executive	Chief Executive
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Committee Lead	b) Audit and Risk Assurance Committee	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Committee Lead	c) People, Organisational Development & Culture Committee	Director of Workforce & OD	Director of Workforce & OD
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Committee Lead	d) Quality, Safety and Experience Committee	Director of Nursing, Quality & Patient Experience	Director of Nursing, Quality & Patient Experience
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Committee Lead	e) Charitable Funds Committee	Director of Nursing, Quality & Patient Experience	Director of Nursing, Quality & Patient Experience
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Committee Lead	f) Mental Health Legislation Committee	Chief Operating Officer	Chief Operating Officer
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Committee Lead	g) Finance and Performance ~~Sustainable Resources~~ Committee	Director of Finance	Director of Finance
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Committee Lead	h) Health and Safety Committee	Director of Allied Health Professions and Health Science	Director of Allied Health Professions and Health Science
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Committee Lead	i)Remuneration and Terms of Service Committee	Chief Executive	Chief Executive
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Committee Lead	j) Strategy and Planning ~~Strategic Development and Operational Delivery~~ Committee	Director of Strategy and Planning	Director of Strategy and Planning
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Committee Lead	k) Digital, Data and Innovation Committee	Director of Finance	Director of Finance
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Committee Lead	l) Healthcare Professionals Forum	Director of Allied Health Professions and Health Science	Director of Allied Health Professions and Health Science
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Committee Lead	m) Stakeholder Reference Group	Communications and Engagement Director	Communications and Engagement Director
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Committee Lead	n) Staff Partnership Forum	Director of Workforce & OD	Director of Workforce & OD
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	N/A	Targeted Intervention SRO	Director of Strategy and Planning	Deputy Director of Operational Planning and Commissioning

SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	N/A	Medical Examiners Service	Medical Director	Medical Director
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	N/A	Engagement with Education Providers	Director of Workforce & OD	Assistant Director of People Development
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	Staff Engagement and Support	a) Occupational Health Service	Director of Workforce & OD	~~Deputy Director of Workforce & OD~~/Assistant Director of People Management
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	Staff Engagement and Support	b) Staff psychological well-being	Director of Workforce & OD	Assistant Director of OD
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	Staff Engagement and Support	c) Staff communication (corporate)	Director of Workforce & OD	Communications and Engagement Director
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	Staff Engagement and Support	d) Staff engagement on service change	Director of Workforce & OD	Communications and Engagement Director
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	Staff Engagement and Support	e) Speak Up Safely	Director of Workforce & OD	Assistant Director of OD
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	Workforce Planning, recruitment and retention	a) Develop & implement a workforce strategy	Director of Workforce & OD	Assistant Director of People Planning
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	Workforce Planning, recruitment and retention	b) Establish & implement workforce plans to address key performance measures in sickness reduction, appraisal rates, mandatory training, job planning and employee relations, support & investigation	Director of Workforce & OD	Head of Strategic Workforce Planning
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	N/A	Organisational Development Strategy	Director of Workforce & OD	Assistant Director of OD
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	N/A	Staff Side and Employee Relations	Director of Workforce & OD	Head of Workforce
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	N/A	Workforce Equality and Diversity	Director of Workforce & OD and Director of Public Health	Assistant Director of Workforce & OD, Business Support, Strategic Partnerships, Diversity & Inclusion
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	Medical Staffing	a) Authorisation above medical and locum cap	Medical Director	Assistant Director (Medical Directorate)
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	Medical Staffing	b) Job Planning	Medical Director	Assistant Director (Medical Directorate)
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	Medical Staffing	c) Monitoring and quality assurance of job plans	Medical Director	Assistant Director (Medical Directorate)
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	Disciplinary investigations and dismissal of staff	a) Chief Executive i) Suspension/ Exclusion ii) Dismissal	Chair of the Board	N/A

SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	Disciplinary investigations and dismissal of staff	b) Director i) Suspension/ Exclusion ii) Dismissal	Chief Executive	N/A
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	Disciplinary investigations and dismissal of staff	c) All Other Staff (excluding Medical and Dental) i) Suspension/ Exclusion ii) Dismissal	Appropriate Line Manager (must be minimum of Band 7) Appropriate Senior Manager (normally will be minimum of Band 8)	N/A
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	Disciplinary investigations and dismissal of staff	d) Medical and Dental Staff i) Suspension/ Exclusion ii) Dismissal	See UPSW (or any subsequent policy which replaces UPSW) Medical Director (or nominated deputy)	N/A
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	Disciplinary investigations and dismissal of staff	Dismissal of Primary Care contracted Medical and Dental staff (and other Contractor professionals) i.e Optometry and Community Pharmacy	Director of Primary Care, Community Strategy and Long Term Care	Director of Primary Care, Community Strategy and Long Term Care
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	N/A	Workforce policies and procedures	Director of Workforce & OD	Head of Workforce
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	N/A	Finance Professional Leadership	Director of Finance	Assistant Directors of Finance and Head of Service Modernisation
SCHEME OF DELEGATION FROM	N/A	CORPORATE	N/A	Responsibility for Quality Impact Assessment	Director of Nursing, Quality & Patient Experience	Director of Nursing, Quality & Patient Experience
SCHEME OF DELEGATION FROM	N/A	CORPORATE	N/A	Responsibility for Integrated Impact Assessment	Director of Nursing, Quality & Patient Experience	Director of Nursing, Quality & Patient Experience
LEGISLATION COMPLIANCE	N/A	Concerns	N/A	NHS Redress (Wales) Measure 2008 (2008 nawm1) - Measures of the Welsh Director of Nursing, Quality & Patient Experience Assistant Director (Legal & Patient Experience) Government to make provision about arrangements for redress in relation to liability in connection with services provided as part of the health service in Wales	Director of Nursing, Quality & Patient Experience	Assistant Director ~~of Nursing~~ (Legal and Patient Support)
LEGISLATION COMPLIANCE	N/A	Concerns	N/A	The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011	Director of Nursing, Quality & Patient Experience	Assistant Director ~~of Nursing~~ (Legal and Patient Support)
LEGISLATION COMPLIANCE	N/A	Corporate	N/A	The Well-being of Future Generations (Wales) Act 2015	Director of Public Health	Director of Public Health
LEGISLATION COMPLIANCE	N/A	Corporate	N/A	Social Services and Well-being (Wales) Act 2014	Director of Primary Care, Community Strategy and Long Term Care	Director of Primary Care, Community Strategy and Long Term Care
LEGISLATION COMPLIANCE	N/A	Corporate	N/A	The Partnership Arrangements (Wales) Regulations 2015	Director of Primary Care, Community Strategy and Long Term Care	Assistant Director of Primary Care
LEGISLATION COMPLIANCE	N/A	Corporate	N/A	Charities Act 2011	Director of Nursing, Quality & Patient Experience	Head of Hywel Dda Health Charities

LEGISLATION COMPLIANCE	N/A	Corporate	N/A	Charities Act 2022	Director of Nursing, Quality & Patient Experience	Head of Hywel Dda Health Charities
LEGISLATION COMPLIANCE	N/A	Corporate	N/A	The National Health Service Act 1977	Chief Executive	All Executives
LEGISLATION COMPLIANCE	N/A	Corporate	N/A	The National Health Services (Wales) Act 2006	Chief Executive	All Executive Directors/Directors
LEGISLATION COMPLIANCE	N/A	Corporate	N/A	The Health and Social Care (Quality and Engagement) (Wales) Act 2020	Director of Nursing, Quality & Patient Experience	All Executive Directors/Directors
LEGISLATION COMPLIANCE	N/A	Corporate	N/A	The Local Health Boards (Establishment and Dissolution) (Wales) Order 2009	Chief Executive	Director of Corporate Governance/Board Secretary
LEGISLATION COMPLIANCE	N/A	Corporate	N/A	The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009	Chief Executive	Director of Corporate Governance/Board Secretary
LEGISLATION COMPLIANCE	N/A	Corporate	N/A	The Local Health Boards (Directed Functions) (Wales) Regulations 2009	Chief Executive	Director of Corporate Governance/Board Secretary
LEGISLATION COMPLIANCE	N/A	Corporate	N/A	The Local Health Boards (Transfer of Staff, Property, Rights and Liabilities) (Wales) Order 2009	Chief Executive	Director of Corporate Governance/Board Secretary
LEGISLATION COMPLIANCE	N/A	Corporate	N/A	The Local Health Boards (Establishment and Dissolution) (Wales) (Amendment) Order 2013	Chief Executive	Director of Corporate Governance/Board Secretary
LEGISLATION COMPLIANCE	N/A	Equality	N/A	Equality Act 2010 - A legal framework to protect the rights of individuals and advance equality of opportunity for all	Director of Workforce & OD	Assistant Director of Workforce & OD, Business Support, Strategic Partnerships, Diversity & Inclusion
LEGISLATION COMPLIANCE	N/A	Equality	N/A	Human Rights Act 1998 - Codifies the protections in the European Convention on Human Rights into UK law	Director of Workforce & OD	Assistant Director of Workforce & OD, Business Support, Strategic Partnerships, Diversity & Inclusion
LEGISLATION COMPLIANCE	N/A	Equality	N/A	Welsh Language Act 1993 – Establishes the principle that Welsh and English languages should be treated on the basis of equality, in the conduct of public business in Wales	Communications and Engagement Director	Communications and Engagement Director
LEGISLATION COMPLIANCE	N/A	Equality	N/A	Welsh Language (Wales) Measure 2011	Communications and Engagement Director	Communications and Engagement Director
LEGISLATION COMPLIANCE	N/A	Estates	N/A	Pollution Prevention and Control Act 1999 & Environmental Permitting Regulations 2010 (previously The Radioactive Substances Act 1993) - Inspections regarding Radioactive Waste, etc. Under Radioactive Substance Act 1993. Registration to keep radioactive substances and authorisation to store and dispose of radioactive waste to comply with the requirements	Director of Allied Health Professions and Health Science	Estates & Facilities Clinical Care Group Service Director
LEGISLATION COMPLIANCE	N/A	Estates	N/A	Energy Act 2008 (c.32) - Combined Heat and Power Quality Assurance (CHPQA)	Director of Allied Health Professions and Health Science	Estates & Facilities Clinical Care Group Service Director
LEGISLATION COMPLIANCE	N/A	Health & Safety	N/A	Health and Safety at Work Act 1974 & Secondary Legislation (Regulations)	Director of Allied Health Professions and Health Science	All Executive Directors/Directors, Clinical Care Group Service Directors, Clinical Service Group General Managers, Assistant Director of EFCM, Digital Director, Deputy Chief Operating Officer

LEGISLATION COMPLIANCE	N/A	Health & Safety	N/A	Fire & Rescue Services Act 2005 & Regulatory Reform (Fire Safety) Order 2005	Director of Allied Health Professions and Health Science ~~Chief Operating Officer~~	All Executive Directors/Directors, Clinical Care Group Service Directors, Clinical Service Group General Managers, Assistant Director of EFCM, Digital Director, Deputy Chief Operating Officer
LEGISLATION COMPLIANCE	N/A	Health & Safety	N/A	Ionising Radiation (Medical Exposure) Regulations 1999	Director of Allied Health Professions and Health Science	Head of Radiology
LEGISLATION COMPLIANCE	N/A	Information Governance	N/A	General Data Protection Regulations 2018 - Protection of personal information	Director of Finance	Digital Director and Head of Information Governance
LEGISLATION COMPLIANCE	N/A	Information Governance	N/A	General Data Protection Regulations 2018 - Non Medical Subject Access Requests	Director of Finance	Digital Director and Head of Information Governance
LEGISLATION COMPLIANCE	N/A	Information Governance	N/A	General Data Protection Regulations 2018 - Acute Subject Access Requests	Chief Operating Officer	Acute Records Manager
LEGISLATION COMPLIANCE	N/A	Information Governance	N/A	General Data Protection Regulations 2018 - Mental Health Subject Access Requests	Chief Operating Officer	Mental Health Administrator
LEGISLATION COMPLIANCE	N/A	Information Governance	N/A	Access to Health Records Act 1990 - Access to the health records of a deceased person	Chief Operating Officer	Health Records Manager/ Mental Health Administrator
LEGISLATION COMPLIANCE	N/A	Information Governance	N/A	Common Law duty of Confidentiality	Director of Finance	Digital Director
LEGISLATION COMPLIANCE	N/A	Information Governance	N/A	Computer Misuse Act 1990 – Securing computer material against unauthorised access or modification; and for connected purposes	Director of Finance	Digital Director
LEGISLATION COMPLIANCE	N/A	Information Governance	N/A	Freedom of Information Act 2000 - Provides public access to information held by public authorities	Director of Corporate Governance/Board Secretary	Assistant Director of Corporate Legal Services and Public Affairs
LEGISLATION COMPLIANCE	N/A	Information Governance	N/A	Environmental Information Regulations 2004	Director of Corporate Governance/Board Secretary	Assistant Director of Corporate Legal Services and Public Affairs
LEGISLATION COMPLIANCE	N/A	Medicines Management	N/A	Health Act 2006 (c.28) & Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008 (under Health Act 2006)	Medical Director	Head of Medicines Management
LEGISLATION COMPLIANCE	N/A	Medicines Management	N/A	Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008 (under Health Act 2006) - Regulations on the management of Controlled Drugs (Jan 2009)	Medical Director	Head of Medicines Management
LEGISLATION COMPLIANCE	N/A	Medicines Management	N/A	Misuse of Drugs Act 1971 (c.38) & Misuse of Drugs Act 2001- Restriction relating to production, supply, possession and destruction of controlled drugs	Medical Director	Pharmaceutical & Prescribing Manager, Head of Medicines Management
LEGISLATION COMPLIANCE	N/A	Mental Health	N/A	Mental Health Act 1983	Chief Operating Officer	~~Director of~~ Mental Health & Learning Disabilities Clinical Care Group Service Director
LEGISLATION COMPLIANCE	N/A	Mental Health	N/A	Mental Health (Wales) Measure 2010	Chief Operating Officer	~~Director of~~ Mental Health & Learning Disabilities Clinical Care Group Service Director
LEGISLATION COMPLIANCE	N/A	Patient Safety	N/A	Human Tissue Act 2004 – Licence Holder	Director of Allied Health Professions and Health Science	Director of Research, Innovation and University Partnerships and Consultant Histopathologist (Pathology Lead)
LEGISLATION COMPLIANCE	N/A	Patient Safety	N/A	Human Transplantation (Wales) Act 2013	Chief Operating Officer	Consultant Histopathologist (Pathology Lead)

LEGISLATION COMPLIANCE	N/A	Patient Safety	N/A	Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015	Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing for Quality, Assurance & Professional Regulation
LEGISLATION COMPLIANCE	N/A	Patient Safety	N/A	Nurse Staffing Levels (Wales) Act 2016	Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing (Nursing Practice)
LEGISLATION COMPLIANCE	N/A	Patient Safety	N/A	Health and Social Care (Quality and Engagement) (Wales) Act 2020 - The Duty of Quality	Director of Nursing, Quality & Patient Experience	Deputy Director Nursing, Quality & Patient Experience/Assistant Director of Nursing Quality & Governance
LEGISLATION COMPLIANCE	N/A	Patient Safety	N/A	Health and Social Care (Quality and Engagement) (Wales) Act 2020 - The Duty of Candour	Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing Quality & Governance ~~(Legal and Patient Support)~~
LEGISLATION COMPLIANCE	N/A	Public Health	N/A	Public Health (Control of Diseases) Act 1984 (c.22) & Health Protection (Notification) (Wales) Regulations 2010 - Cases of notifiable diseases, death and disposal of bodies	Director of Public Health	Head of Health Emergency Planning
LEGISLATION COMPLIANCE	N/A	Public Health	N/A	Smoke-Free Premises (Wales) Regulations 2007	Director of Public Health	Public Health Officer (Tobacco)
LEGISLATION COMPLIANCE	N/A	Public Involvement	N/A	Local Government and Public Involvement in Health Act 2007 (c.28) – Disclosure of information, ethical standards, patient and public involvement	Director of Public Health	Communications and Engagement Director
LEGISLATION COMPLIANCE	N/A	Public Safety	N/A	Civil Contingencies Act 2004 - Establishes a coherent framework for emergency planning	Director of Public Health	Head of Health Emergency Planning
LEGISLATION COMPLIANCE	N/A	Safeguarding	N/A	Children's Act 1989, 2004 - Provides the legislative framework for child protection in Wales	Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing for Quality, Assurance & Professional Regulation
LEGISLATION COMPLIANCE	N/A	Safeguarding	N/A	Care Standards Act 2000 - Provides for the administration of a variety of care institutions, including, independent hospitals, nursing homes and residential care homes	Director of Primary Care, Community Strategy and Long Term Care	Head of Long Term Care
LEGISLATION COMPLIANCE	N/A	Safeguarding	N/A	Protecting Vulnerable Groups Act 2006 - Provides the legislative framework for the new Vetting and Barring scheme	Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing for Quality, Assurance & Professional Regulation
LEGISLATION COMPLIANCE	N/A	Safeguarding	N/A	Mental Capacity Act 2005 - Provides a statutory framework for people who lack capacity to make decisions for themselves	Chief Operating Officer	Head of Consent & Mental Capacity
LEGISLATION COMPLIANCE	N/A	Finance	N/A	The Social Partnership and Public Procurement (Wales) Act 2023 (effective from 1 April 2024).	Director of Finance	Director of Finance
LEGISLATION COMPLIANCE	N/A	Partnerships	N/A	The Social Partnership and Public Procurement (Wales) Act 2023 (effective from 1 April 2024).	Director of Public Health	Director of Public Health
LEGISLATION COMPLIANCE	N/A	Childrens	N/A	Corporate Parenting Charter 2024	Chief Operating Officer	Community and Integrated Medicine Clinical Care Group Service Director
LEGISLATION COMPLIANCE	N/A	Childrens	N/A	Additional Learning Needs and Education Tribunal (Wales) Act 2018	Director of Allied Health Professions and Health Science	Director of Allied Health Professions and Health Science
CAPITAL SCHEMES	N/A	N/A	N/A	Women & Children's Phase 2. GGH	Director of Acute Services (SRO)	Project Director - Lisa Humphrey
CAPITAL SCHEMES	N/A	N/A	N/A	Fire Enforcement Work WGH	Director of Strategy and Planning (SRO)	Project Director - RE - Director of Estates, Facilities & Capital Management (to replace with new job title)

CAPITAL SCHEMES	N/A	N/A	N/A	Fire Enforcement Work GGH	Director of Strategy and Planning (SRO)	Project Director - RE - Director of Estates, Facilities & Capital Management (to replace with new job title)
CAPITAL SCHEMES	N/A	N/A	N/A	Diagnostic Imaging – All Schemes	Chief Operating Officer (SRO)	Project Director - Clinical Care Director for Radiology ~~Sarah Perry~~
CAPITAL SCHEMES	N/A	N/A	N/A	Carmarthen Hwb	Director of Strategy and Planning (SRO)	Project Director - Joanna Jones ~~TBC~~
CAPITAL SCHEMES	N/A	N/A	N/A	Cross Hands Health & Wellbeing Centre, Cross Hands, Carmarthenshire	Director of Primary Care, Community Strategy and Long Term Care	Project Director - Sarah Perry ~~TBC~~
CAPITAL SCHEMES	N/A	N/A	N/A	Aseptic Unit, Withybush General Hospital	Director of Primary Care, Community Strategy and Long Term Care	Project Director - Owain Williams ~~Christopher Brown~~
CAPITAL SCHEMES	N/A	N/A	N/A	Business Continuity Programme Business Case	Director of Strategy and Planning (SRO)	Project Director - RE - Director of Estates, Facilities & Capital Management (to replace with new job title)
CAPITAL SCHEMES	N/A	N/A	N/A	Cylch Caron, Tregaron	Director of Primary Care, Community Strategy and Long Term Care	Clinical Care Group Service Director – Community and Integrated Medicine
CAPITAL SCHEMES	N/A	N/A	N/A	Aberystwyth Integrated Care Centre	Chief Operating Officer (SRO)	Clinical Care Group Service Director – Community and Integrated Medicine
CAPITAL SCHEMES	N/A	N/A	N/A	Fishguard Wellbeing Centre	Director of Primary Care, Community Strategy and Long Term Care	Jessica Svetz ~~Care Group Director~~
CAPITAL SCHEMES	N/A	N/A	N/A	Llandovery Health and Wellbeing Hub	Director of Strategy and Planning (SRO)	Project Director - TBC
CAPITAL SCHEMES	N/A	N/A	N/A	Chemotherapy Day Unit Bronglais	Chief Operating Officer (SRO)	Project Director - Clinical Care Group Service Director – Community and Integrated Medicine

3

10:10, 0 Mins

3 - Audit Wales

3.1 **10:10, 5 Mins**

3.1 - Audit Wales Update Report

Urvisha Perez

For assurance

Attachments

3.1 Audit Wales ARAC Update (15.04.25).pdf

Archwilio Cymru
Audit Wales

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

Date issued: April 2025

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

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

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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 Annual Report and Accounts	Director of Finance	To provide an audit opinion on the Health Board's 2024-25 Annual Report and Accounts.	Audit Planning	June 2025
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.	Not yet started	To be confirmed

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 2024 Structured Assessment will review: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and Corporate financial planning and management arrangements.	Planning	December 2025

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

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

Area of work	Executive Lead	Focus of the work	Status	Planned date for consideration
Review of the management of outpatients (Local work 2024)	Director of Operations	The focus of this work will be the management of outpatients, including assessing the Health Board's progress on the recommendations made in our 2015 and 2018 Review of Follow-up Outpatient Appointments. We will keep the Audit and Risk Assurance Committee updated as we develop this work.	Fieldwork underway	August 2025
Structured Assessment 2025 Deep Dive - review of the arrangements to manage estates	To be confirmed	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 already underway examining the Health Board's arrangements for managing capital prioritisation.	Planning	To be confirmed

Area of work	Executive Lead	Focus of the work	Status	Planned date for consideration
Review of cancer services	To be confirmed	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	To be confirmed
Review of Radiology Services (Local work 2025)	To be confirmed	This work will focus on the Health Board's radiology service, with the option to follow-up recommendations made in the 2017 radiology service report. Whilst the exact scope of this work is yet to be determined, we will assess the radiology service to ensure it is delivered efficiently, effectively, and economically, and there are clear plans to meet current and future population needs.	Planning	To be confirmed

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
The Biodiversity and Resilience of Ecosystems Duty	**March 2025**
Addressing workforce challenges in NHS Wales	**February 2025**
Cancer Services in Wales	January 2025
The National Fraud Initiative in Wales 2022-23	October 2024

Additional information

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

Title	Publication Date
Annual Plan 2025-26	April 2025

8 There are no relevant Audit Wales consultations currently underway.



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

3.2

10:15, 10 Mins

3.2 - Audit Wales Audit Plan 2025

Anne Beegan, Urvisha Perez, David Williams

For approval

Attachments

3.2 2025 Detailed Audit Plan (HDUHB).pdf

Hywel Dda University Health Board– Detailed Audit Plan 2025

Audit year: 2024-25

Date issued: March 2025

Document reference: 4786A2025



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mailto:For further information, or if you require any of our publications in an alternative format and/or language, please contact us by telephone on 029 2032 0500, or email info@audit.wales.

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

Introduction



Adrian Crompton

Auditor General for Wales

I am pleased to share my 2025 Audit Plan. The Plan sets out how I will undertake your audit.

My audit team has developed the Plan following a structured and risk-based planning process, which will remain ongoing throughout the audit. My Code of Audit Practice provides further detail on how my audit and certain other functions are to be carried out by my auditors.

At the core of all our work is our commitment to maintaining the highest standards of professional integrity, objectivity, independence and audit quality. Our three lines of assurance model (page 23) sets out how we will ensure those standards of quality are met. Our latest annual quality report, Audit Quality Report 2024, provides more information about our audit quality arrangements.

My audit team will work constructively with your staff to understand the issues you are facing, ensure the audit process operates as smoothly as possible, and provide valuable insights about any areas for improvement.

My local performance audit work programme, as outlined in this Plan, sits alongside other national audit work that may include coverage of your organisation. Local performance audit work may also inform wider national reporting.

Should you have any questions about your audit my audit team will be happy to discuss them with you. They will also keep you regularly updated as work progresses.

Our aims and ambitions

Our purpose

- Assure people that public money is being managed well
- Explain how that money is being spent
- Inspire the public sector to improve

Our vision

- Fully exploiting our unique perspective, expertise and depth of insight
- Strengthening our position as an authoritative, trusted and independent voice
- Increasing our visibility, influence, and relevance
- Being a model organisation for the public sector in Wales and beyond

Our areas of focus

- A strategic, dynamic, and high-quality audit programme
- A targeted and impactful approach to communications and influencing
- A culture and operating model that enables us to thrive

You can find out more about Audit Wales in our Annual Plan 2024-25 and Our Strategy 2022-27.

Financial audit work

Audit of financial statements

I am required to issue a report on your financial statements which includes an opinion on their 'truth and fairness', their proper preparation in accordance with accounting and legal requirements, and the regularity of income and expenditure and the proper preparation of key elements of your Accountability and Performance Report. I lay them before the Senedd together with any report that I make on them.

I will also report by exception on a number of matters which are set out in more detail in our Statement of Responsibilities.

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

There have been no limitations imposed on me in planning the scope of this audit.

Financial statements materiality

I do not seek to obtain absolute assurance on the truth and fairness of the financial statements and related notes but adopt a concept of materiality. My aim is to identify material and correct misstatements, that is, those that might result in a reader of the accounts being misled. Materiality applies not only to financial misstatements, but also to disclosure requirements and adherence to the applicable accounting framework and law.

I set planning and performance materiality to:

- Determine the level of misstatement that could cause the user of the accounts to be misled;
- Assist in the scoping of our audit approach and resultant audit tests;
- Determine sample sizes;
- Assess the effect of known and likely misstatements in the financial statements; and

- Report to those charged with governance any unadjusted misstatements above a trivial level, our reporting threshold.

The levels at which I judge such misstatements to be material is set out below.

Planning materiality

represents 1% of gross expenditure based upon 2023/24 audited financial statements.

£13.39m

Performance materiality

represents 75% of materiality.

£10.04m

Reporting threshold (trivial)

represents 5% of materiality.

£0.67m

There are some areas of the accounts that may be of more importance to the user of the accounts, and we have set a lower materiality level for these:

Remuneration report

£5,000 (including exit packages)

Related party disclosures

£10,000 (Individuals)
£13.39m (Other Bodies)

My audit team will assess materiality levels throughout the audit.

Significant financial statements risks

Significant risks are identified risks of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk or those which are to be treated as a significant risk in accordance with the requirements of other International Standard on Auditing (ISAs). The ISAs require us to focus more attention on these significant risks.

Risk of management override

The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].

Our planned response

My audit team will:

- test the appropriateness of journal entries and other adjustments made in preparing the financial statements;
- review accounting estimates for bias; and
- evaluate the rationale for any significant transactions outside the normal course of business.

Other areas of focus

I set out below other identified risks of material misstatement which, although not determined to be significant risks as above, I would like to bring to your attention.

Failure of financial duties

Health Boards are required to meet two statutory duties – known as the first and second financial duties.

The Health Board will fail to meet your first financial duty to break even over a three-year period. The position at month 10 shows a year-to-date deficit of £21.003 million and a forecast year-end deficit of £24.000 million. This, combined with the outturns for 2022-23 and 2023-24, predicts a three-year deficit of £148.859 million.

Where you fail this financial duty, we will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion.

Whilst there is virtually no risk of management judgements and estimates being biased to enable the Health Board to achieve the financial duty to break-even over three years, there is however an expectation that the Health Board will meet its in-year control total set by Welsh Government of £31.5m (deficit).

The second financial duty requires Health Boards to prepare and have approved by Welsh Ministers a rolling three-year integrated medium-term plan. Should you fail this financial duty, we will place a substantive report on the financial statements highlighting this fact.

Our planned response

My audit team will.

- continue to monitor the Health Board's financial position for 2024-25 and the cumulative three-year position to 31 March 2025; and
- undertake testing on areas of the financial statements which contain judgements such as year-end accruals; to ensure that transactions have been reported in the correct accounting period.

Remuneration report disclosures

There have been some new permanent and interim appointments to senior officer and board member posts during 2024-25 which need to be captured in the remuneration report.

There is a risk that these are not appropriately disclosed in the remuneration report as remuneration paid to senior officers and board members continues to be of high interest and is material by nature.

Therefore, there is a risk that even low value errors in the disclosure could result a material misstatement.

Our planned response

My audit team will:

- understand the movements in the senior management team during 2024-25;
- ensure that remuneration disclosed is consistent with supporting evidence;
- ensure that amounts paid are consistent with those approved by the Board and are in accordance with Welsh Government pay rates; and
- ensure that disclosures are complete based on the team's knowledge and are prepared in accordance with requirements.

Valuation of property assets

The value of property assets reflected in the balance sheet and notes to the accounts are material estimates.

Property assets are required to be held on a valuation basis which is dependent on the nature and use of the assets. This estimate is subject to a high degree of subjectivity, depending on the specialist and management assumptions, and changes in these can result in material changes to valuations.

Assets are required to be formally revalued every five years as a minimum, with indexation applied in interim years, but values may also change year on year, particularly where there are ongoing refurbishment projects resulting in subsequent expenditure being capitalised.

There is a risk that the carrying value of assets recognised in the accounts could be materially different to the current value of assets as at 31 March 2025.

Our planned response

My audit team will:

- review the indices used by management for reasonableness;
- evaluate the competence, capabilities and objectivity of the professional valuer who provide indices to management and undertake valuations as necessary;
- test a sample of assets revalued in the year to ensure the valuation basis, key data and assumptions used in the valuation process are reasonable, and the revaluations have been correctly reflected in the financial statements;
- confirm that indexation has been appropriately applied and has been correctly reflected in the financial statements; and
- test the reconciliation between the financial ledger and the asset register.

Related party disclosures

The financial statements must disclose any related party relationships along with the transactions and balances between the Health Board and the other body/party.

The Health Board has many relationships that could be considered a related party. Many are well known for example, Welsh Government as funder.

However, where related party relationships arise via individual officer or member relationships, there is likely to be less transparency regarding these relationships. These transactions are of high interest and are considered to be material by their nature

There is a risk of material misstatement due to incomplete or inaccurate disclosures, even where these are of relatively low value.

Our planned response

My audit team will:

- review management's process for identifying related party relationships and associated transactions and balances;
- undertake procedures to confirm the completeness of related party relationships; and
- ensure disclosures are complete, accurate, consistent with evidence and are in accordance with requirements.

Financial statements audit timetable

Below is a timetable showing the key stages of the audit and our key audit deliverables that we will provide to you.

Exhibit 1: Financial statements audit timetable

Planning **January to March 2025**	Planning meeting High level risk assessment procedures Draft Outline Audit Plan Fraud risk assessment Accounting estimates planning IT environment risk assessment Indicative audit fee Draft Detailed Audit Plan
Interim **January to March 2025**	Information flows Detailed risk assessment procedures IT controls review Develop testing strategy Early sample testing
Fieldwork **May to June 2025**	Update risk assessment Audit of financial statements to include narrative report and annual governance statement Complete audit testing Evaluate audit findings Audit closure meeting

Reporting	
June to July 2025	Audit of Accounts Report Recommendations for improvement Present findings to those charged with governance Auditor General certification Submission of accounts to Welsh Government Laying of accounts with Senedd Cymru Annual audit summary Post project learning

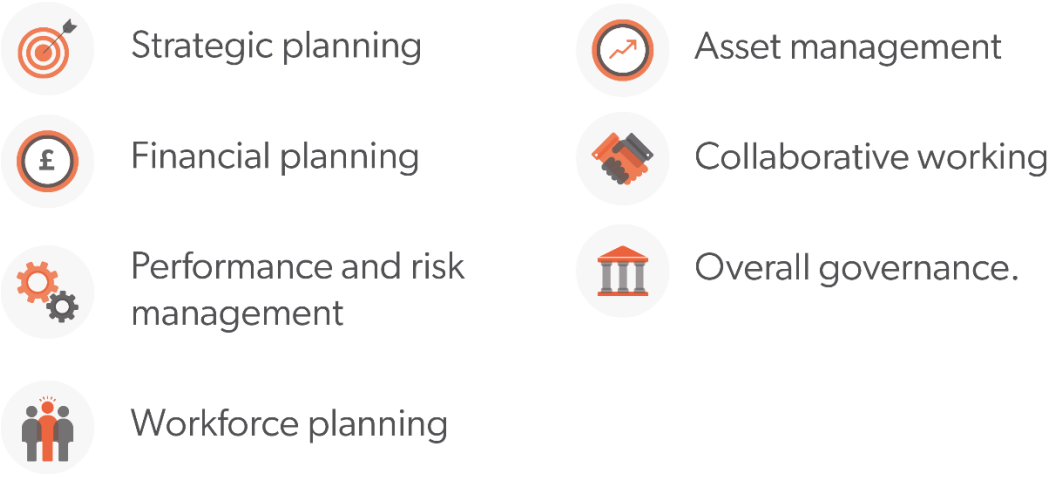
Performance audit work

Proper arrangements

As set out in the Code of Audit Practice, I must satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources ('value for money'), and conclude accordingly.

I do this by undertaking an appropriate programme of performance audit work each year. I base my work programme on an assessment of risks of the Health Board and the wider NHS in Wales not having the proper arrangements in place, with the work typically focusing on the areas of greatest risk.

In designing the programme, my auditors must have considered corporate and service level arrangements, including:



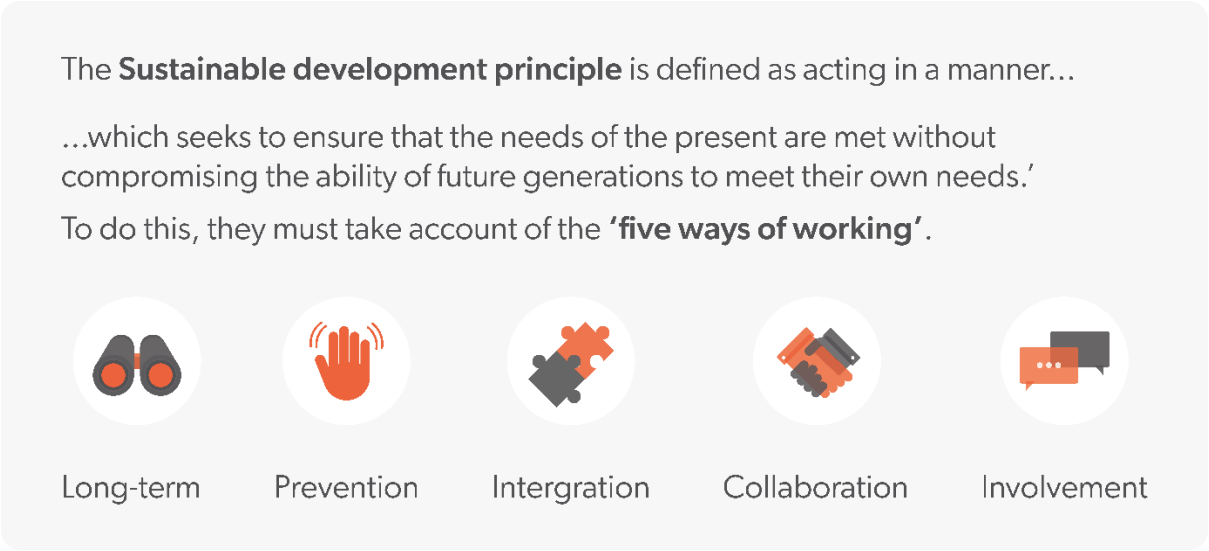
My auditors will also have taken account of relevant work that is being undertaken or planned by other audit, regulatory and inspection bodies at the Health Board.

I conduct my performance audit work using the ISSAI 3000 standard developed by the International Organisation of Supreme Audit Institutions (INTOSAI). INTOSAI is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special

consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

Well-being of future generations

Section 15 of the Well-being of Future Generations (Wales) Act 2015 (the Act) requires me to carry out examinations of public bodies for the purposes of assessing the extent to which a body has acted in accordance with the sustainable development principle when setting well-being objectives and taking steps to meet those objectives.



I must carry out these examinations at each public body covered by the Act at least once during a specified period.

These could be stand-alone examinations as part of my performance audit programme. However, where relevant and appropriate to do so, my auditors will integrate the work required into other planned performance audit work for the Health Board. My auditors will continue to engage closely with the Office of the Future Generations Commissioner for Wales to help coordinate our respective activities.

Planned performance audit work

I set out below details of my performance audit work.

Structured Assessment – core

Scope of the work

Structured assessment will continue to form a key part of the work my audit teams do at each NHS body to examine the existence of proper arrangements for the efficient, effective, and economical use of resources.

My core 2025 structured assessment work will review the following areas:

- Board and committee cohesion and effectiveness.
- Corporate systems of assurance.
- Corporate planning arrangements; and
- Corporate financial planning and management arrangements.

My structured assessment work will also include a review of the arrangements that are in place to track progress against previous audit recommendations. This allows the audit team to obtain assurance that the necessary progress is being made in addressing areas for improvement identified in previous audit work. It also enables us to more explicitly measure the impact our work is having.

Indicative timescales

Fieldwork to commence between June and August 2025 and reporting by the end of December 2025.

Structured Assessment – review of the arrangements to manage estates

Scope of the work

In addition to the core structured assessment work described above, my audit teams will also review certain arrangements at NHS bodies in more depth. This year, my audit teams 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 the work in the Health Board, my audit team will take into account the local work already underway to examine the Health Board's arrangements for managing capital prioritisation as part of my previous audit plan.

Indicative timescales

Fieldwork to commence between April and May 2025 and reporting by the end of September 2025.

All-Wales thematic review of cancer services

Scope of the work

I plan to undertake work following on from my recent review of the national leadership arrangements for cancer services. Whilst the exact focus of this work is still 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.

Indicative timescales

Fieldwork to commence between September and October 2025 and reporting by the end of March 2026.

Local project work – Review of Radiology Services

Scope of the work

Where appropriate, my audit team will also undertake performance audit work that reflects issues specific to the Health Board. The Health Board has one of the highest levels of waits over eight weeks for radiology services, risking patients receiving timely diagnostic and interventional services.

My local performance work will focus on the Health Board's radiology service, with the option to follow-up recommendations made in my 2017 radiology service report. Whilst the exact scope of this work is yet to be determined, my team will assess the radiology service to ensure it is delivered efficiently, effectively, and economically, and there are clear plans to meet current and future population needs.

Indicative timescales

Fieldwork to commence September and reporting by March 2026.

Timing of Performance Audit Work

My team will work with officers in the Health Board to arrange exact timescales for the individual projects and will be communicated regularly through our Audit Committee update. My auditors aim to substantially complete the performance audit work set out in this plan by the end of March 2026.

Audit fee

In January 2025 we published our 2025-26 Fee Scheme following approval by the Senedd Finance Committee which details the average increase to fee rates of 1.7%.

The actual fee that any individual audited body will pay depends not just on our fee rates but on the quantum of work and the skill mix required.

In 2022-23 you will recall that we implemented a fundamentally different audit approach for our financial audit work, required by new international auditing standards. This required a richer, more costly skill mix that was reflected in higher fees. We have now reviewed the implementation of this new audit approach and identified efficiencies which allow us to provide a refund of £6,627 against the 2024 audit of the financial statements fee, and to maintain a reduced fee for the audit in 2025.

Planning will be ongoing, and changes to my programme of audit work, and therefore my fee, may be required if any key new risks emerge. I shall make no changes without my auditors first discussing them with the Director of Finance. **Exhibit 2** sets out a further breakdown of your estimated audit fee.

Your estimated total audit fee: £414,625

I base my audit fee on the following assumptions:

- The agreed audit deliverables set out the expected working paper requirements to support the financial statements and include timescales and responsibilities.
- The audit requirements of my individual performance audit projects are met by the audited body, or suitable alternative arrangements are put in place that satisfy the needs of my audit team.
- No matters of significance, other than as summarised in this plan, are identified during the audit.

Exhibit 2: Breakdown of my estimated audit fee for 2025 (and 2024 for comparison)

Estimated fee for 2025 (£)[1]		Estimated fee for 2024 (£)[2, 3]	
Audit of financial statements	Performance audit work	Audit of financial statements	Performance audit work
£226,598	£188,027	£226,184	£184,852
Total fee: £414,625		**Total fee: £411,036**	

[1] The fees shown in this document are exclusive of VAT.

[2] The 2024 audit fee remains an estimate until all performance audit work is completed

[3] Includes a refund of £6,627 due to efficiencies on the audit of financial statements work

Audit team

My audit team will continue to work and engage remotely using technology, but some on-site audit work will continue where it is appropriate to do so.

Audited bodies have a responsibility to ensure the safety and wellbeing of Audit Wales staff when they are on your premises.

The main members of my team, together with their contact details, are summarised in **Exhibit 3**.

Exhibit 3: My local audit team

Engagement Director	Anthony Veale anthony.veale@audit.wales	
	Financial Audit	**Performance Audit**
Engagement Lead	Anthony Veale anthony.veale@audit.wales	Dave Thomas dave.thomas@audit.wales
Audit Manager	David Williams david.williams@audit.wales	Anne Began anne.began@audit.wales
Audit lead	Eleanor Ansell eleanor.ansell@audit.wales	Urvisha Perez urvisha.perez@audit.wales

I can confirm that my team members are all independent of the Health Board and your officers.

Staff secondment

An employee of Audit Wales was on secondment with you. In order to safeguard against any potential threats to auditor independence and

objectivity, the following restrictions apply in line with the Financial Reporting Council's Revised Ethical Standard 2024:

- the secondee will not undertake any management responsibilities; and
- the secondment will be for a maximum of 12 months.

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by the Institute of Chartered Accountants in England and Wales and our Chair of the Board, acts as a link to our Board on audit quality. For more information see our Audit Quality Report 2024.



Our People

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



Arrangements for achieving audit quality
Selection of right team

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



Independent assurance

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

Supporting you

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

3.3

10:25, 0 Mins

3.3 - Review of Urgent and Emergency Care

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

DEFERRED to 24 June 2025 meeting

For assurance

3.4

10:25, 0 Mins

3.4 - Planned Care Review

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

DEFERRED to 24 June 2025 meeting

For assurance

3.5

10:25, 20 Mins

3.5 - Cancer Services in Wales: A review of the strategic approach to improving the timeliness of diagnosis and treatment

Anne Beegan, Urvisha Perez, Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Keith Jones (Hywel Dda UHB - Director of Operational Planning & Performance)

For discussion

Attachments

3.5 Cancer Services in Wales - English.pdf

3.5 Cancer Services in Wales - Welsh.pdf

3.5 Management Response - Cancer Services.pdf

Archwilio Cymru
Audit Wales

Cancer Services in Wales:

A review of the strategic approach to improving the timeliness of diagnosis and treatment

January 2025



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Key facts

Exhibit 1: key facts

Cancer is the **leading cause of death** in Wales

Wales has the **second highest** cancer mortality in the UK. The UK has one of the highest cancer mortality rates of all OECD countries

Five-year cancer survival has improved. **62%** of people diagnosed with cancer between 2016-2022 survived at five years compared to **54%** of people diagnosed between 2002-2006

4 in 10
annual cancer cases in Wales could be prevented

At £719 million in 2022-23, spending on cancer services was the **third highest area of NHS spending** after mental health and trauma and orthopaedics

Real terms spending on cancer services has **increased by 54%** from 2009-10 to 2022-23

Since August 2020, no health board has met the overall target that **75%** of patients should start their first definitive treatment within **62 days** of first suspicion of cancer

From August 2023 to August 2024, between **53%** and **61%** of patients started treatment within **62 days**

In 2021, **24%** of cancer patients were diagnosed at stage 4 and **18%** at stage 3

Survival decreases as stage advances for all cancer types

Bowel screening eligibility has expanded in stages since October 2021. It now includes people aged **50 to 74** and uses a more sensitive test.

From July 2023 to July 2024, just **21%** of bowel screening participants referred to their health board for a colonoscopy were offered the procedure within 4 weeks against a standard of **90%**

Breast and cervical screening uptake were **below standard**

Non-melanoma skin cancer, bowel, female breast, lung and prostate cancers are the most **common cancers** in Wales

Source: Audit Wales

Notes: *Welsh Government data: NHS Expenditure by programme budget category and year, 'cancer and tumours', on StatsWales

Key messages

Context

1 One in two people in the UK born after 1960 will be diagnosed with some form of cancer during their lifetime[1]. Many people go on to survive cancer and lead healthy lives. Early diagnosis and timely treatment are key to survival for most cancers.

2 Services to detect, diagnose and treat cancers and to support cancer patients are provided by many public and third sector organisations. Some services, notably Systemic Anti-Cancer Therapy[2] and radiotherapy, mostly serve cancer patients. However, much of the outpatient, diagnostic and surgical capacity needed for cancer patients is part of the wider planned care system.

3 The Welsh Government is responsible for setting the vision and targets for health care and for the allocation of funding. It sets out a range of expectations for the NHS Executive, including supporting improvement in cancer services, through an annual remit letter. The National Strategic Clinical Network for Cancer[3] is part of the NHS Executive and brings together clinicians and health professionals to support improvement. Health boards are responsible for providing high quality care to patients and meeting performance targets. **Appendix 1** explains roles and responsibilities for cancer services and key elements of the strategic approach.

4 Our work has examined the coherence of the national arrangements to drive improvements in cancer services in Wales. The report includes an overview of NHS Wales' performance in providing cancer diagnosis and treatment and offers views on the prospects for improvement, including through prevention. The report does not comment on the performance of individual NHS bodies as this will be examined as part of the Auditor General's 2025 programme of local audit work at those bodies. **Appendix 3** provides more detail about our work.

1 Cancer Research UK.

2 Systemic Anti-Cancer Therapy includes chemotherapy, immunotherapy and hormonal therapy.

3 Called the Wales Cancer Network at the time. We refer to the Network as the 'Cancer Network' throughout the report for ease of reference.

Overall conclusions

5 Overall, we found that despite increased investment, there is a continuing failure to meet the national performance targets for cancer with a minority of patients facing unacceptably long waits for diagnosis and/ or treatment. Cancer outcomes in Wales have improved over recent years but are still poor compared to other countries. Stronger and clearer national leadership is urgently needed to help drive the necessary improvements in the timeliness and sustainability of cancer diagnosis and treatment.

Key findings

Performance and resources

6 Demand from suspected cancer patients is increasing ahead of the NHS' ability to meet it. As a result, the waiting list for diagnosis and treatment is growing. Our indicative modelling shows that without a significant increase in activity to diagnose and treat patients, the waiting list will not return to pre-pandemic levels.

7 The national target that 75% of cancer patients should start their first definitive treatment within 62 days of first suspicion has not been met by any of Wales' health boards since August 2020. Performance deteriorated following the pandemic and has been stable since early 2022 with between 52% and 61% of patients starting their treatment within the target time. Waiting times for some cancer types are particularly long with some patients waiting over 100 days for treatment[4]. There are also growing waits between diagnosis and the start of treatment.

8 A significant minority of people are being picked up with late-stage cancer which impacts their likelihood of survival. In 2021, patients diagnosed with cancers of the gall bladder, pancreas and lung were more likely than patients with other types of cancers to be diagnosed at stage four (74%, 52% and 48% of patients).

9 Screening plays a vital role in early detection. While the standard for uptake of bowel screening is being achieved, this is not the case for breast and cervical screening programmes.

4 See **Exhibit 8.**

10 Patient outcomes have improved over time. But Wales has the second highest cancer mortality rate in the UK after Scotland. The UK itself has a worse rate than many OECD countries. Mortality rates in Wales are significantly worse for people living in deprived areas and the gap between the most and least deprived is growing.

11 Real terms spending on cancer care over the last 13 years has grown considerably more than the overall increase in real terms NHS spending. However, this increase does not necessarily translate into extra activity as there are a range of inflationary cost pressures, including costs of drugs and new treatments. There are also challenges around capacity – including gaps in the workforce and concerns about a shortage of modern scanning equipment.

Strategic direction

12 The Welsh Government has set out its high-level strategic vision for cancer services in its 2021 Quality Statement for Cancer. In February 2023, at the request of the then Minister for Health and Social Care, the Cancer Network published a three-year Cancer Improvement Plan as a collated NHS response to the Quality Statement. The NHS Executive is developing a National Cancer Recovery Programme as part of the wider national approach to transforming planned care. The Welsh Government has also launched a 'Cancer: Improving Outcomes' initiative through its Life Sciences Hub aimed fostering innovation and collaboration between the NHS and industry.

13 Whilst these various developments demonstrate a clear national commitment to improve cancer services, their collective efficacy is undermined by a lack of clarity over the status of the three-year Cancer Improvement Plan. Welsh Government officials were clear that the Plan was not their document but rather the collated response of the NHS to the Quality Statement.

14 However, NHS and third sector bodies are confused about the Cancer Improvement Plan's status and what, if anything, they should be doing to implement it. Many were also confused about the links between the Improvement Plan, the National Cancer Recovery Programme and the Cancer: Improving Outcomes initiative.

15 There is similar confusion about the split of leadership and accountability between the Welsh Government and the NHS Executive and about roles within the NHS Executive. Overall, we identified a consensus, including within the Welsh Government and the NHS Executive, that the arrangements were not yet providing the strong leadership needed to drive system-wide improvement in cancer services.

16 We identified examples of important Welsh Government investment to improve cancer services and broader planned care including rapid diagnostic centres and a new cancer centre for Velindre NHS Trust. However, the pace at which some new developments are taken forward can be slow, in areas such as digital cellular pathology and lung cancer screening.

17 There is also a risk that the Welsh Government may not get a good return on its £3.4 million investment in a National Imaging Academy. The Academy is training more radiologists to address workforce shortages, but some NHS bodies have not been able to create jobs for newly qualified people.

18 The Welsh Government relies heavily on its performance management arrangements to oversee and drive improvement. However, these arrangements are focussed predominantly on the 62-day timeliness target, which only covers part of the patient pathway. The Welsh Government told us it also focuses on delivery of National Optimised Pathways, although at the time of drafting the NHS Executive was still developing plans for monitoring compliance with those pathways.

19 The Welsh Government's Quality Statement does not set out any specific expectations in respect of cancer prevention despite around 38% of cancers being preventable. Whilst there are other Welsh Government strategies and frameworks aimed at encouraging healthier lifestyles these do not constitute a coherent policy framework for population health and disease prevention.

20 Data and digital are two other key areas for improvement. We identified inaccuracies in national data and a need for more consistent national data that helps track delivery across the patient pathway. Work is underway to replace the previous outdated cancer information system. However, progress has been slow, and services continue to rely on fragmented digital systems that consume time and carry risks to patient safety.

The Welsh Government's Quality Statement, the identification of nationally optimised pathways and the publication of a Cancer Improvement Plan are all examples of a clear commitment to secure high quality cancer care for the people of Wales.

However, despite this and increased investment over recent years, too many people are experiencing unacceptably long waits for cancer diagnosis and treatment. Variations in performance and outcomes persist within and between health bodies in Wales, and insufficient attention is being placed on prevention of the lifestyle factors that can cause cancer and other major health conditions.

The arrangements for the national leadership and oversight of cancer services in Wales need to be clarified and strengthened as a matter of urgency. This must include a clear statement on the status of the NHS Wales Cancer Improvement Plan and how the Welsh Government and NHS Executive expect it to be used, alongside other programmes and initiatives, to shape the improvements which are needed in cancer services in Wales.

Adrian Crompton
Auditor General for Wales



4 Recommendations

Exhibit 2: recommendations

Setting out a coherent, long-term strategic approach for cancer in Wales, supported by clear system leadership and informed oversight

R1 The Welsh Government should publicly clarify the status of the Cancer Improvement Plan and its links to the National Cancer Recovery Programme and the Cancer: Improving Outcomes initiative. As part of this the Welsh Government should clarify how it intends to hold NHS bodies to account for delivery of the Cancer Improvement Plan.

R2 The Welsh Government should set out a coherent model for system leadership in respect of cancer services that clarifies its own role and that of the NHS Executive and sets out how it will bring on board clinicians and other key stakeholders to build a common view of cancer service performance, quality and opportunities for improvement.

R3 The Welsh Government should review its oversight and performance framework in respect of cancer services to focus on a broader range of issues, including a more explicit alignment to the ambitions and quality attributes set out in the Quality Statement for Cancer.

Developing the strategic approach to population health improvement and disease prevention

R4 The Welsh Government should develop a more coherent approach to population health improvement by setting out how it intends to use its Science Evidence Advice: NHS in 10+ Years to harness the opportunities associated with prevention to reduce the incidence of cancer and other major conditions.

Exploiting specific opportunities for improvement

R5 The Welsh Government should work with Public Health Wales to accelerate decision making for a national lung screening programme. It should clarify as soon as possible whether it will fund national lung screening for Wales and the timescale for implementing such a programme.

R6 As part of a wider approach to encourage greater regional working between health boards, the Welsh Government and the NHS Executive should work with the service to understand and help address any key barriers to delivering regional services. This should include working with DHCW to identify digital solutions to support shared waiting lists for cancer diagnosis and treatment, where it is appropriate to do so.

R7 The Welsh Government should work with the NHS Executive, HEIW and other NHS bodies to ensure there are employment opportunities for radiologists who have been trained in the National Imaging Academy.

Improving Data and Digital

R8 The Welsh Government should clarify national roles and responsibilities for monitoring and ensuring compliance with its data standards including how it will hold NHS bodies to account for poor compliance.

R9 The Welsh Government should work with the NHS Executive (particularly the Cancer Network), DHCW and Public Health Wales NHS Trust to develop a more comprehensive set of publicly available data on cancer services, which as a minimum should include:

- the number of people currently waiting for cancer diagnosis or treatment (open pathway data).
- performance against the 62-day target for the health board providing diagnosis and treatment and health board of residence, including people living Powys Teaching Health Board area.
- performance across the patient pathways including timeliness of diagnostic reporting across different tumour sites; timeliness from the decision to treat a patient to the start of that treatment (including surgery, radiotherapy and Systemic Anti-Cancer Therapy); and diagnosis and treatment of recurrent disease. Performance information should be provided at cancer sub-tumour level where possible.
- timeliness of diagnosis and treatment for patients referred from the breast and cervical screening programmes.
- accurate information on equity of access, including ethnicity of cancer patients as well as the experiences of different patient groups (this should include children and young people).

R10 The Welsh Government should work with DHCW and NHS England to share regular and consistent data on the timeliness of diagnosis and treatment for Welsh cancer patients treated by NHS England.

Source: Audit Wales

Performance and resources

01

1.1 This part of the report looks at how well services to diagnose and treat cancer are performing, including against national targets. It considers performance in the wider context of demand, financial and capacity pressures.

What we looked for

We looked for evidence that the NHS is sustainably meeting demand to diagnose and treat cancer; whether it is meeting the national performance targets for timeliness of cancer diagnosis and treatment; and for evidence that outcomes for cancer patients are improving and compare well internationally.

Demand is increasing ahead of the NHS's ability to meet it and the waiting list for diagnosis and/ or treatment is growing

The number of people referred for suspected cancer has continued to rise following a sharp drop during the pandemic

1.2 Suspected cancer referrals create demand for NHS services even though the vast majority of those referrals (over 84%[5]) go on to find out that they do not have cancer. Around 80% of patients with suspected cancer are referred by GPs. However, because they are far less likely than those coming from other routes[6] to actually have cancer, those referred by GPs only make up around 54% of patients who go on to start treatment.

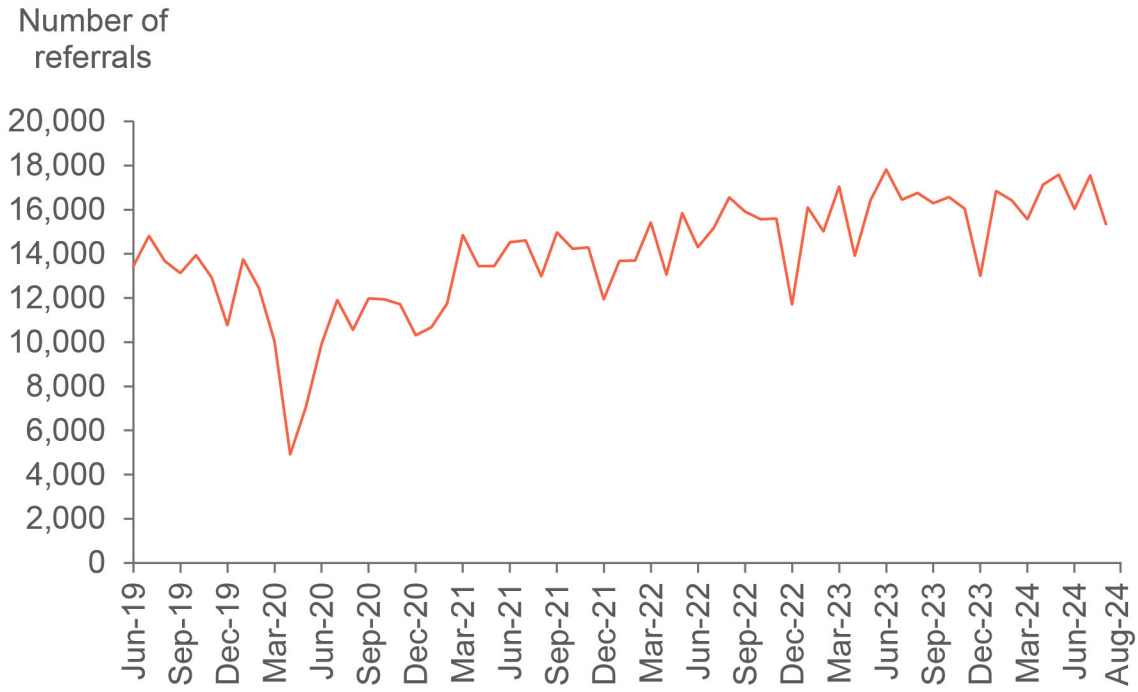
1.3 The number of suspected cancer referrals increased by 14% from June 2019 to August 2024 (**Exhibit 3**); equivalent to around 3% growth each year. Referrals have increased after a drop at the start of the pandemic. The highest numbers of referrals in August 2024 were for skin (excluding basal cell carcinoma[7]) and lower gastrointestinal cancers (17% and 15% of referrals respectively).

5 Since November 2020.

6 Other routes include screening services, emergency departments, and other secondary care professionals.

7 Basal cell carcinoma is the most common type of skin cancer and less likely than other skin cancers to spread to other parts of the body. NHS Wales does not refer suspected basal cell carcinomas via the suspected cancer pathway unless there is a concern that delayed investigation may cause significant impact to the patient in line with NICE Guidance NG12, last updated October 2023.

Exhibit 3: urgent suspected cancer referrals, June 2019 – August 2024



Source: DHCW, Suspected Cancer Pathway – Open Pathways Dataset, on StatsWales.

Note: data from June 2019 to November 2021 is based on experimental analysis on StatsWales and may not be directly comparable to the validated data from December 2021 onwards.

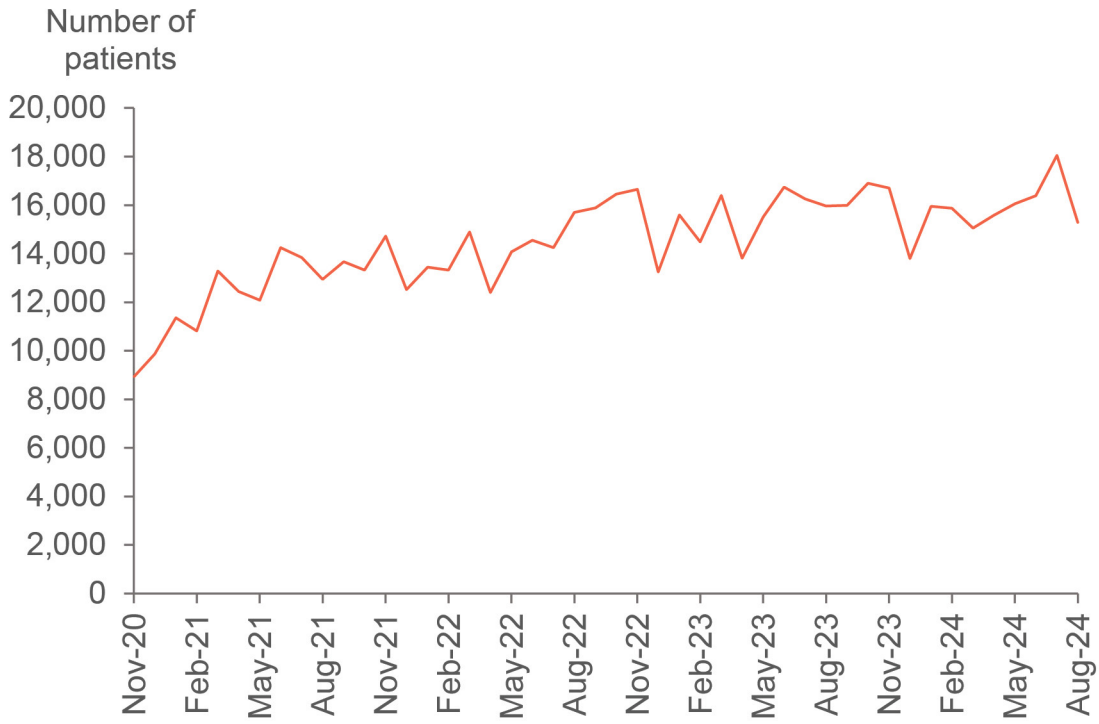
1.4 The number of newly diagnosed cancer patients has also increased over time (by 22% from 2002 to 2021) (see **Appendix 2, Exhibit 26**). Numbers fell in 2020, probably because fewer people accessed healthcare during the pandemic. Numbers of newly diagnosed cancers increased in 2021 but have not yet returned to pre-pandemic levels. The Welsh Cancer Intelligence and Surveillance Unit (WCISU)[8] has not yet published clinical cancer registry data beyond 2021.

8 WCISU is part of the Public Health Wales NHS Trust.

The sharp increase in activity after the pandemic seems to have levelled off

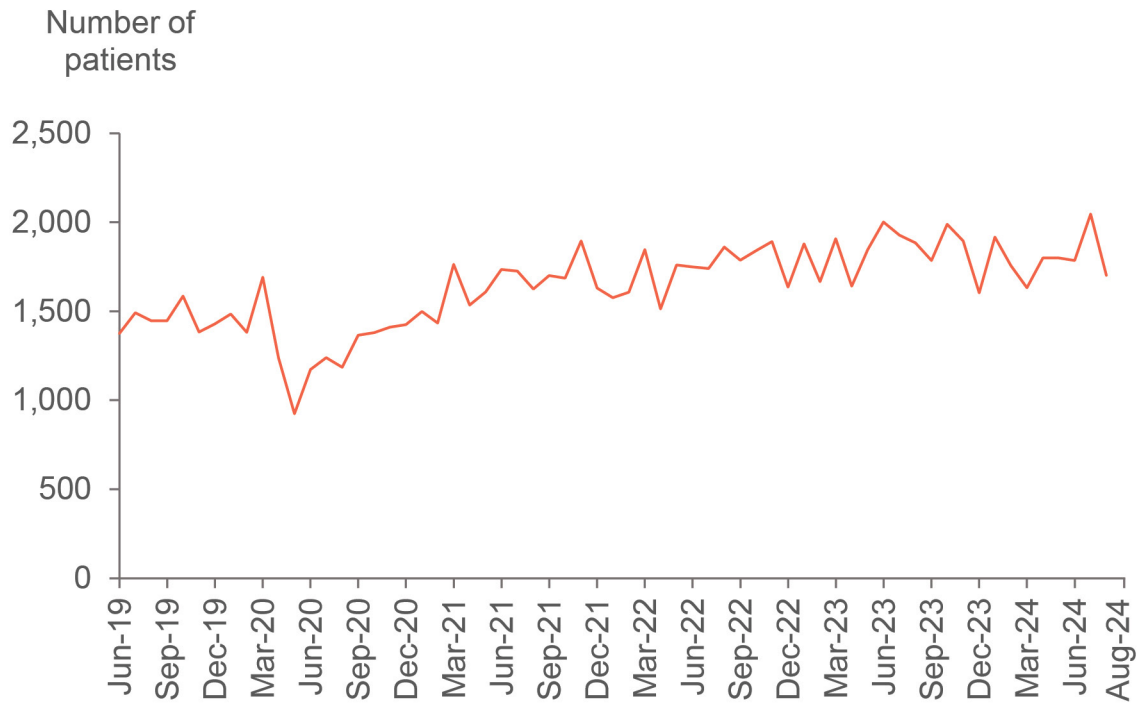
1.5 Activity to diagnose and treat suspected cancer patients[9] has increased since the pandemic but seems to be levelling off. The overall number of pathways closed – including those who were told they do not have cancer and those who started treatment – has increased since November 2020 (**Exhibit 4a**). There is no comparable historic data to show how overall activity levels compare with pre-pandemic levels. However, the number of patients starting treatment for cancer increased quickly after a drop at the start of the pandemic and exceeded pre-pandemic figures by March 2021 (**Exhibit 4b**). The number of patients starting treatment appears to have to broadly levelled out from November 2022.

Exhibit 4a: all closed pathways November 2020 – August 2024



9 As measured by pathways closed.

Exhibit 4b: pathways closed due to patient starting first treatment, June 2019 – August 2024



Source: DHCW, Suspected Cancer Pathway – Closed Pathways Dataset, on StatsWales.

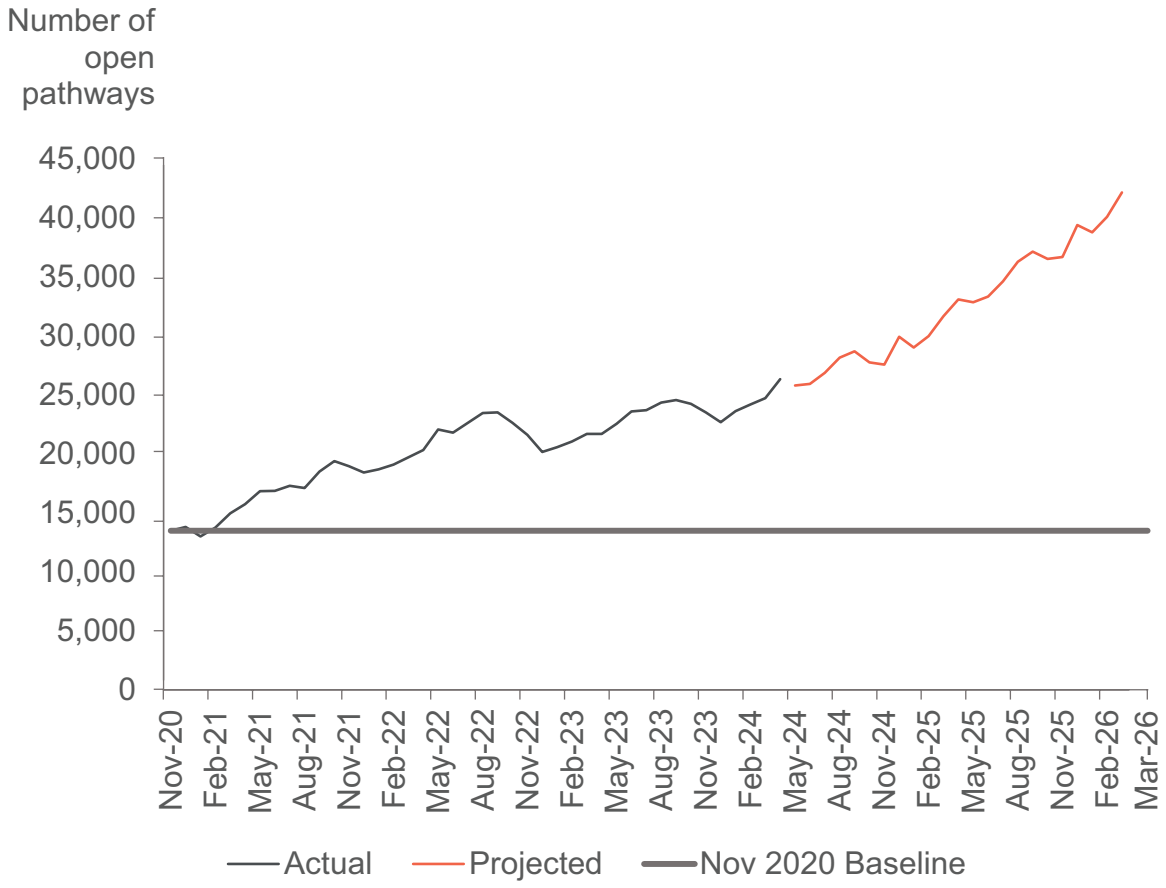
1.6 The available data understates the amount of activity because it only includes activity to the point of first treatment. Many people will need multiple episodes of care after they start their first treatment. It is likely that the amount of activity after first starting treatment is growing with the increasing complexity of new treatments, particularly in immunotherapy. The three cancer centres in Wales[10] hold information on the timeliness of access to radiotherapy and Systemic Anti-Cancer Therapy. However, inconsistencies in the way some of the data is collected means it cannot currently provide any insight on national trends or comparative timeliness of ongoing treatment across Wales.

10 In north Wales, southwest Wales, and south Wales. The centres are managed individually by Betsi Cadwaladr University Health Board, Swansea Bay University Health Board and Velindre NHS Trust.

The numbers of patients awaiting diagnosis or treatment is growing and our analysis suggests the NHS needs to further increase activity if it is to reduce the backlog and sustainably meet demand

1.7 As part of its vision for quality cancer care, the Welsh Government wants to see the waiting list volume return to pre-pandemic levels. It has also set a target that 80% of cancer patients start treatment within 62-days by March 2026. However, the waiting list for diagnosis and/ or treatment has continued to increase, and it is difficult to see how that target will be achieved (**Exhibit 5**). Our indicative modelling shows that the list will continue to grow based on recent trends of demand and activity. It is clear that without a significant increase in activity to diagnose and treat more patients the waiting list is unlikely to return to previous levels.

Exhibit 5: actual and modelled numbers of open suspected cancer pathways to March 2026



Source: Audit Wales analysis of DHCW data, open suspected cancer pathways at month end

Note: Patients may have more than one pathway if they are waiting for diagnosis or treatment for more than one cancer.

Our projection assumed demand, as measured by referrals, increases by 3% a year in line with recent trends and that activity increases by 1% a year.

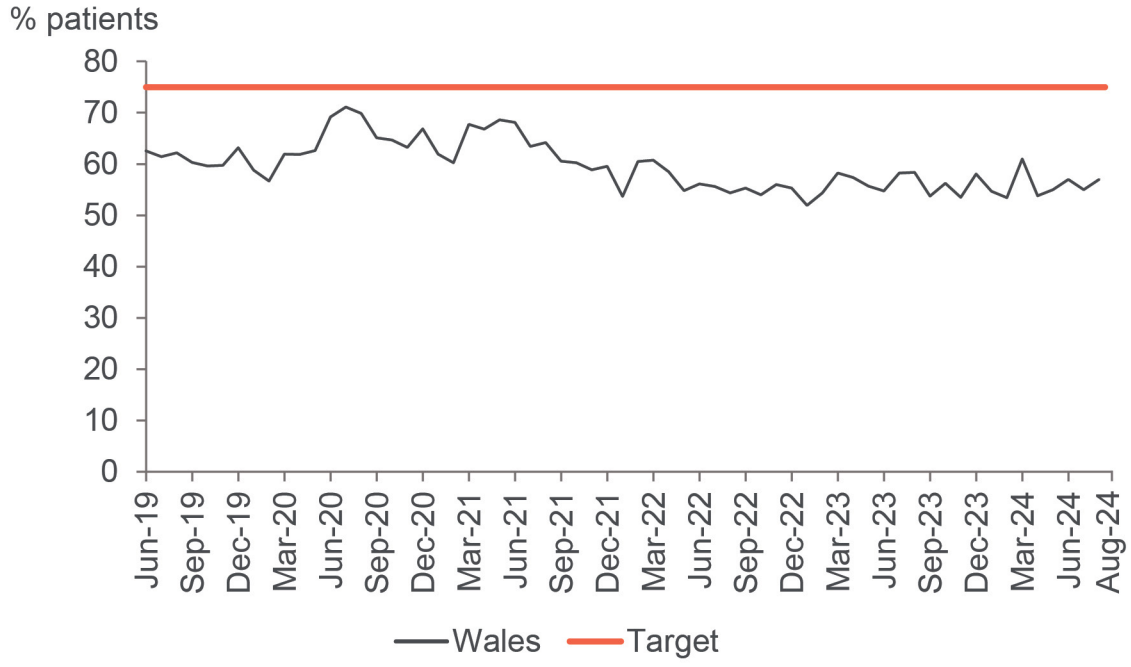
1.8 Much of the capacity the NHS uses to diagnose and treat cancer patients is also used for other non-cancer patient pathways. Achieving the political and policy ambitions to improve access to both cancer and wider planned care within the system's existing capacity will therefore be challenging. Priorities on cancer care will need to be balanced with other planned care priorities. A consideration of how existing capacity can be better used or expanded will also be needed.

The NHS in Wales is continuing to miss the national performance target for cancer treatment

While the majority of patients start their treatment within 62 days, performance is well short of the national target of 75%

1.9 The Welsh Government started implementing its Suspected Cancer Pathway in June 2019, with a target that 75% of cancer patients should start their first definitive treatment within 62 days of the first suspicion of cancer[11]. No health board has met the overall 75% target since August 2020 although performance has been better for some individual tumour sites (**paragraphs 1.10 and 1.11**). During the summer of 2020, referrals were lower and health boards were prioritising urgent and cancer care over other patients due to the pandemic. Since then, despite some month on month variations, performance has stayed between 52 and 61% (**Exhibit 6**).

Exhibit 6: performance against the 62-day Suspected Cancer Pathway Target, June 2019 – August 2024

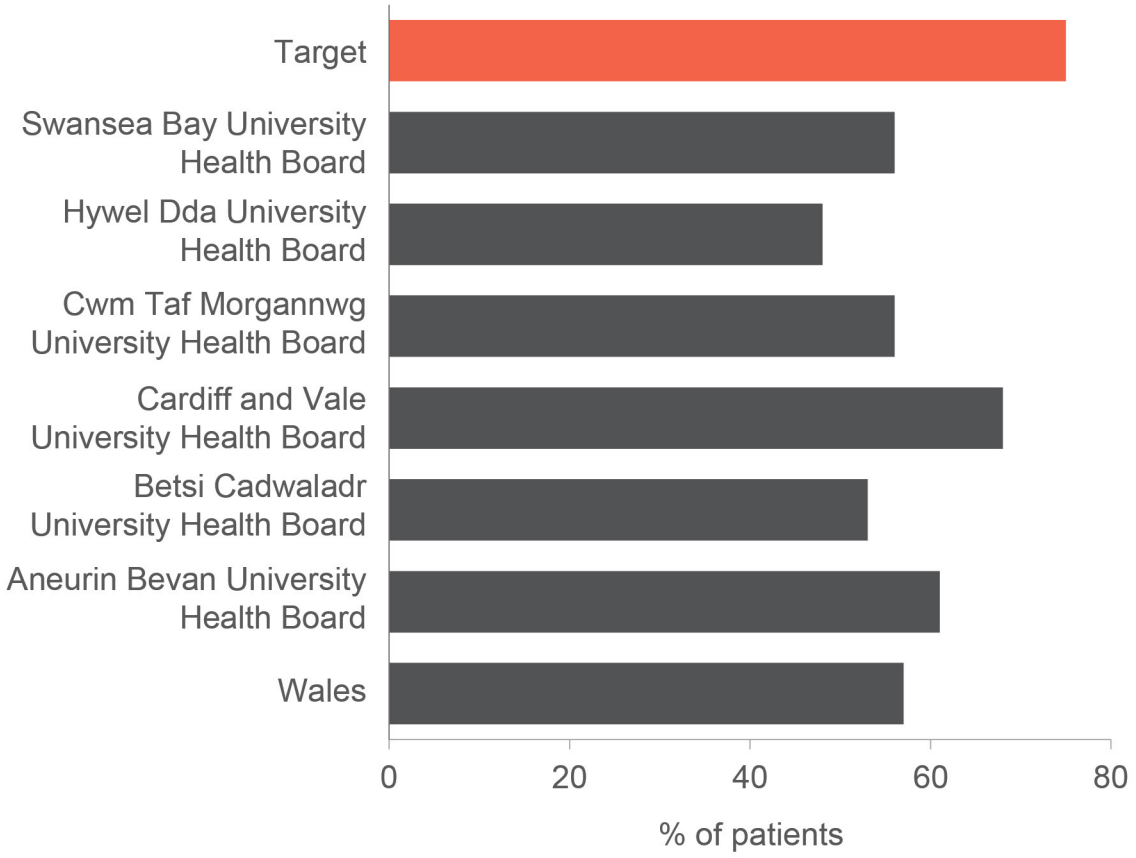


Source: DHCW, Suspected Cancer Pathway – Closed Pathways Dataset, on StatsWales.

11 Some data on performance against the target is available from June 2019 and the Welsh Government officially required health boards to report against the target from February 2021.

1.10 There is considerable variation and fluctuation in performance against the target by health board area. In August 2024, Cardiff and Vale University Health Board was closest to meeting the target at 68%, and Hywel Dda University Health Board was the worst performer at 48% (**Exhibit 7**). Health board performance has fluctuated considerably since 2019 (see **Appendix 2, Exhibits 27a to f**).

Exhibit 7: health board performance against the 62-day Suspected Cancer Pathway Target, August 2024



Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Note: StatsWales publishes data for residents of each health board unless they are treated by NHS England. Residents of Powys Teaching Health Board treated by other Welsh health boards are included in that health boards' figures. StatsWales does not distinguish between residents of Powys and residents of the health board they are treated by.

Time to start treatment varies by type of cancer and some patients can face unacceptably long waits

1.11 Waiting times vary depending on the site of the cancer. Waiting times for skin cancer, excluding basal cell carcinoma (BCC) have been consistently above the 75% target, aside from a brief dip in November 2023. However, waiting times for other tumour sites have rarely been at or above the target at an all-Wales level[12]. Waiting times for gynaecological, lower gastrointestinal and urological cancers, and sarcoma are particularly poor with less than half of patients starting their first treatment within 62 days of first suspicion in August 2024 (**Exhibit 8**). Performance may vary within the sub-tumour sites[13] for these cancers but there is no nationally available information to understand performance by sub-tumour site (**recommendation 9**).

12 Performance for breast and lung cancers briefly met the target in June 2021 but has deteriorated since. Brain and central nervous system and haematological cancers, acute leukaemia and sarcoma have all met the target at various points from November 2020 to June 2024 but represent low numbers of patients.

13 For instance, cervical and ovarian cancers are both gynaecological sub tumour sites.

Exhibit 8: performance against the Suspected Cancer Pathway target, median and 75th percentile waits for gynaecological, lower gastrointestinal, skin, and urological cancers, and sarcoma, and August 2024

	Performance against the 75% target	Median waiting times	75th percentile waiting times
Skin (excluding BCC)	80%	35 days	61 days
Sarcoma	20%	No data	No data
Urological	40%	86 days	132 days
Gynaecological	35%	83 days	115 days
Lower gastrointestinal	45%	70 days	106 days

Source: DHCW, Suspected Cancer Pathway – Closed Pathways Dataset on StatsWales (data on performance against the 75% target) and DHCW data on the Suspected Cancer Dashboard (data on median and 75th percentile waits).

Note: Median waiting time is point where half the people have had their treatment and the other half are still waiting. The 75th percentile represents the time when 75% of people have had their treatment but 25% are still waiting.

While diagnostic waits are getting shorter, waits between diagnosis and starting treatment are getting longer

1.12 Health board, NHS Executive and Welsh Government officials told us that delays at diagnostic stage are one of the main reasons for poor performance against the 62-day cancer target. Median waits from first suspicion of cancer to first diagnostic test have fallen from 20 days in February 2021 to 16 in August 2024. Depending on the type of cancer, patients usually face another wait between having a diagnostic test and finding out whether they have cancer (diagnosis). Median waits from first suspicion to actual diagnosis increased from 26 days in February 2021 to 36 in January 2022 but fell to 27 in August 2024[14].

1.13 Our analysis[15] points to problems between diagnosis and starting treatment. Between February 2021 and August 2024, median waits from diagnosis to treatment increased by 38% from 21 days to 29. Waits between diagnosis and treatment vary between tumour sites, with patients with lower gastrointestinal and breast cancers waiting longer than those with other cancer types in August 2024[16] (**Exhibit 9**).

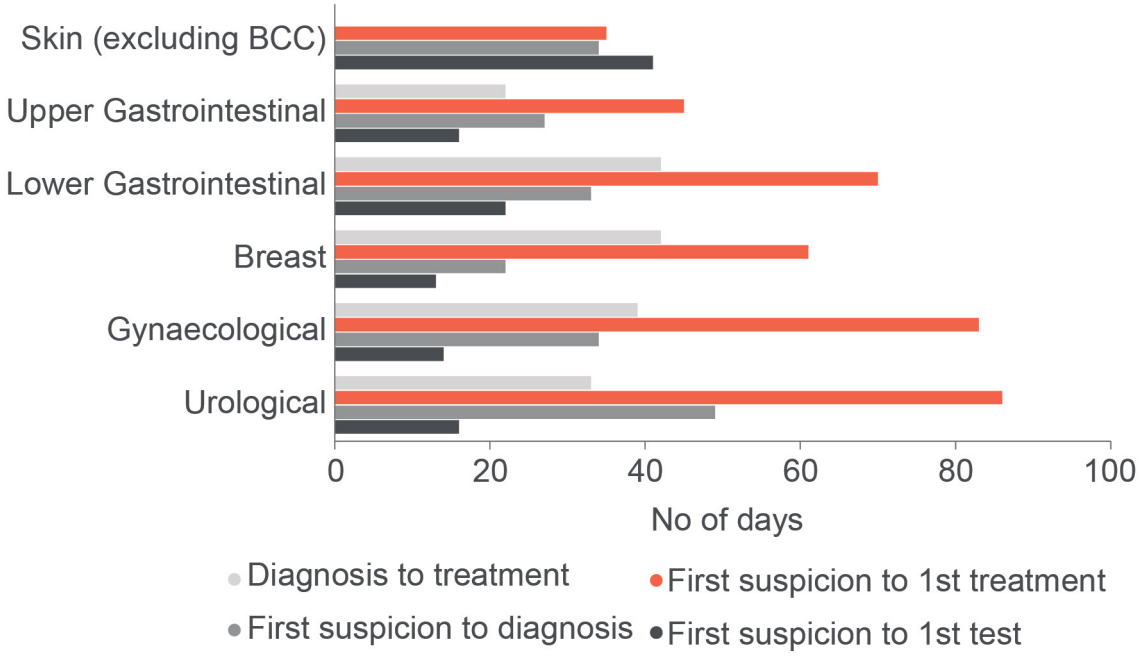
1.14 There are also considerable variations in waits at other stages of the pathway across tumour sites. For instance, in August 2024, the median wait for urological cancers was 16 days from first suspicion to diagnostic test, 49 days from first suspicion to diagnosis, and 86 days from first suspicion to the start of treatment. By comparison, the median wait for skin cancers was 41 days from first suspicion to diagnostic test and 34 days from first suspicion to diagnosis, and 35 days from first suspicion to the start of treatment (**Exhibit 9**).

14 **Appendix 2, Exhibit 28** gives median waits from first suspicion to diagnosis over time.

15 Of DHCW data from the Suspected Cancer Pathway Dashboard. DHCW only publishes median waits for the tumour sites included in **Exhibit 9.**

16 The Welsh Government does not publish median waits for all tumour sites.

Exhibit 9: median wait from first suspicion of cancer to first test, diagnosis and starting first treatment, August 2024



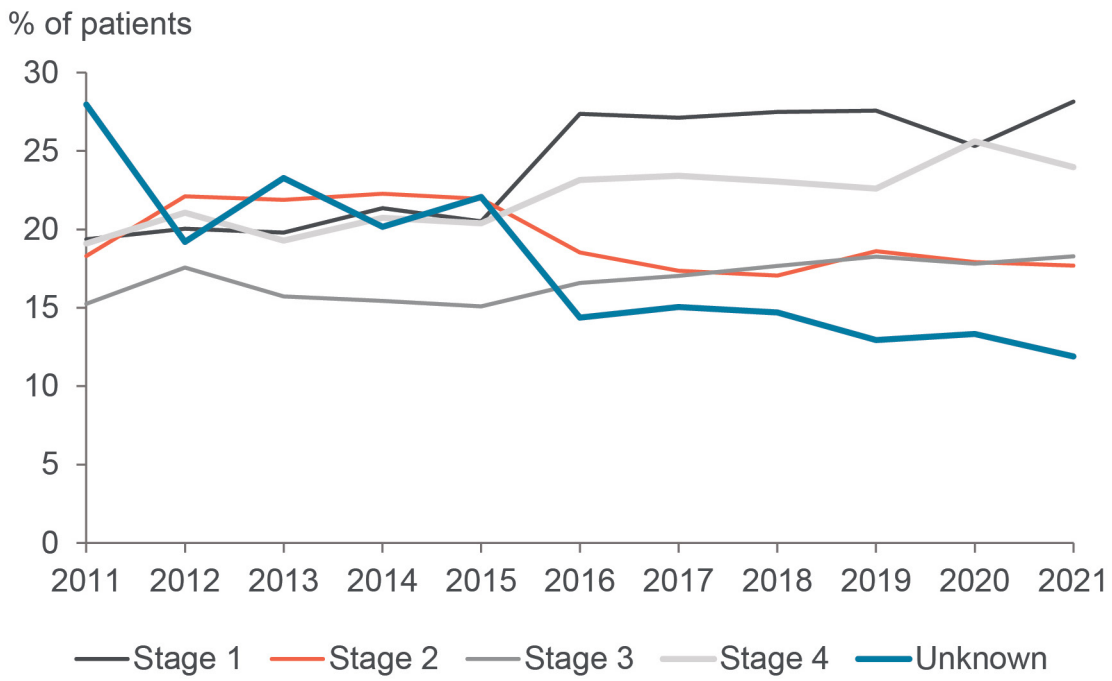
Source: DHCW data from the Suspected Cancer Pathway Dashboard

A significant minority of people are being picked up with late-stage cancer which impacts their likelihood of survival

1.15 Survival decreases as stage at diagnosis advances for all cancer types[17]. In 2021, 24% of cancer patients were diagnosed at stage four and 18% at stage 3 (**Exhibit 10**). The increase in the proportion of cancer patients diagnosed at stage 1 between 2011 and 2021 corresponds with a fall in patients diagnosed at stage 2 and patients whose stage is unknown at diagnosis. With the exception of an increase in 2020, the proportion of cancer patients diagnosed at stage 4 has ranged between 19% and 24% during the same period. Positively, the overall proportion of cancer patients whose stage at diagnosis was 'unknown' has significantly decreased since 2011.

17 WCISU, Cancer Survival in Welsh Residents Diagnosed Between 2002 and 2020, November 2023.

Exhibit 10: proportion of cancer patients by stage at diagnosis, 2011 to 2021



Source: WCISU cancer incidence data

Note: Our analysis is based on WCISU cancer incidence data which does not include 'non-stageable' cancer, non-melanoma skin cancer, and some rare cancer types.

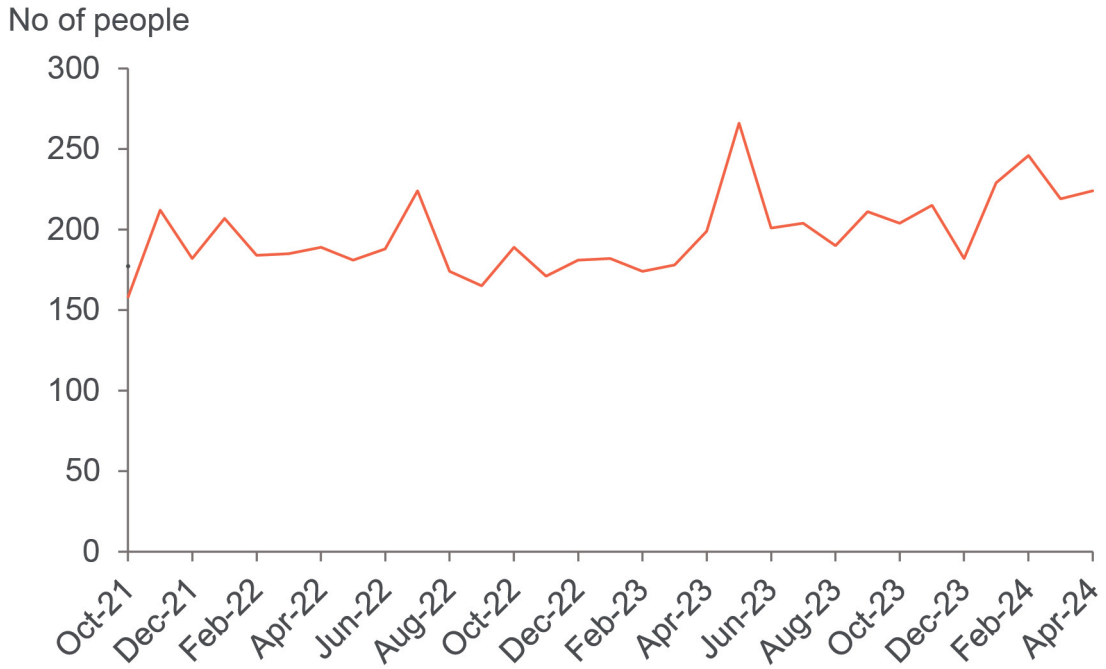
1.16 Some cancers are more likely than others to be diagnosed at a late stage, particularly asymptomatic cancers. In 2021, patients with gall bladder, pancreatic, and lung cancer were more likely than other cancer patients to be diagnosed at stage four[18]. 48% of lung cancer patients were diagnosed at stage four in 2021 (1,175 people). To illustrate the importance of early diagnosis, five-year survival for lung cancer diagnosed during 2016-2020 is 55% at stage one, 30% at stage two, 13% at stage three, and just 3% at stage four[19].

1.17 Although the numbers are relatively small, the number of people whose suspected cancer was identified via emergency departments has increased by over 40% from October 2021 to April 2024 (**Exhibit 11**).

18 74% of patients with gall bladder cancer and 52% of patients with pancreatic cancer were diagnosed at stage 4 in 2021.

19 WCISU, Cancer Survival in Welsh Residents Diagnosed between 2002 and 2020, November 2023.

Exhibit 11: number of urgent suspected cancer referrals via emergency departments from October 2021 to April 2024.



Source: Audit Wales analysis of DHCW Suspected Cancer Pathway Data – closed pathways by source of suspicion.

1.18 Research by the International Cancer Benchmarking Partnership[20] found that countries with higher rates of cancer diagnosis after emergency presentation had poorer survival rates[21]. It explained that Wales and Scotland have some of the highest rates amongst comparable countries. Our own analysis found that suspected cancer patients referred from emergency departments were more likely than those referred via other routes to die before being diagnosed or starting treatment[22]. While some caution is needed due to the small numbers, there is an upwards trend in patients referred from emergency departments dying before treatment or diagnosis.

20 The Partnership brings together international clinicians, policymakers and researchers to identify best practice and support improved cancer outcomes for patients.

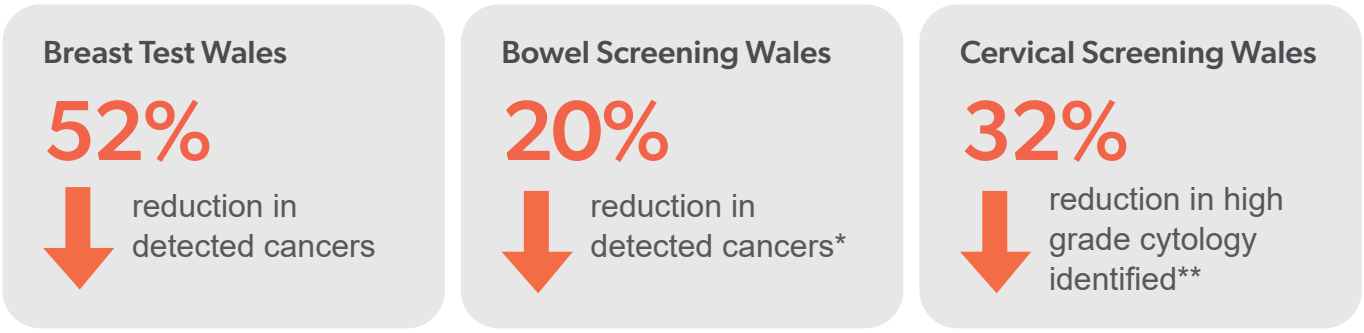
21 Abd Elkader, Alv, R; Barclay, M; Johnson, S; McPhail, S; Swann, R, Risk Factors and Prognostic Implications of Diagnosis of Cancer Within 30 Days After and Emergency Admission (Emergency Presentation): An International Cancer Benchmarking Partnership Population Based Study, 2022.

22 Based on our analysis of on our analysis of DHCW Suspected Cancer Pathway Data. In April 2024, 4% of suspected cancer patients referred from an emergency department died before starting treatment or finding out they did not have cancer compared to 1% of all suspected cancer referrals.

There is scope to increase uptake of screening to detect cancers earlier

1.19 Screening plays a vital role in early detection. Public Health Wales NHS Trust (PHW) runs Wales's three cancer screening programmes: Breast Test Wales, Bowel Screening Wales and Cervical Screening Wales. The Trust estimates that brief pauses to its screening programmes[23] at the start of the pandemic reduced the number of detected cancers in 2021 compared to previous years (**Exhibit 12**).

Exhibit 12: reduction in cancers detected via screening, from April 2020 to March 2021 compared to the previous year



Source: PHW, Update on Population Based Screening Programmes in Wales to the Quality, Safety and Improvement Committee, June 2021

Note: * from April 2020 to February 2021.

**abnormal cells with the potential to develop into cervical cancer.

1.20 Whilst bowel screening is achieving its uptake standards, there are opportunities to increase screening uptake for the breast and cervical screening programmes which were both below the standard in August and April 2024 respectively (**Exhibit 13**). In 2022, the Trust reported differences in screening uptake for all three programmes depending on age, the health board area people live in, and whether the area is deprived or not[24]. It is working to address inequity in screening uptake via its Screening Equity Strategy but has not published a progress report on screening equity since June 2022.

23 Audit Wales, A Review of Arrangements to Recover Screening Services at Public Health Wales NHS Trust, August 2023, provides more information the pause and recovery screening services including performance measures, eligibility and coverage standards for each programme.

24 Public Health Wales NHS Trust, Screening Division Inequities Report 2020-21, June 2022.

Exhibit 13: screening coverage against target, April and August 2024

	Eligibility	Standard	Uptake
Breast Test Wales	Women aged 50 to 70 years invited for screening every three years	70%	68%*
Bowel Screening Wales	People aged 50 to 74 years invited for screening every two years	60%	65%**
Cervical Screening Wales	Women and people with a cervix aged 25-64 years invited for screening every 5 years if Human papillomavirus (HPV) negative or more frequently if HPV positive	80%	69%***

Source: Audit Wales, based on information and wording from PHW, October 2024.

Note:

*Rolling annual rate at August 2024
**Average over the previous year at August 2024
***Age appropriate coverage at April 2024

1.21 Referrals from breast and bowel screening programmes were amongst the most likely to go on to start cancer treatment (92% and 28% respectively in 2023-24 compared to 12% overall)[25]. However, there is no national data on the timeliness of subsequent cancer diagnosis and treatment for people referred from breast or cervical screening. From July 2023 to July 2024, just 21% of eligible people referred from bowel screening were offered a colonoscopy by the relevant health board within four weeks of phoning to book[26]. The target is 90%. Waiting times for colonoscopies varied between health boards from four to 14 weeks.

25 Based on our analysis of DHCW Suspected Cancer Pathway Data. We have excluded cervical screening referrals from our analysis due to low numbers. Less than 5 people are referred with suspected cancer following cervical screening each month.

26 Public Health Wales NHS Trust, October 2024.

Survey data suggests that patients are generally satisfied with their cancer care, though the latest survey pre-dates the recent decline in performance

1.22 Data on patient experience is collected via the annual Wales Cancer Patient Experience Survey commissioned by the Cancer Network and Macmillan Cancer Support. The most recent data is from 2021 and pre-dates the downturn in performance against the 62-day target.

1.23 The vast majority of cancer patients who responded to the survey rate their overall care highly. The average rating for overall care was 9 out of 10 across Wales, based on 5,859 responses. The positive results reflect the hard work and compassionate care of the many staff working across the NHS to care for and support cancer patients. 87% of respondents said that the different professionals treating and caring for them worked well together to give them the best possible care either ‘always’ or ‘most of the time’. The survey does not ask patients how they felt about the overall length of time they waited from first suspicion to starting treatment.

Outcomes for cancer patients are generally improving but lag behind comparable countries and are worse for people living in deprived areas

1.24 Cancer is the leading cause of death[27] in Wales, accounting for 25% of all deaths in 2022. Lung, bowel, and prostate cancer account for the largest proportions of cancer deaths[28]. The number of cancer deaths has increased from 8,295 in 2002 to 9,154 in 2022 and is projected to increase by 27% by 2040 (based on 2021 levels)[29]. The rise in cancer deaths is primarily explained by the changing age structure of the population. The age standardised rate[30] of cancer deaths has generally decreased since 2011 although there was a slight increase in 2022 (**Exhibit 14**).

1.25 The cancer death rate in Wales compares poorly to other UK nations and internationally[31]. Wales has had the second highest age standardised cancer death rate in the UK almost consistently since 2010 (**Exhibit 14**). The OECD compared age standardised cancer death rates in 2023, based on 2021 data. It placed the UK 35th out of 45 countries[32].

27 In 2022, 24% of deaths were caused by diseases of the circulatory system, 12% by diseases of the respiratory system, 10% by dementia and Alzheimer's, and 29% by other causes.

28 WCISU cancer mortality data.

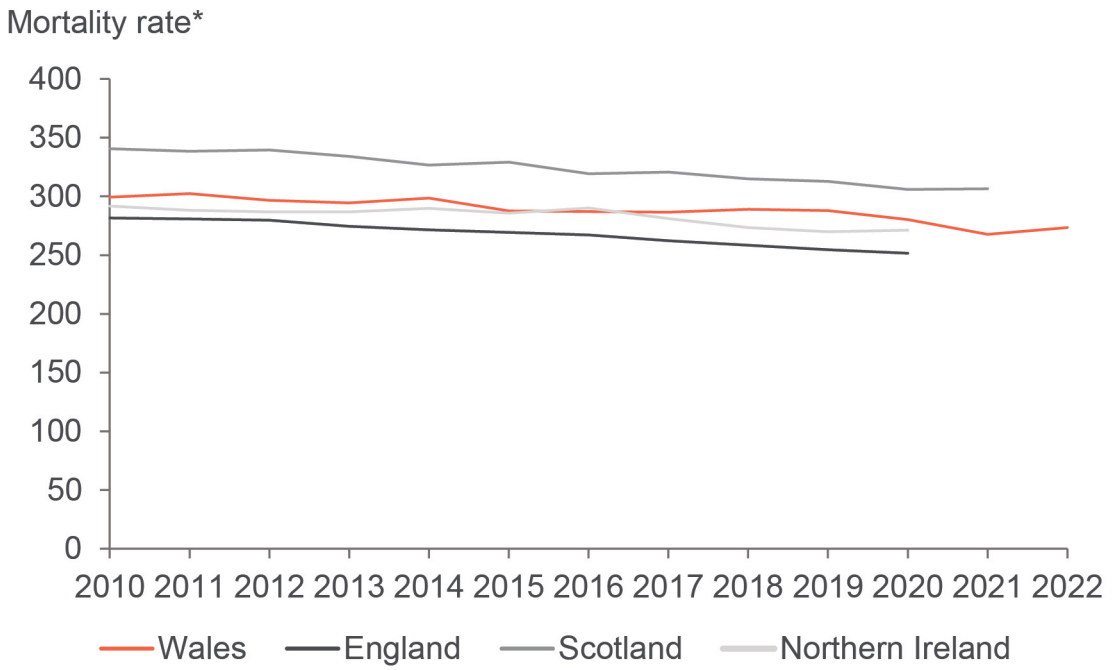
29 National Strategic Clinical Network for Cancer, A Cancer Improvement Plan for NHS Wales 2023-26, 2023.

30 Deaths per 100,000 of the population taking account of differences in the age structure of different parts of Wales.

31 Many factors affect cancer incomes including the relative wealth and spending on healthcare in each country, underlying population health, and deprivation.

32 OECD, Health At A Glance 2023: OECD Indicators, OECD, 2023.

Exhibit 14: age standardised cancer mortality rates in UK countries (excluding non-melanoma skin cancer), 2010 to 2022



Source: WCISU cancer mortality data

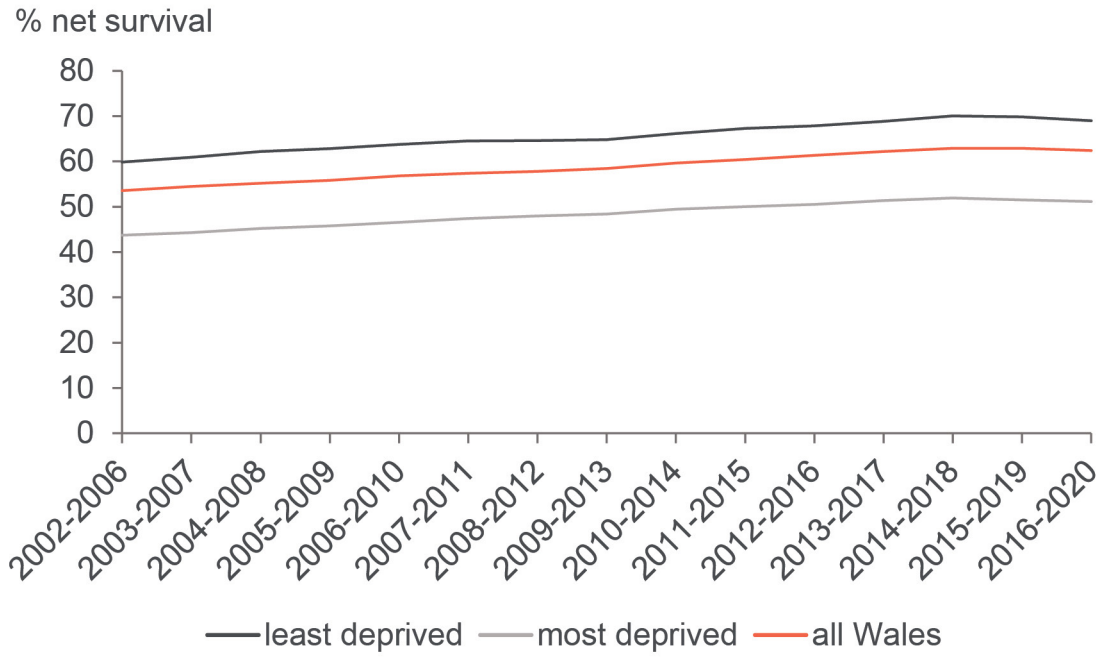
Note: *per 100,000, adjusted to reflect the age of the population

1.26 Cancer survival[33] improved between 2002 and 2020. 54% of patients diagnosed with cancer from 2002-2006 survived their cancer at five years compared to 62% of patients diagnosed between 2016 and 2020. There is not yet data available to track the impact of the pandemic on survival rates. Differences in data collection methods makes it difficult to compare overall survival figures across UK countries.

1.27 There is a significant deprivation gap in survival rates. While 69% of cancer patients living in the most affluent parts of Wales survive cancer at five years, that falls to 51% for those in the most deprived areas (**Exhibit 15**). Worryingly, the deprivation gap has widened from a difference of 16 percentage points for people diagnosed between 2002-06 to 18 percentage points for people diagnosed between 2016-20.

33 Cancer mortality figures show the number of deaths where cancer was the underlying cause whilst survival figures show how many people who have had cancer are still alive after a certain period of time so it takes several years for accurate data to be published.

Exhibit 15: percentage unstandardised rolling net survival at five years comparing most and least deprived areas with the all Wales figure for patients diagnosed in the periods 2002-2006 to 2016-20 (excluding non-melanoma skin cancer).



Source: WCISU cancer survival data

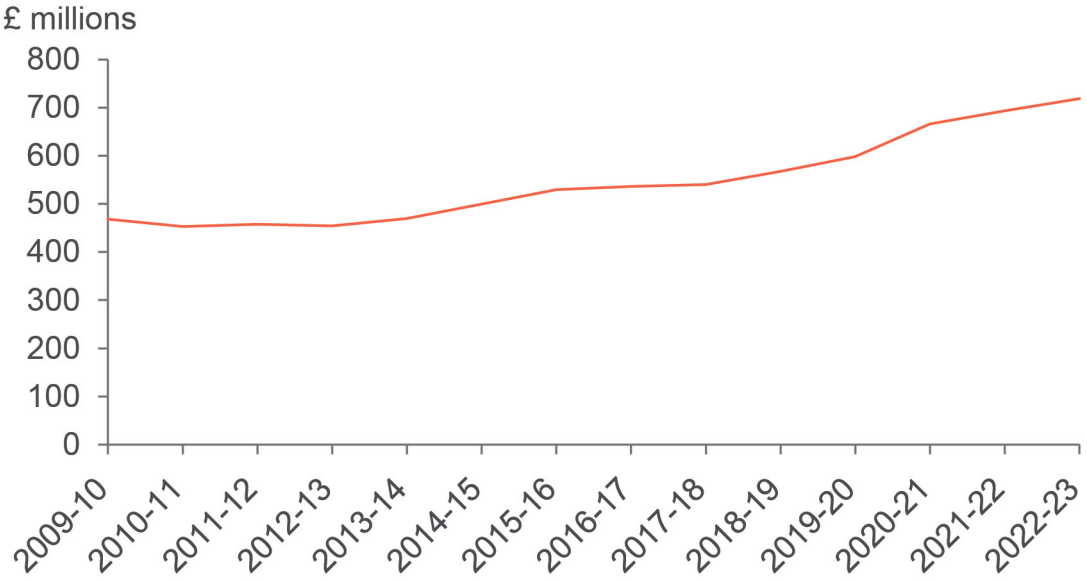
Spending on services to diagnose, treat and support cancer patients has risen faster than overall NHS spending but there are gaps in staffing capacity

Real terms spending on services to diagnose, treat and support cancer patients has grown more than overall growth in NHS Wales spending but there are significant cost pressures on those services

1.28 Real terms spending on services to diagnose, treat and support cancer patients increased by 54% from just over £450 million in 2009-10 to almost £720 million in 2022-23 (**Exhibit 16**). This increase is considerably greater than the overall 33% real terms growth in NHS Wales spending[34]. As a proportion of overall NHS spending, spending on services to diagnose, treat and support cancer patients has increased slightly from 7% in 2009-10 to 8% in 2022-23. Increased spending does not necessarily translate to additional capacity or activity. There are lots of cost pressures on services including rising workforce costs associated with pay growth and the use of agency staff; rising costs of existing drugs; new drugs and new technologies to improve treatment.

34 Based on revenue spending in the Welsh Government's NHS expenditure by programme budget category data on StatsWales for consistency with cancer spending figures. The NHS Finances Data Tool on our website is based on published Welsh Government budgets and gives a slightly different figure.

Exhibit 16: real terms NHS spending on cancer, 2009-10 to 2022-23



Source: Welsh Government, NHS Expenditure by programme budget category and year, 'cancer and tumours', on StatsWales.

Note: Real terms figures are adjusted to take account of inflation. We used HM Treasury GDP deflators at market prices and money for 2022-23, March 2024.

The Welsh Government confirmed that this data is based on NHS Wales patient activity costs including staff, consumables, medicines and overhead costs such as estates, catering, HR and finance costs.

1.29 In 2022-23 NHS Wales spent £230 per head of the population on services to diagnose, treat and support cancer patients[35]. Spend per head ranged from £206 in Cardiff and Vale to £270 in Swansea Bay University Health Board. An examination of the reasons behind differing spending figures across health board areas was outside the scope of this review but it is likely to reflect different local models of care and population factors including demography and deprivation.

1.30 Despite improvements in cancer waiting times being one of the key priorities for NHS Wales, the prospects for spending on services to diagnose, treat and support cancer patients are uncertain. UK public finances are under pressure. NHS bodies in Wales are already under financial strain, with six out of seven health boards overspending in 2023-24 and most projecting deficits for 2024-25. It is unclear whether they will be able to prioritise services for urgent suspected cancer patients to increase activity sufficiently to meet demand and reduce waiting times. Health boards are also under pressure to prioritise other parts of the system where performance is poor, including long waits for unscheduled care and for planned care.

35 There is no comparable data from other UK or comparable countries.

Workforce capacity is a significant challenge and there is an absence of information on the availability and condition of equipment

1.31 Despite spending increases, workforce capacity remains a significant challenge and workforce shortages are reducing service capacity[36]. HEIW's Education and Training Plan 2025-26[37] describes 'significant national shortages and longstanding gaps' in specialist professional roles impacting diagnostics, cancer, emergency care and mental health. It highlights particular shortages in dermatologists, clinical oncologists, consultant urology surgeons, and histopathologists. It cites pressure from increasingly complex cancer reporting and the evolving field of geonomics on histopathology, and demand from cancer patients on urology.

1.32 The Royal College of Radiologists describes shortfalls of 34% and 12% in the radiology and clinical oncology workforces, likely to deteriorate to 38% and 28% respectively by 2028[38]. We also heard that there are shortages of medical physicists, specialist and district nurses, and in the geonomics, Systemic Anti-Cancer Therapy and radiotherapy workforce.

1.33 HEIW set out its plans to address workforce shortages in its Education and Training Plan and Integrated Medium-Term Plan 2024-27. In line with its commitment in the Cancer Improvement Plan, HEIW has published its workforce plans for pharmacy and for geonomics, and intends to publish its plan for nursing in early 2025. The Ten-Year Workforce Strategy for Health and Social Care 2020 sets out the broader strategic approach.

1.34 As well as sufficient staff, NHS Wales needs sufficient equipment to deliver timely and effective diagnosis and treatment. The NHS Executive is building up a picture of capacity associated with the age and availability diagnostic imaging equipment including the age and availability of equipment. We heard anecdotal evidence that Wales has fewer imaging machines than comparable countries, and that some machines are old and prone to breaking down. Whilst it was beyond the scope of this review examine those claims, we did hear that limitations in access to diagnostic equipment are putting pressure on staff, affecting recruitment and retention, and restricting HEIW's ability to offer training places for diagnostic students[39].

36 Audit Wales, Workforce Data Briefing, 2023, sets out broad workforce issues, with many affecting services for cancer patients where services are not specific to cancer patients (such as diagnostics and surgery).

37 The Plan sets out commissioning and training recommendations for the health professional workforce in Wales.

38 Royal College of Radiologists, Radiology Workforce Census 2023, June 2024.

39 It is exploring using simulated training environment as an alternative.

Strategic direction

02

2.1 This part of the report looks at national strategic direction and leadership to improve cancer care in Wales. **Appendix 1** explains key elements of the strategic approach and broad roles and responsibilities for cancer services.

What we looked for

We looked for evidence of a clear strategic direction for improving cancer outcomes and services, and for reducing demand for cancer services by preventing cancer occurring in the first place. We also looked for evidence of appropriate and clear leadership structures to direct, oversee and support improvement and tackle barriers at a national level.

There is a lack of clarity on the status of the Cancer Improvement Plan and how it aligns with other cancer improvement initiatives

The Cancer Improvement Plan has not been sufficiently integrated into the wider strategic approach for improving cancer services

2.2 The Welsh Government set out its vision of what 'good' cancer services should look like in the Quality Statement for Cancer (2021). The Statement is generally high-level but is underpinned by tumour specific national optimal pathways. The pathways set out what should happen at different stages of the patient journey according to professional guidance. The Welsh Government instructed health boards to start embedding the pathways by September 2022[40]. When it published the Statement, the Welsh Government said that the Cancer Network would develop a rolling, three-year plan to achieve the national vision.

40 Via Welsh Health Circular (2022) (021).

Exhibit 17: vision set out in the Quality Statement for Cancer

The Cancer Quality Statement sets out that its ultimate aim is to improve population survival and reduce cancer mortality rates. It identifies key areas for action:

- that cancer is effectively prevented where possible,
- that cases of cancer are detected at earlier more treatable stages,
- that complex treatment pathways are optimised, while throughout people are properly supported and co-produce their care.

The statement sets out a series of attributes, indicating what good quality care looks like, under six headings:

- Equitable
- Safe
- Effective
- Efficient
- Person centred
- Timely

Source: Welsh Government Quality Statement for Cancer, 2021.

2.3 In 2023, the Network published A Cancer Improvement Plan for Wales 2023-26 (the Plan) at the request of then Minister for Health and Social Services. The Plan encompasses a broad range of cross-sector actions to improve cancer patient outcomes and reduce health inequalities. It's three year horizon was deliberately aligned to local health board planning cycles. However, this means the Plan lacks focus on longer-term actions to build sustainable cancer services. It also lacks detail on prevention, palliative and end-of-life care, and on services for children and young people and does not cover the full range of ambitions in the Quality Statement.

2.4 The then Minister used the Plan to set the new expectation that by March 2026, 80% of patients would start their first treatment within 62 days. The Minister announced publication of the Plan in an oral statement, describing it as a collective NHS Wales approach to delivering the policy intentions in the Quality Statement for Cancer. The Welsh Government told us that it is not a Welsh Government Plan. It considers that it does not require a national plan to implement the Quality Statement because health boards and trusts are responsible for implementing the vision through their own local plans.

2.5 Nonetheless, the Plan exists at the request of the Minister and many of its actions require national direction and leadership to support successful implementation. This would include consideration of the funding needed to support the Plan's actions and using national planning and performance management frameworks to clarify requirements around the Plan's delivery (**recommendation 1**).

2.6 The Cancer Improvement Plan commits the Welsh Government to monitoring delivery of the Plan through its existing performance arrangements. However, during our fieldwork, Welsh Government officials told us that such monitoring was not taking place. Since then, at the then Minister's request, the Cancer Network has collated a retrospective progress 'update' on delivery of the Plan. However, the Welsh Government is not routinely monitoring implementation in line with its commitment in the Cancer Improvement Plan.

New national initiatives to improve cancer services have merit but stakeholders are confused about how they link to the Cancer Improvement Plan

2.7 Since publication of the Plan in 2023, the Welsh Government and NHS Executive have set up new programmes aiming to improve cancer services (**Exhibit 18**). While there are merits in each programme, stakeholders are unclear about how they align with the Cancer Improvement Plan.

Exhibit 18: new programmes to improve cancer services

Programme	Description
Cancer: Improving Outcomes initiative	The Welsh Government commissioned Life Science Hub Wales to develop the initiative, which is aimed at focusing innovation on key problem areas and removing the barriers to delivering innovation at pace.
National Cancer Recovery Programme	The NHS Executive set up the programme, which is aimed at reducing long waits to achieve a target that 80% of suspected cancer patients start treatment within 62 days by 31st March 2026.

Source: Audit Wales.

2.8 The NHS Executive is currently finalising arrangements for its National Cancer Recovery Programme. The Programme focuses on five specific tumour sites[41] with some cross-cutting actions to improve more general services to diagnose and treat cancer patients. Rather than large-scale, whole-system transformation, the Programme aims to improve performance and improve compliance with the National Optimal Pathways within existing budgets.

2.9 The Welsh Government has repurposed Cancer Network funding to provide £2 million per annum for 2024-25 to 2026-27 for the NHS Executive to implement the Programme. Around half of this funding will pay for staff costs in line with the Programme aims around encouraging improvement within existing budgets. NHS Executive officials told us that the Programme may identify improvement opportunities which would then be costed and developed into business cases for additional Welsh Government funding.

41 Breast, gynaecological, lower gastrointestinal, skin, and urological cancers.

Many NHS bodies and third sector partners are confused about the strategic direction

2.10 NHS and third sector organisations told us they are confused about the strategic direction for cancer services in Wales. Some all-Wales NHS bodies have embraced the commitments in the Plan (for example **paragraph 1.33**). Others have rejected actions attributed to their organisation and saw some actions in the Plan as irrelevant (for example **paragraph 2.37**).

2.11 Health boards have developed local initiatives to improve diagnosis, treatment and support for cancer patients but it is not clear how they link to the Cancer Improvement Plan. During our fieldwork it was apparent that NHS bodies were not clear about the status of the Plan and how it should be shaping their activities. NHS and third sector bodies told us that the development of the new initiatives and programmes so soon after the publication of the Cancer Improvement Plan has increased their confusion about the strategic direction.

National leadership, decision-making and oversight arrangements are not effective and there is an over-reliance on narrow performance management

There is a lack of clarity as to who is responsible and accountable for driving system wide improvement to cancer services

2.12 The Welsh Government established the NHS Executive to drive improvements in the quality and safety of care. It brings together existing improvement organisations to better coordinate and drive improvements to the quality and safety of care[42]. However, officials in NHS bodies and third sector representatives we interviewed, were confused about the differing roles of the Welsh Government and NHS Executive. We also heard that there was confusion about the different roles and functions within the NHS Executive. At the time of our review, three NHS Executive functions had responsibility for driving cancer improvement:

- the Strategic Planned Care Programme had responsibility for supporting improvement in the timeliness of cancer diagnosis and treatment;
- the Performance Assurance Directorate provided direct support to NHS bodies to improve cancer performance; and
- the Cancer Network worked with clinicians, health professionals, and third sector and patient representative organisations to improve outcomes and care for cancer patients.

2.13 We found a general consensus, including within the Welsh Government and NHS Executive, that the Executive is not yet providing the intended strong leadership to drive improvement. Many NHS and third sector bodies described arrangements after the establishment of the Executive as a 'step backwards' or 'worse than ever.'

42 The NHS Wales Delivery Unit, the NHS Wales Finance Delivery Unit, the NHS Wales Health Collaborative; and Improvement Cymru.

2.14 Stakeholders raised various concerns about the national leadership and accountability arrangements for cancer services including:

- the Cancer Network lacking the authority to make decisions and commit the level of resources needed to secure change;
- lack of integration of the Cancer Network within the NHS Executive's leadership and with the wider NHS, and gaps in arrangements to share frontline insight from clinicians;
- third sector bodies are struggling to know who to engage with and how to share important intelligence and more generally feeling under-appreciated for the extensive support they provide to the system[43] and individuals and their families (**recommendation 2**);
- overlap and duplication between the cancer recovery work carried out by the Strategic Planned Care Programme and the intervention work led by the Performance Assurance Directorate; and
- lack of communication between the Welsh Government and NHS Executive to assess whether funding for additional capacity is being allocated to areas of greatest need.

2.15 Since our fieldwork the NHS Executive has established a Network Clinical Leadership Group to support closer working between clinicians and wider NHS Executive senior leadership. Whilst this is a positive development, wider action is needed to strengthen national leadership arrangements. The gaps, lack of clarity and duplication described above have led to a situation where many stakeholders from inside and outside of the NHS told us: 'we don't know who is in charge' (**recommendation 2**). The Senedd Health and Social Care Committee's report on gynaecological cancers[44] raised similar concerns and called on the Welsh Government to be 'more accountable' for driving improved cancer services.

43 The third sector has a wealth of knowledge and insight and provides funding for some services in Wales (such as the Teenage Cancer Trust cancer ward in Cardiff). We also found examples of third sector organisations attracting private sector funding to drive innovation, and developing data resources which are now used by NHS Wales.

44 Welsh Health and Social Care Committee, Unheard: Women's Journey through Gynaecological Cancer, December 2023.

National decision-making and leadership arrangements are not sufficiently robust to systematically identify and prioritise opportunities to improve cancer services

2.16 Cancer treatment is an area of significant innovation, with opportunities to improve outcomes and efficiency. We identified examples of Welsh Government investment and decision making to improve cancer and planned care. For instance, it has worked with health boards and the NHS Executive to introduce rapid diagnostic centres; supported improvements to the bowel screening programme and is funding a new cancer centre for Velindre NHS Trust[45].

2.17 However, the Welsh Government recognises that it lacks a robust approach to identifying, assessing and prioritising such opportunities. Current arrangements need strengthening to ensure there is sufficient capacity to assess and prioritise initiatives for funding. Arrangements should address gaps in decision making structures to prioritise investment in areas such as digital, workforce and diagnostics (**recommendation 2**). **Exhibit 19** sets out two areas of opportunity to improve efficiency and outcomes, where decision making has been slow.

45 We are conducting a separate examination of decision-making relating to the development of the new Velindre Cancer Centre. We aim to publish that report in 2025.

Exhibit 19: potential innovations where decision making has been slow

Programme	Description
Digital cellular pathology	During our review, NHS bodies and third sector organisations cited frustration with the speed of national decision making on the use of digital cellular pathology. Betsi Cadwaladr University Health Board was a pioneer of the approach and transformed its pathology service in 2014. Laboratories could scan and upload images onto digital systems to be analysed remotely rather than transporting samples between locations. Alongside a broader transformation programme*, the approach dramatically improved the timeliness of pathology results and helped the health board recruit and retain staff because it facilitated flexible working arrangements. The National Pathology Programme has been working with the Welsh Government and health boards to develop a consistent all-Wales approach to digital cellular pathology since 2019. Despite general consensus on the benefits of the approach, progress has been restricted by uncertainty about who would fund modern scanning equipment and digital storage. Health boards have been reluctant to commit funds without clarity on the Welsh Government's financial contribution. Despite investing in other aspects of digital cellular pathology, at the time of our review, the Welsh Government was not clear about whether it would fund the equipment and storage to establish an all-Wales approach. The National Pathology Programme was still working with health boards to agree a business case share ongoing annual costs of around £3 million for the scanning equipment and storage. Wales now lags behind the rest of the UK for digital cellular pathology capacity, making it a less attractive employment option for newly qualitied pathologists in an already competitive market.

Programme	Description
Lung Screening	In 2019, the Cancer Network started exploring evidence on the effectiveness lung screening. It concluded that screening could increase the percentage of cancers identified at an early stage and had the potential to reduce lung cancer mortality by 20%. The work informed a pilot lung health check programme in Cwm Taf Morgannwg University Health Board, which started in 2022 and was funded by third sector organisations and private industry. The UK National Screening Committee recommended that UK nations develop targeted lung screening for people aged 55-74 years with a history of smoking in June 2022. Despite an endorsement from the Wales Screening Committee in November 2022, the Welsh Government did not task PHW with developing options for a national programme until July 2023. The Welsh Government has asked PHW to provide interim proposals on a national lung screening programme by May 2025. If PHW meets the 2025 deadline, it will have taken three years from the UK National Screening Committee's recommendation just to develop interim proposals. Finalising proposals and implementing a national programme would take more time after this point (**recommendation 5**).

Source: Audit Wales.

Note: *The digital cellular pathology approach was part of a wider transformation programme including combining regional services into a single Betsi Cadwaladr University Health Board Cellular Pathology Service.

2.18 We also heard concerns about the Welsh Government's ability to secure the benefits from its investment in capacity and new ways of working. In particular, stakeholders frequently cited an incoherent approach that has seen the Welsh Government invest in the training and recruitment of radiologists only for many to be unable to find work in NHS Wales (**Exhibit 20**).

Exhibit 20: investment in training and radiologists

A National Imaging Academy opened in 2019, as a result of the Welsh Government providing £3.4 million to HEIW to establish the facility to help meet identified workforce gaps in respect of radiologists and imaging professionals.

However, many of the newly qualified radiologists are leaving Wales because, despite workforce gaps there are no jobs for them. Some health boards told us that financial pressures have led to recruitment freezes which limited their ability to recruit diagnostic staff. We also heard that weaknesses in health board workforce planning including projections of future need and slow recruitment processes were part of the problem*.

The NHS Executive's National Diagnostics Implementation Plan** contains a weak commitment to work with HEIW to 'advocate' for commitment to employment from health boards when requesting training numbers. It is unclear what role the Welsh Government intends to play in ensuring the benefits of its investment in training the future workforce are not lost to Wales (**recommendation 7**).

Source: Audit Wales

Notes:

* Our review of workforce planning made specific recommendations to health boards to improve workforce planning. Individual reports for each NHS body are available on our website www.Audit.Wales.

** NHS Executive, National Diagnostic Implementation Plan 2023-25.

2.19 Regional working across health board areas can help to share capacity and bolster fragile services. Health boards are developing regional approaches in some areas that can increase capacity in the system[46]. The NHS Executive is also developing plans for two regional diagnostic hubs in South Wales to provide additional shared diagnostic capacity for the region. However, the overall pace of regional collaboration is slow. Whilst there is a clear onus on health boards to take forward regional working, there is also a need for national leadership and co-ordination from the Welsh Government and the NHS Executive. In that regard the recent creation of a dedicated senior role within the NHS Executive to support regional working is a welcome development. However, success will also depend on action to tackle barriers to regional working such as a lack of integration between digital systems making it difficult to share waiting lists across health boards[47] (**recommendation 6**).

Welsh Government oversight is narrowly focussed on the 62-day target

2.20 The Welsh Government's NHS Performance Framework (2024-25) sets out the measures (but not the targets) against which NHS bodies are accountable. The 62-day measure is the main cancer specific measure. There is a measure on the timeliness of colonoscopy for bowel screening referrals (**paragraph 1.21**) but no measures for breast or cervical screening referrals. Previous performance frameworks[48] included coverage measures for all three cancer screening programmes. There is also a measure for uptake of the human papillomavirus (HPV) vaccine (**paragraph 2.24**).

2.21 The Performance Framework does not include any measures on cancer incidence, mortality and survival rates. It does not clearly link to the six quality attributes set out in the Quality Statement for Cancer and the Framework makes no reference to compliance with the National Optimal Pathways that underpin the Quality Statement. While the Welsh Government has made the NHS Executive responsible for monitoring compliance with the pathways it is still developing methods for doing so.

46 Including developing regional approaches to diagnostics and treatment in North, Southeast and Southwest Wales using Welsh Government planned care recovery funding.

47 Welsh Health and Social Care Committee, Unheard: Women's Journey through Gynaecological Cancer, December 2023.

48 NHS Wales Performance Framework 2022-23.

2.22 There is a well-established framework for oversight of NHS bodies' planning and performance through activities such as scrutiny of NHS bodies' annual or medium-term plans, monthly Integrated Quality, Planning and Delivery meetings and twice yearly Joint Executive Team meetings between Welsh Government, the NHS Executive and individual NHS bodies. In addition, monthly cancer performance meetings provide a specific focus on the diagnosis and treatment of cancer patients. Collectively this represents a significant volume of performance management activity and includes positive developments around collaboration and information sharing between the Welsh Government and NHS Executive. However, the focus is largely on short-term delivery of the 62-day cancer performance target, rather than broader system change and wider delivery of the vision in the Quality Statement (**recommendation 3**).

The strategic approach lacks a coherent focus on cancer prevention, and is undermined by gaps in data and fragmented digital services

There is no coherent strategic approach to prevention, even though many cancers are preventable and doing so could save lives and reduce demand for NHS services

2.23 The Cancer Improvement Plan states that 38% of cancers each year in Wales are preventable. There are considerable opportunities to tackle lifestyle factors which increase the risks of some cancers. Many of the lifestyle risk factors for cancer are similar across major conditions accounting for the majority of planned and emergency care in the UK. Data from PHW's Public Health Outcomes Framework[49] showed that in 2022-23, 13% of adults in Wales smoked; 17% drank more alcohol than recommended guidelines[50]; and only 36% of working age adults were a healthy weight[51].

2.24 There are also opportunities associated with increasing the uptake of the human papillomavirus (HPV) vaccine. Since its introduction in 2008, the vaccine has reduced cancer rates by almost 90% in women in their 20s and is expected to save hundreds of lives a year in the UK[52]. PHW reported that 74% of children in school year 9 during 2023-24 had the vaccine. There was considerable variation in uptake ranging from 60% in Cardiff and Vale University Health Board to 88% in Swansea Bay. Changes in eligibility for the vaccine make it difficult to compare changes in uptake over time[53].

49 Public Health Wales NHS Trust Observatory, Public Health Outcomes Framework.

50 Based on adults who reported drinking over 14 units of alcohol per week.

51 Smoking and alcohol consumption data uses age standardised rates to account for differences in age structures of different parts of Wales. Data on healthy weight is age specific.

52 Public Health Wales NHS Trust: immunisation and vaccines.

53 Public Health Wales, Vaccine Uptake in Children in Wales, Quarterly Report January to March 2024, May 2024.

2.25 The World Health Organisation states that prevention offers the most cost-effective long-term strategy for managing cancer[54]. The Welsh Government's Science Evidence Advice[55] agrees that there are considerable opportunities to reduce the burden of disease on the NHS by preventing cancer and other major conditions. It identifies scope for long-term financial savings and calls for 'drastic action' to address increases in lifestyle risk factors, making many suggestions to reshape services around prevention.

2.26 The Welsh Government's NHS Planning Framework 2024-27 refers health boards to the Science Evidence Advice, explaining that it expects to see evidence of prevention in health boards plans. However, the Welsh Government does not go further in encouraging and leading health boards to develop local preventative initiatives.

2.27 Preventing cancer would also reduce demand on NHS capacity. **Exhibit 21** sets in crude terms what impact a 10%, 20% and 38% reduction in cancer cases could have, based on 2022-23 activity levels. The potential annual financial savings from the reduction in bed days would be in the order of £8.2 million to £31.4 million[56]. There could also be significant savings from reducing outpatient appointments and drugs costs. However, there would also be costs associated with activity to prevent cancer.

54 World Health Organisation, Health Topics – Cancer Prevention.

55 Welsh Government, Science Evidence Advice – NHS in 10+ Years – An Examination of the Projected Impact of Long-Term Conditions and Risk Factors in Wales', September 2023.

56 Savings calculation based on £500 per day cost of an NHS bed in Wales.

Exhibit 21: potential capacity gains associated with preventing cancer occurring in the first place based on 2022-23 activity

				
2022-23	**90,532** finished consultant episodes	**84,583** admission episodes	**164,971** bed days	**10,864** regular attenders*
-10% 	**81,479** finished consultant episodes (9,053 reduction)	**76,125** admission episodes (8,458 reduction)	**148,474** bed days (16,497 reduction)	**9,778** regular attenders (1,086 reduction)
-20% 	**72,426** finished consultant episodes (18,106 reduction)	**67,666** admission episodes (16,917 reduction)	**131,977** bed days (32,994 reduction)	**8,691** regular attenders (2,173 reduction)
-38% 	**56,130** finished consultant episodes (34,402 reduction)	**52,441** admission episodes (32,142 reduction)	**102,282** bed days (62,689 reduction)	**6,736** regular attenders (4,128 reduction)

Source: Audit Wales analysis of DHCW data from the Patient Episode Database for Wales, Headline Figures and Primary Diagnosis Datasets, Welsh Providers

Note:

*Our analysis is indicative of potential capacity gains based on averages. We calculated potential gains associated with a 38% reduction in activity based on the assertion in the Cancer Improvement Plan that 38% of cancers each year are preventable.

*Regular attenders are patients who are admitted to hospital on a regular basis to receive treatment.

2.28 Despite compelling evidence and it being a long-standing ambition, the Welsh Government has yet to translate broader aims on prevention into more concrete and cohesive policy approaches aimed at shifting the balance of care towards prevention (**recommendation 4**). In particular:

- it has never set out a clear, over-arching strategic approach to achieving this shift across the many public sector bodies whose priorities, choices and behaviours would need to change;
- it has a piecemeal approach with individual strategies on healthy weight and tobacco control[57] but no plan related to the health impacts of alcohol use; and
- the Future Generations Commissioner, amongst others, criticised the Welsh Government for cutting its preventative health improvement budgets in 2024-25[58].

There are gaps in the availability and quality of data to understand how well cancer care is being provided

2.29 Good quality data is essential for the planning, delivery and improvement of cancer care. The NHS Executive has improved the timeliness and accessibility of performance data in an unpublished interactive dashboard used by health boards, the Executive, and the Welsh Government. DHCW publishes a different Suspected Cancer Pathway Dashboard with less detailed information[59].

2.30 However, there are gaps in published data right across the patient pathway (**Exhibit 22**). The Welsh Government publishes data on 'closed' pathways showing how many patients were treated within 62 days but does not publish 'open' pathway waits to show how many patients are currently waiting for treatment.

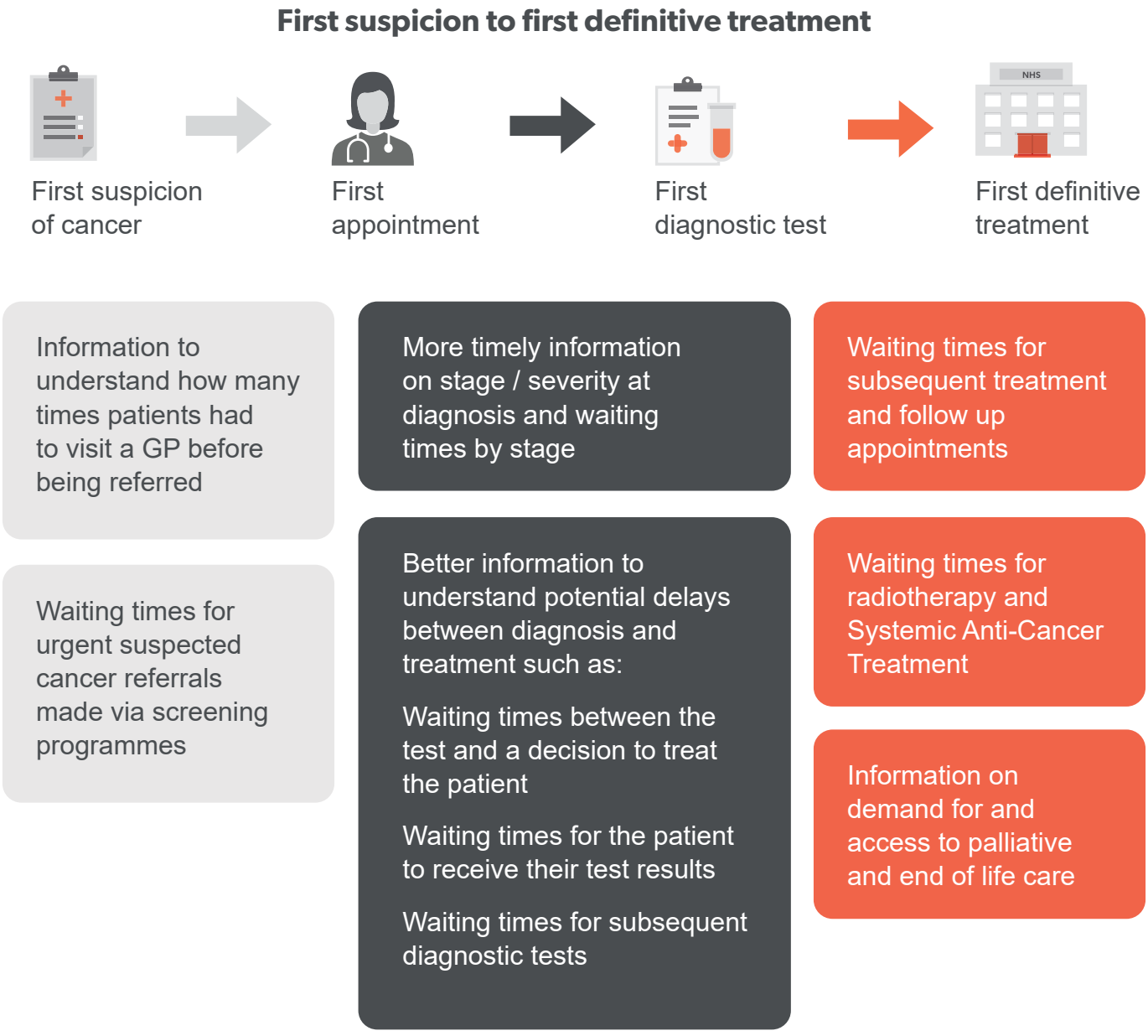
2.31 Much of the available data focusses narrowly on the period between referral and diagnosis or first treatment. There is no national data on the activity and timeliness leading up to a referral. There is also no available data on activity after the first treatment starts (see **paragraph 1.6**), including follow-up tests, ongoing treatment and access to palliative and end-of-life care (**recommendation 9**).

57 Welsh Government, Healthy Weight Healthy Wales, 2019 and Welsh Government, A Smoke Free Wales – Our Long-term Tobacco Control Strategy, 2022.

58 The budget for health improvement and healthy living reduced by £3.8 million bringing the total budget to £10.8 million; the substance misuse action plan fund by £2.5 million bringing the total budget to £47.5 million); and the health promotion budget fell by £710,000 to £12.2 million.

59 DHCW's dashboard uses data which has been validated to identify errors but the internal NHS Executive dashboard is unvalidated performance data.

Exhibit 22: gaps in data at different stages of the cancer pathway



Source: Audit Wales

2.32 There is very limited data to track progress against the ambitions in the Quality Statement. Against the overarching ambition of prevention and early detection, we found limited information on the causes of growing demand that can be used to prevent or detect cancer early amongst those most at risk. For instance, little is known about why some people are presenting at a more advanced stage, or as an emergency. There is also limited information about the demographic profile and location of people with unhealthy lifestyles. A new project led by WCISU has the potential to improve national intelligence on cancer risk factors. It will link Cancer Registry data to Census 2021 information via the SAIL databank to explore the influence of factors like ethnicity, income and educational status on cancer outcomes[60].

2.33 There is also very limited information to understand how equitable cancer support services are. For example:

- the Welsh Government requires heath boards to record the ethnicity of cancer patients[61] but compliance is extremely low. We were unable to analyse waiting list and timeliness trends by ethnicity because over two thirds of the pathways had no information on patient ethnicity.
- DHCW reports performance against the 62-day target by sex but there is little information to understand patient experience and outcomes by sex. The Senedd inquiry into gynaecological cancers found that women can experience many barriers to accessing cancer treatment but there is little information to understand how many women are affected[62].
- there is insufficient public data to understand potential differences in the timeliness of cancer diagnosis and treatment across Wales, particularly for people living in Powys. Timeliness data for Powys residents treated by other Welsh health boards is included in data for those health boards. The data is not disaggregated to show timeliness for Powys residents or the residents of the health board providing treatment[63]. There is also a lack of data on Welsh patients from any health board who are treated by NHS England (**recommendation 10**).
- there is also little information to understand equity of provision for children and young people. DHCW groups all data for under 30-year-olds together in the Suspected Cancer Dashboard data whereas other patients are grouped ten-year age bands. Under 16-year-olds are excluded from the Macmillan cancer patient experience survey.

60 The project aims to report its findings in late 2024.

61 Under Data Standards Change Notices from 2020 onwards (DCSN 2020/21 and DSCN 23/45). The Notices mandate compliance with data standards.

62 Welsh Parliament Health and Social Care Committee, Unheard: Women's Journey Through Gynaecological Cancer, December 2023.

63 Other published NHS Wales data does include distinct health board 'residence' and 'provider' performance data. For instance the Referral for Treatment data on StatsWales.

2.34 There are problems with the quality of some of the available data. WCISU officials told us Wales is a year behind England in publishing Cancer Registry data because a high volume of errors in the source data is creating extra work for its staff. NHS bodies told us that poor compliance with data standards by NHS staff inputting patient information is creating data errors. We found that there is confusion around who is responsible for improving compliance (**recommendation 8**). We have not specifically reviewed data quality as part of this review but have uncovered several inaccuracies in published data and bespoke analysis provided by DHCW.

Digital systems are fragmented and progress implementing the new cancer information system has been slow

2.35 Progress in updating the core digital system for cancer patients has been extremely slow. The previous system (Canisc) was constructed using a programming language in 1997 which Microsoft stopped supporting in 2014. Following our 2018 report on NHS Wales informatics systems[64], the Senedd Public Accounts Committee inquiry raised serious concerns about slow progress replacing Canisc[65]. It took a further five years to implement the first phase of the new cancer information system. DHCW told us that the pandemic has added to delays. The Welsh Government has recently confirmed funding for the second phase of the programme, aimed at improving integration and digital processes and dealing with requests for specific changes from individual NHS bodies.

2.36 More broadly, NHS bodies told us that lack of integrated digital systems is consuming valuable staff time because they are using manual 'workarounds' to transfer patients across the different patient administration systems. The process is frustrating staff and diverting their time from seeing patients. It also carries risks to patient safety because details could be transferred incorrectly or not at all. DHCW is responsible for delivering national digital systems for NHS Wales but not their local configuration. DHCW described considerable barriers to getting those systems to join up. In particular, there are numerous examples of NHS bodies either procuring their own digital systems rather than using the national products, or adapting the national products which limits interoperability.

2.37 The Cancer Improvement Plan committed PHW, the Cancer Network and DHCW to developing a cancer version of the national Digital and Data Strategy for Wales by the end of June 2023. No such plan had been created at the time of our review and we found confusion about the commitment to create one in the first place. DHCW told us there is no need to create a separate digital cancer plan because the overarching Digital and Data Strategy sets out the system wide approach to improve digital provision.

64 Wales Audit Office, Informatics Systems in NHS Wales, 2018.

65 National Assembly for Wales Public Accounts Committee, Informatics Systems in NHS Wales, 2018.

Appendices

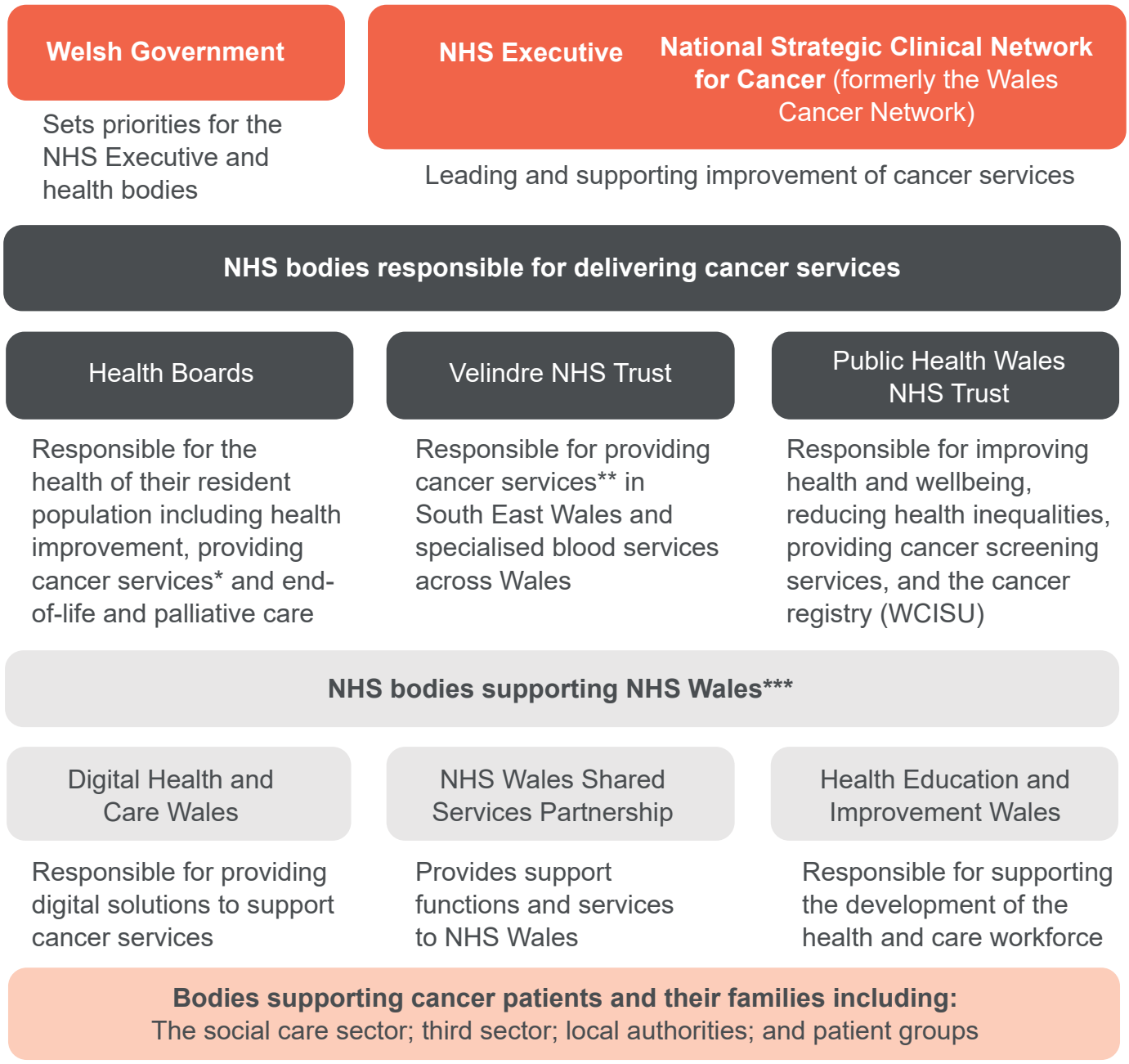
1 Strategic context

2 Additional data analysis

3 About our work

1 Strategic context

Exhibit 23: broad roles and responsibilities for cancer services in Wales



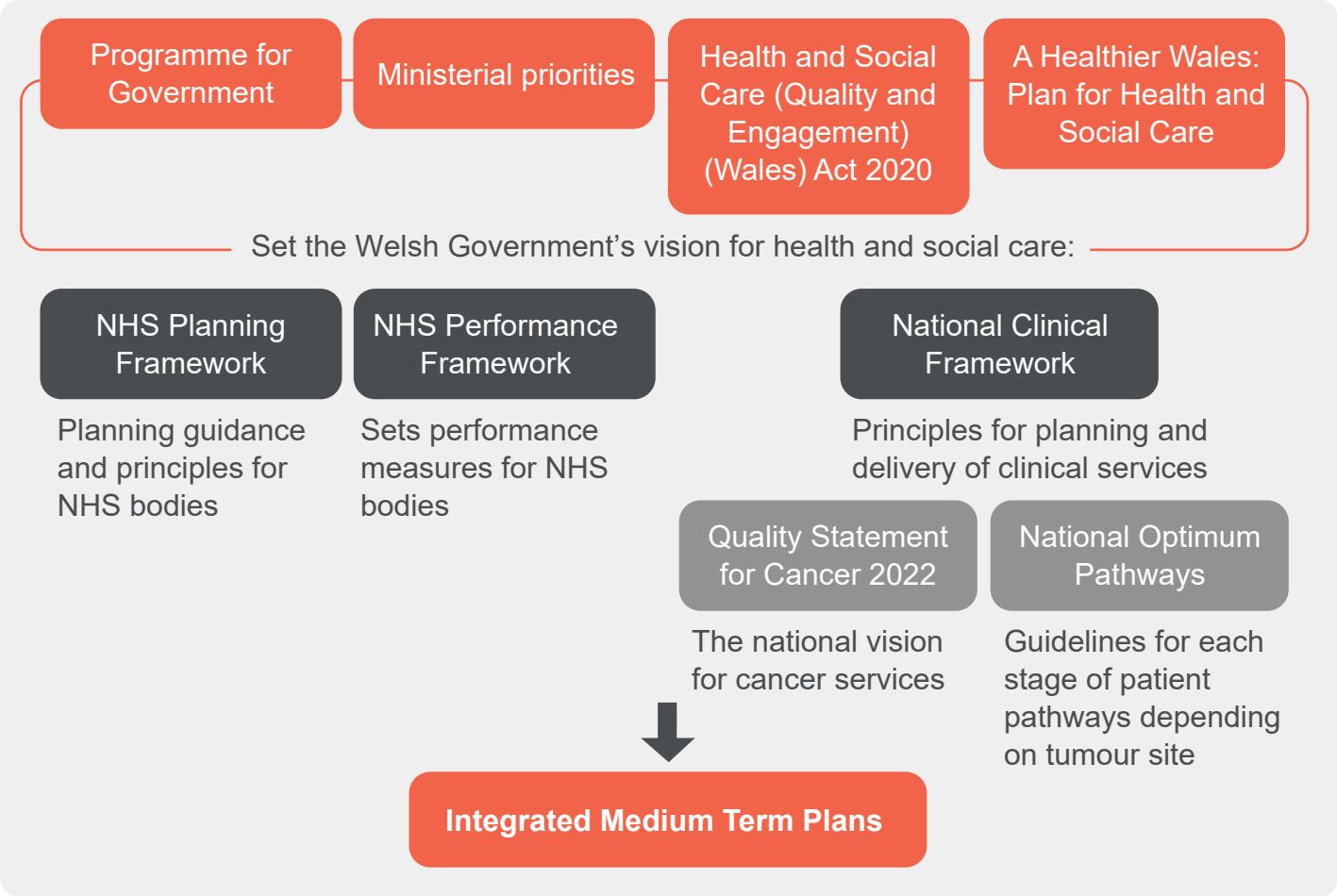
Source: Audit Wales

Note:

*Including diagnostic tests; treatment; and support and advice for patients. The level and type of services provided differs between health boards because some services are provided by other healthcare providers. For instance, Powys Teaching Health Board provides some diagnostic services but commissions other cancer services from other NHS providers in England and Wales.

**Including chemotherapy; radiotherapy; and support and advice for patients.
***There are also organisations and groups responsible for research, development and innovation including: Geonomics Partnership Wales; Health and Care Research Wales; Life Sciences Hub Wales; and the Wales Cancer Research Centre.

Exhibit 24: key elements of the strategic approach to cancer services in Wales



Source: Audit Wales

2 Additional data analysis

Data on demand for cancer services

Exhibit 25: Patients who were treated by source of suspicion, monthly average across 2023-24

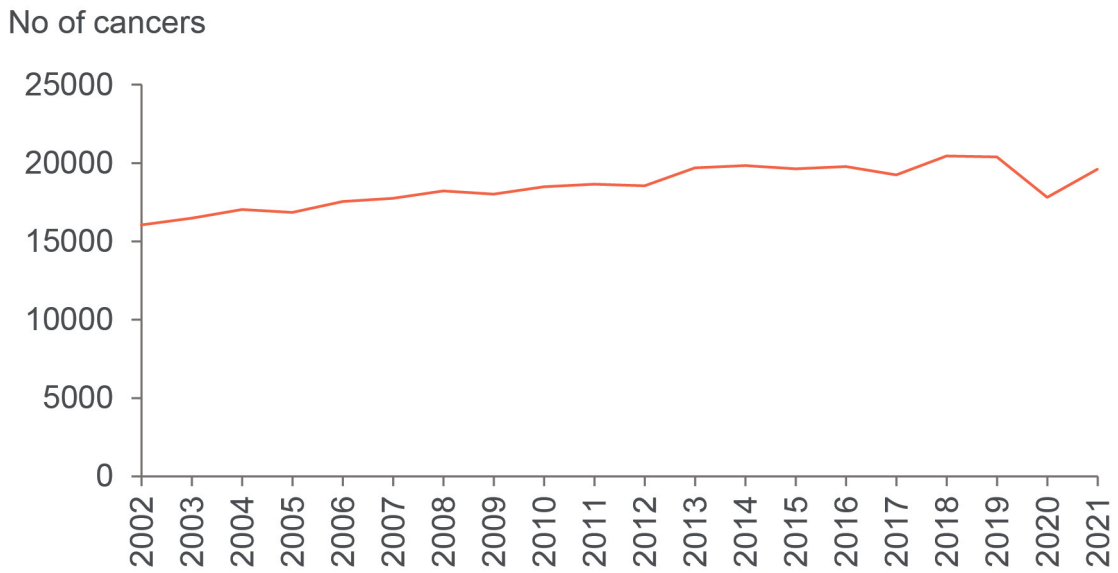
Source of suspicion / referral	% overall suspected cancer referrals	% of patients starting treatment as a proportion of referrals by source of suspicion
GP	**80%** (12,635 people)	**8% of GP referrals** (975 people)
Internal secondary care	**10%** (1,570 people)	**17% of internal secondary care referrals** (266 people)
Following a diagnostic test	**6%** (911 people)	**37% of referrals following a diagnostic test** (341 people)
Bowel screening	**1%** (120 people)	**28% of bowel screening referrals** (33 people)
Breast screening	**1%** (106 people)	**92% of breast screening referrals** (98 people)
Cervical screening	**<1%***	**50% of cervical screening referrals***
Emergency department	**1%** (214 people)	**38% of emergency department referrals** (81 people)
Other primary care professional	**1%** (120 people)	**5% of referrals from other primary care professionals***
Other health professional	**<1%** (66 people)	**15% of referrals from other health professionals***
Consultant from another health board	**<1%** (38 people)	**21% of referrals from external consultants***

Source: Audit Wales analysis of DHCW Suspected Cancer Pathway Data – closed pathways by source of suspicion.

Note: A small number of patient pathways did not have data on the source of suspicion / referral.

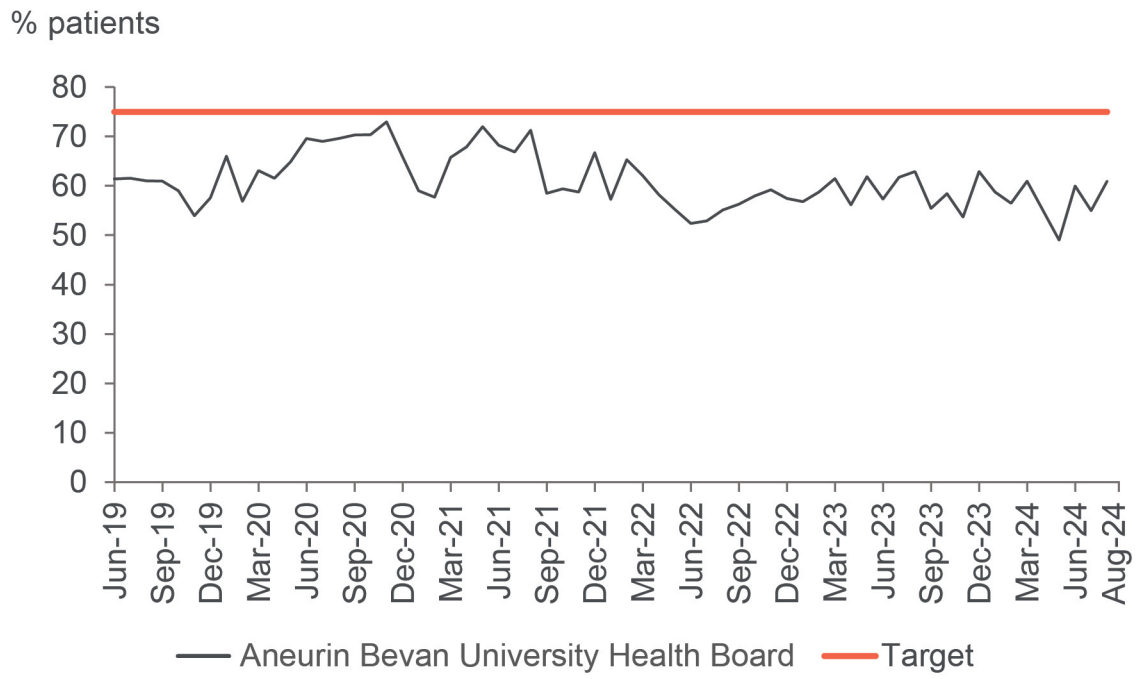
*Where there are 10 people or less.

Exhibit 26: number of newly diagnosed cancers in Wales (excluding non-melanoma skin cancer), 2002-2021



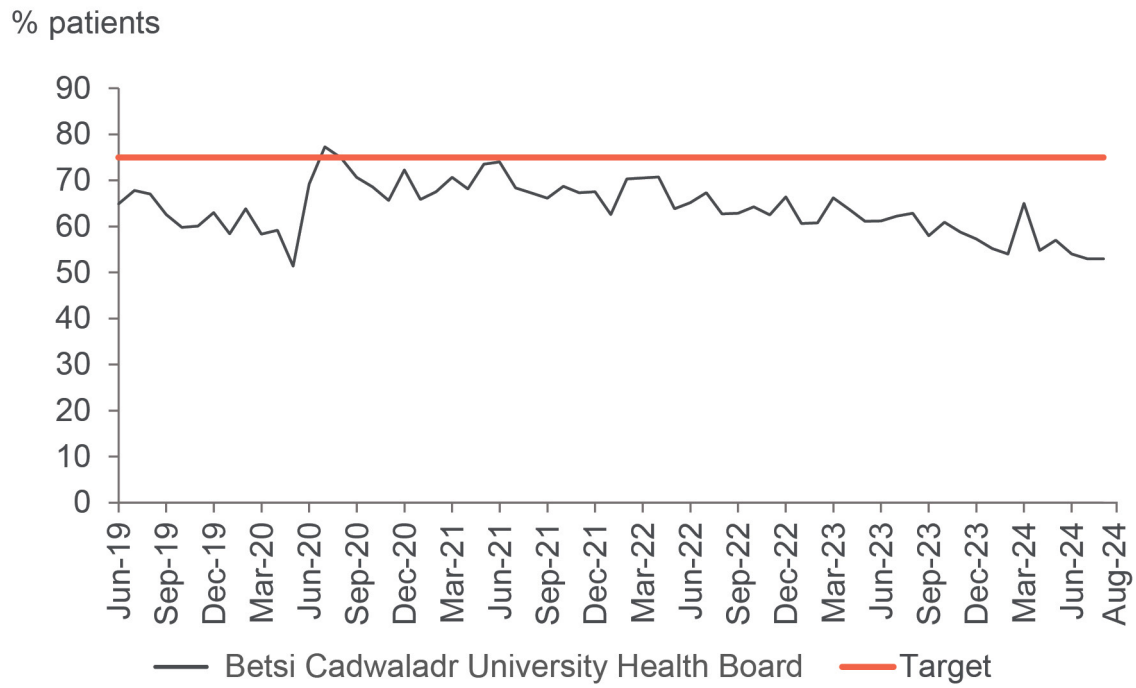
Source: WCISU cancer incidence data

Exhibit 27a: performance against the 62-day target by Aneurin Bevan University Health Board, June 2019 to August 2024



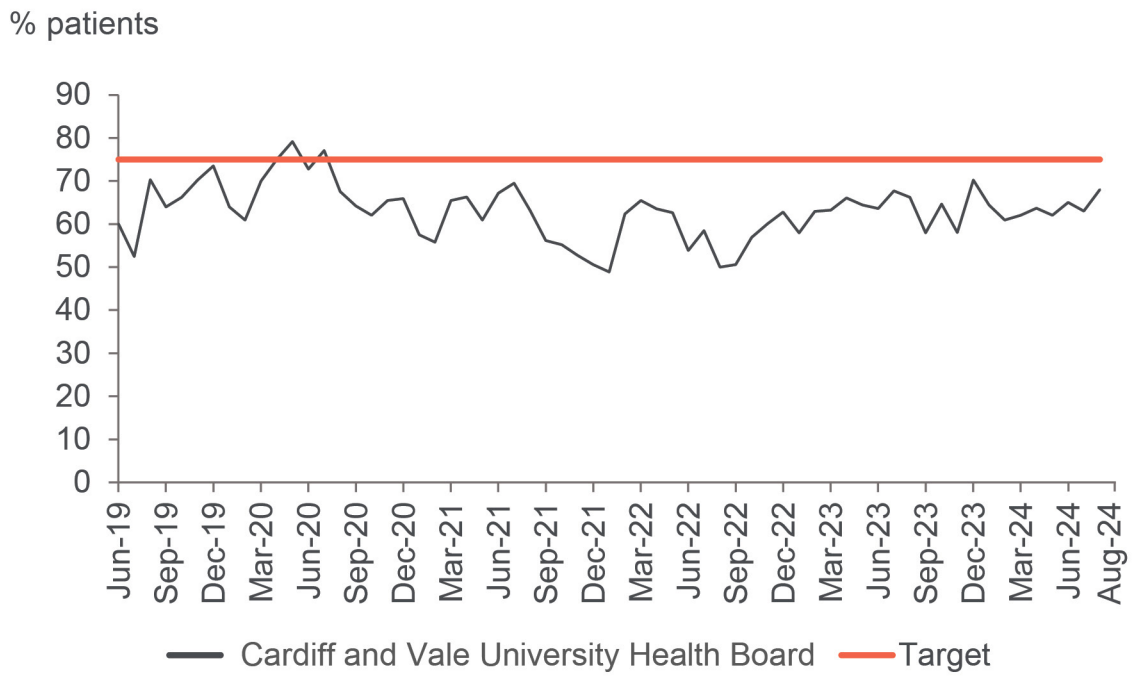
Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Exhibit 27b: performance against the 62-day target by Betsi Cadwalladr University Health Board, June 2019 to August 2024



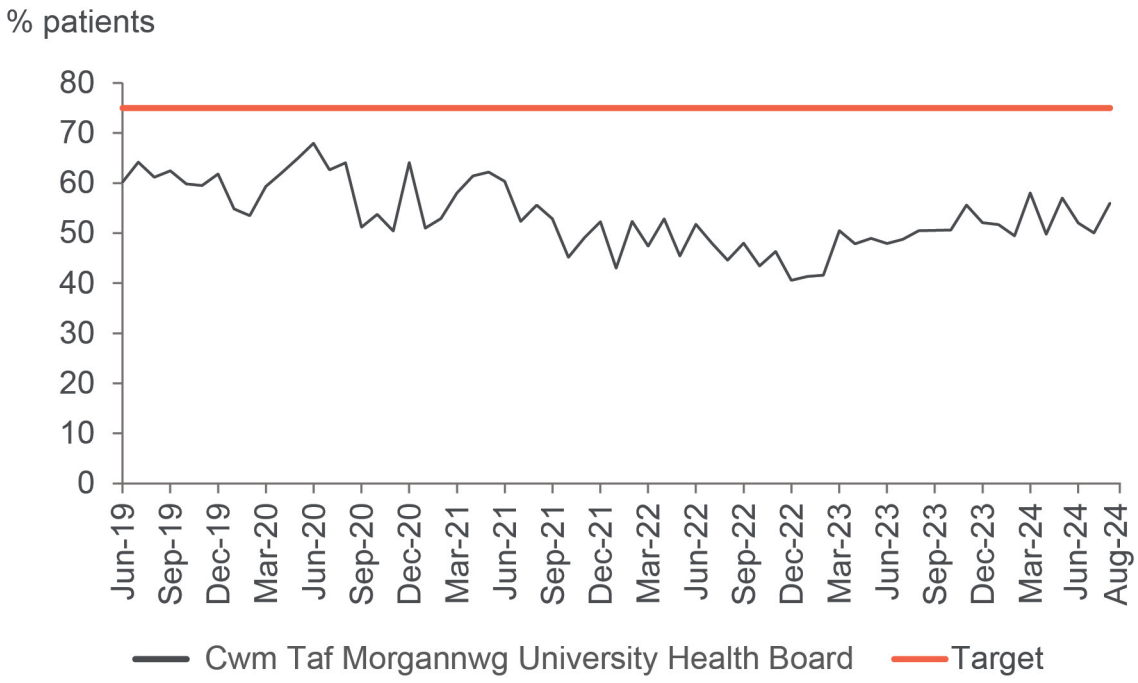
Source: DHCW, Suspected Cancer Pathway – Closed Pathways, on StatsWales.

Exhibit 27c: performance against the 62-day target by Cardiff and Vale University Health Board, June 2019 to August 2024



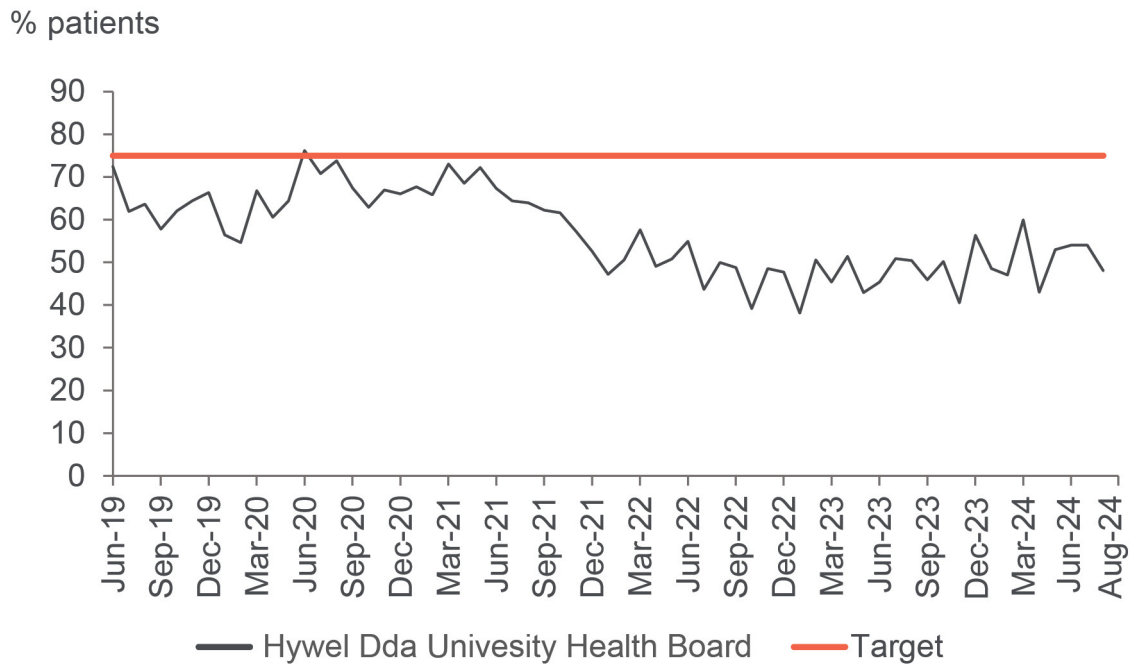
Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, On StatsWales.

Exhibit 27d: performance against the 62-day target by Cwm Taf Bro Morgannwg University Health Board, June 2019 to August 2024



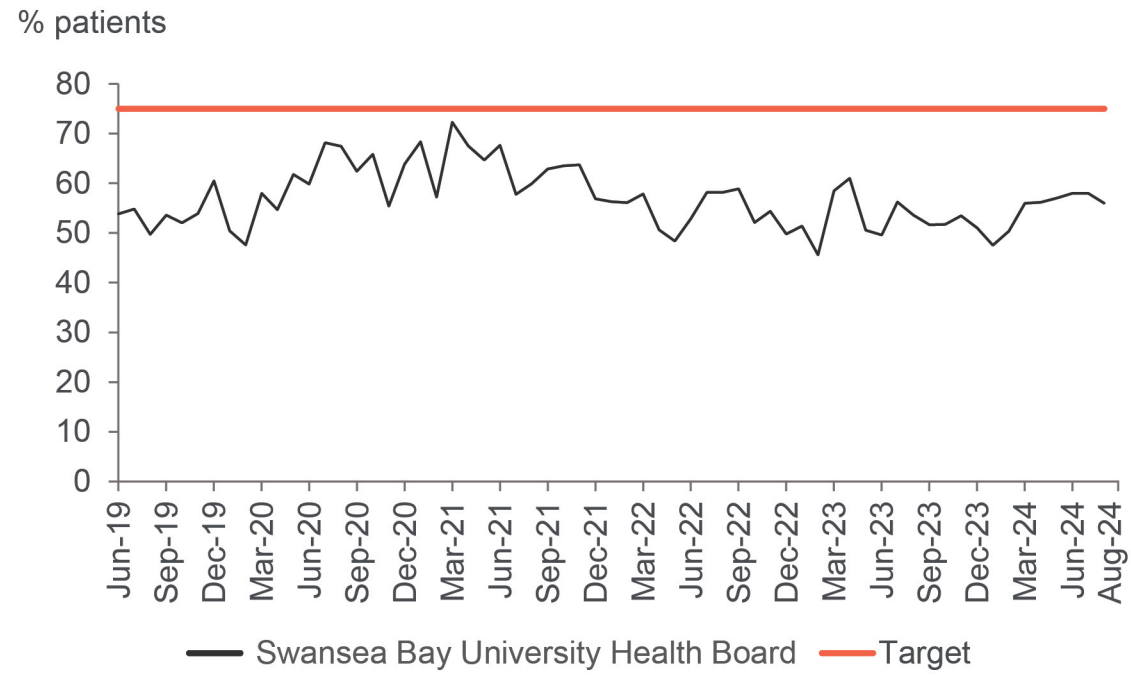
Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Exhibit 27e: performance against the 62-day target by Hywel Dda University Health Board, June 2019 to August 2024



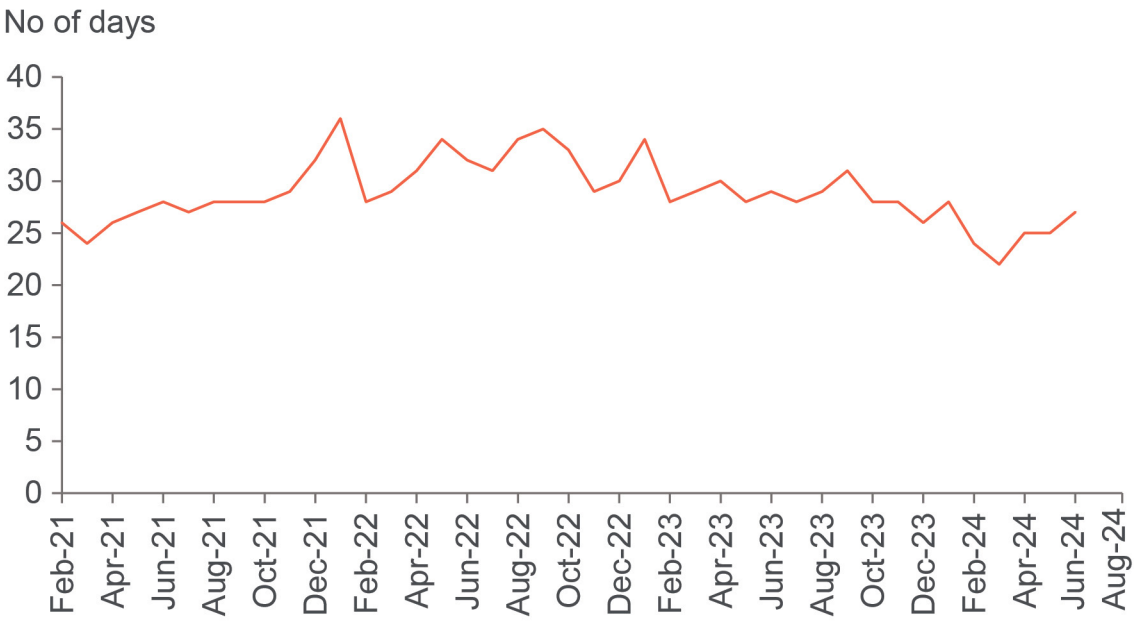
Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Exhibit 27f: performance against the 62-day target by Swansea Bay University Health Board, June 2019 to August 2024



Source: DHCW, Suspected Cancer Pathway – Closed Pathways dataset, on StatsWales.

Exhibit 28: median waits from first suspicion to diagnosis, February 2021 to August 2024



Source: DHCW data from the Suspected Cancer Pathway Dashboard

3 About our work

Audit question, scope and criteria

We chose to focus on the national strategic approach to improving the timeliness of cancer diagnosis and treatment because we identified significant systemic challenges facing cancer services during our scoping. This review focuses on the Welsh Government and NHS Executive (and its National Strategic Clinical Network for Cancer) as system leaders, recognising that health boards and trusts have responsibility for the operational delivery of different aspects of cancer services. We will consider the merits of further work focusing on NHS bodies' approach to delivering cancer services in our 2025-26 work programme.

We developed our audit criteria based on learning from our previous audits of planned care[66] and local health audit work, analysis of key strategic documents[67], and research from relevant organisations on the challenges associated with cancer services in Wales.

66 Audit Wales, NHS Wales Waiting Times for Elective Care in Wales, 2015; Audit Wales, 10 Opportunities for Resetting and Restarting the NHS Planned Care System, 2020; and Audit Wales, Tackling the Planned Care Backlog in Wales, 2022.

67 Including Welsh Government, A Healthier Wales – a Long Term Plan for Health and Social Care, 2021; Welsh Government, Our Programme for Transforming and Modernising Planned Care and Reducing Waiting Lists in Wales, 2022, Welsh Government, The Quality Statement for Cancer, 2022, Welsh Government, Diagnostics Recovery and Transformation Strategy for Wales 2023 to 2025; and the National Strategic Clinical Network for Cancer, A Cancer Improvement Plan for NHS Wales 2023-26, 2023.

Audit methods

Document review

We reviewed relevant documentation including:

- documents setting out the national strategic approach. Key documents include the Quality Statement for Cancer, Cancer Improvement Plan, the Diagnostic Recovery and Transformation Strategy, National Clinical Framework, National Optimal Pathways and NHS planning and performance frameworks
- documents relating to the NHS Executive's national cancer recovery programme
- individual NHS body plans setting out their approach to delivering cancer services, and relevant board and committee papers on cancer performance
- papers from the Welsh Government's performance management meetings
- Public Health Wales NHS Trust information on the delivery of population screening servicesinformation on cancer data and population health including reports from the Welsh Cancer Surveillance and Intelligence Unit and the Welsh Government's Science Evidence Advice[68]
- the Senedd Health and Social Care Committee's report on its inquiry on gynaecological cancers[69] and supporting evidence

Semi-structured interviews

We interviewed officials from the following organisations:

- the Welsh Government;
- the NHS Executive including its National Strategic Clinical Network for Cancer;
- a sample of health boards including officials from Betsi Cadwaladr, Hywel Dda and Swansea Bay University Health Boards, and Powys Teach Health Board;
- officials from other NHS bodies including Digital Health and Care Wales, Health Education and Improvement Wales, Public Health Wales and Velindre NHS Trusts; and
- we also met with officials from the NHS Executive, Cardiff and Vale, Hywel Dda and Swansea Bay University Health Boards to inform our scoping.

68 Welsh Government, Science Evidence Advice – NHS in 10+ Years – An Examination of the Projected Impact of Long-Term Conditions and Risk Factors in Wales', September 2023.

69 Welsh Parliament Health and Social Care Committee, Unheard: Women's Journey Through Gynaecological Cancer, December 2023.

Workshop with third sector representatives

We held a workshop with representatives from the third sector on 1st May 2024 organised by the Wales Cancer Alliance[70]. We asked participants for their views of the strengths and weaknesses of the national strategic approach and invited further written responses with more detail on the same topic. We conducted follow-up interviews with some organisations for clarification where necessary. Representatives from the organisations below took part in the workshop:

- ALK Positive UK
- Association of the British Pharmaceutical Industry
- Blood Cancer UK
- Bowel Cancer UK
- Breast Cancer Now
- Cancer Research UK
- Fair Treatment for the Women of Wales
- Leukaemia Care
- MacMillan Cancer Support
- Marie Curie
- Prostate Cancer UK
- Royal College of Pathologists
- Royal College of Paediatrics and Child Health
- Royal College of Physicians
- Tenovus Cancer Care
- Young Lives vs Cancer
- We established an expert panel to inform our understanding of the systemic barriers to the timeliness of cancer diagnosis and treatment and provide critical challenge on our findings. The panel included representatives from Marie Curie, the Association of the British Pharmaceutical Industry, the Royal College of Physicians, and the Wales Cancer Alliance.

70 A coalition of charities working to prevent cancer, improve care, fund research and influence policy in Wales.

Data analysis

We reviewed data from different sources including:

- DHCW published data on open and closed cancer pathways, on StatsWales;
- DHCW published data on hospital admissions. We also requested data on discharge destinations of cancer patients admitted to hospital;
- we requested data from the Suspected Cancer Pathway dataset managed by DHCW that is not published elsewhere. We analysed data on performance against the Suspected Cancer Pathway target by ethnicity; source of suspicion ; and closed pathways by whether patients started treatment for cancer, were downgraded for not having cancer, or died before being downgraded or starting treatment; and
- Welsh Cancer Surveillance and Intelligence Unit data on cancer incidence, mortality and survival.

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Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

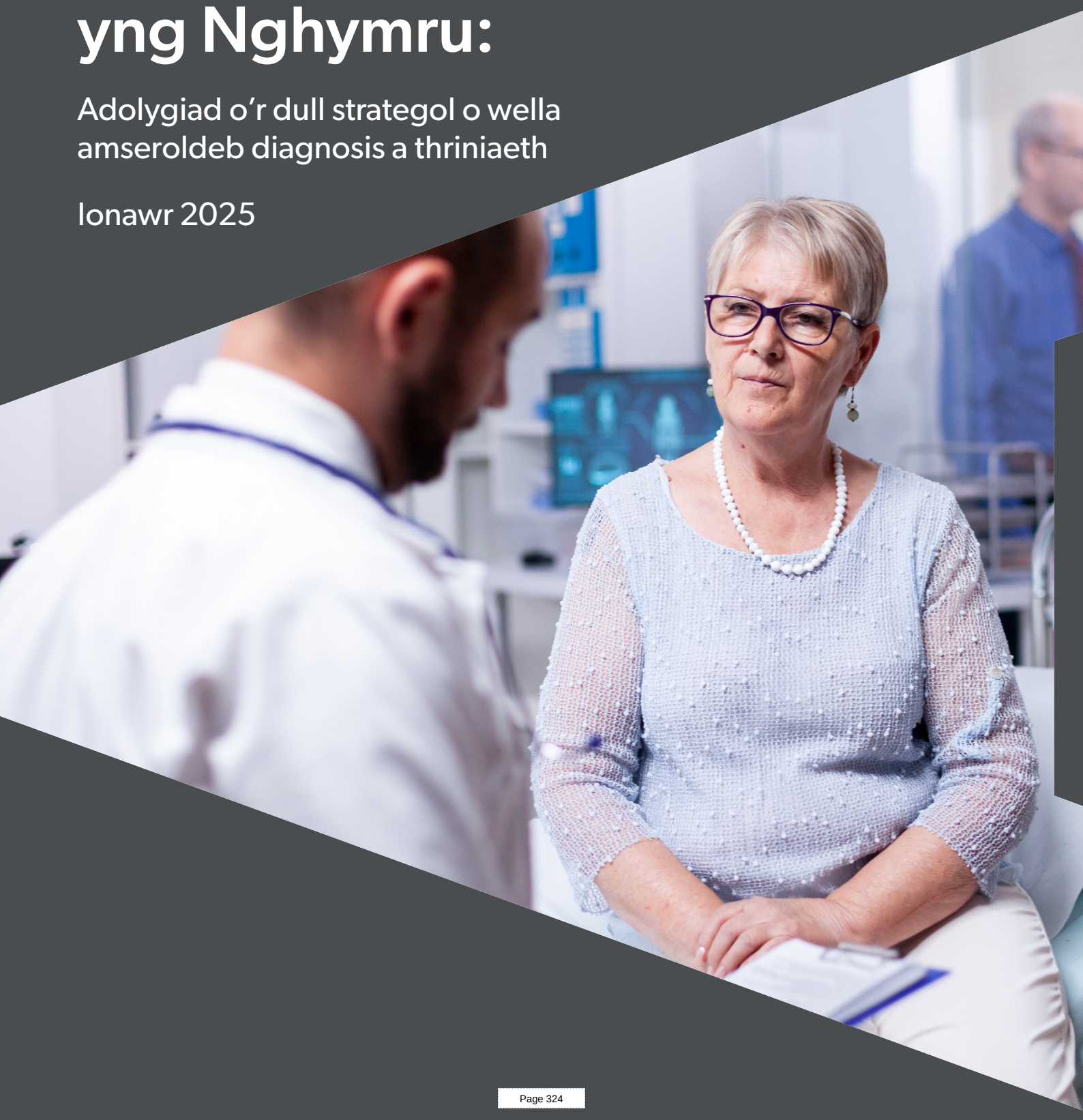
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Gwasanaethau Canser yng Nghymru:

Adolygiad o'r dull strategol o wella amseroldeb diagnosis a thriniaeth

Ionawr 2025



Paratowyd yr adroddiad hwn i'w gyflwyno i'r Senedd o dan Ddeddf Llywodraeth Cymru 1998 a Deddf Llywodraeth Cymru 2006.

Mae'r Archwilydd Cyffredinol yn annibynnol o'r Senedd ac o lywodraeth. Mae'n archwilio ac yn ardystio cyfrifon Llywodraeth Cymru a'r cyrff cyhoeddus sy'n gysylltiedig â hi ac a noddir ganddi, gan gynnwys cyrff y GIG. Mae ganddo'r pŵer i gyflwyno adroddiadau i'r Senedd ar ddarbodaeth, effeithlonrwydd ac effeithiolrwydd y defnydd a wna'r sefydliadau hynny o'u hadnoddau wrth gyflawni eu swyddogaethau, a sut y gallent wella'r defnydd hwnnw.

Mae'r Archwilydd Cyffredinol hefyd yn archwilio cyrff llywodraeth leol yng Nghymru ac yn cynnal astudiaethau gwerth am arian llywodraeth leol.

Mae'r Archwilydd Cyffredinol yn ymgymryd â'i waith gan ddefnyddio staff ac adnoddau eraill a ddarperir gan Swyddfa Archwilio Cymru, sydd yn fwrdd statudol wedi'i sefydlu ar gyfer y nod hwnnw ac i fonitro a chynghori'r Archwilydd Cyffredinol.

Archwilio Cymru yw brand ymbarél Archwilydd Cyffredinol Cymru a Swyddfa Archwilio Cymru, sy'n endidau cyfreithiol ar wahân gyda'u swyddogaethau cyfreithiol eu hunain. Nid yw Archwilio Cymru ei hun yn endid cyfreithiol. Er bod gan yr Archwilydd Cyffredinol y swyddogaethau archwilio ac adrodd a ddisgrifir uchod, prif swyddogaethau Swyddfa Archwilio Cymru yw darparu staff ac adnoddau eraill ar gyfer arfer swyddogaethau'r Archwilydd Cyffredinol, ac i fonitro a chynghori'r Archwilydd Cyffredinol.

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Cewch ailddefnyddio'r cyhoeddiad hwn (heb gynnwys y logos) yn rhad ac am ddim mewn unrhyw fformat neu gyfrwng. Os byddwch yn ei ailddefnyddio, rhaid i chi ei ailddefnyddio'n gywir ac nid mewn cyd-destun camarweiniol.

Rhaid cydnabod y deunydd fel hawlfraint Archwilydd Cyffredinol Cymru a rhaid rhoi teitl y cyhoeddiad hwn. Lle nodwyd deunydd hawlfraint unrhyw drydydd parti bydd angen i chi gael caniatâd gan ddeiliaid yr hawlfraint
dan sylw cyn ei ailddefnyddio.

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Rydym yn croesawu galwadau ffôn yn Gymraeg a Saesneg. Gallwch ysgrifennu atom hefyd, yn Gymraeg neu'n Saesneg, a byddwn yn ymateb yn yr iaith rydych chi wedi ei defnyddio. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

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Cynnwys

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Ffeithiau allweddol

Arddangosyn 1: ffeithiau allweddol

Canser yw **prif achos marwolaeth** yng Nghymru

Cymru sydd â'r gyfradd marwolaethau canser ail uchaf yn y DU. Mae gan y DU un o'r cyfraddau marwolaeth canser uchaf ymhlith holl wledydd y Sefydliad ar gyfer Cydweithrediad a Datblygiad Economaidd

Mae'r cyfraddau goroesi canser bum mlynedd ar ôl cael diagnosis wedi gwella. Goroesodd **62%** o'r bobl a gafodd ddiagnosis o ganser rhwng 2016–2022 bum mlynedd ar ôl cael diagnosis o'u cymharu â **54%** o'r bobl a gafodd ddiagnosis rhwng 2002–2006

Gellid atal **4 o bob 10** achos o ganser blynyddol yng Nghymru

Ar £719 miliwn yn 2022-23, gwariant ar wasanaethau canser oedd y **trydydd maes gwariant uchaf y GIG** ar ôl iechyd meddwl a thrawma ac orthopedeg

Bu **cynnydd o 54%** mewn gwariant termau real ar wasanaethau canser rhwng 2009–10 a 2022–23

Ers mis Awst 2020, nid oes yr un bwrdd iechyd wedi cyflawni'r targed cyffredinol sef y dylai **75%** o'r cleifion ddechrau eu triniaeth diffiniol cyntaf o fewn **62 o ddiwrnodau** i'r amheuaeth gyntaf o ganser

Rhwng mis Awst 2023 a mis Awst 2024, dechreuodd rhwng **53%** a **61%** o'r cleifion driniaeth o fewn **62 o ddiwrnodau**

Yn 2021, cafodd **24%** o'r cleifion canser ddiagnosis yn ystod cam 4, a **18%** ohonynt yn ystod cam 3

Ar gyfer pob math o ganser, mae gostyngiad yn y nifer sy'n goroesi wrth i gam y canser fynd rhagddo

Rhwng mis Gorffennaf 2023 a mis Gorffennaf 2024, dim ond **21%** o'r cyfranogwyr sgrinio'r coluddyn a gyfeiriwyd at eu bwrdd iechyd i gael colonosgopi a gafodd gynnig y driniaeth o fewn 4 wythnos, o'u cymharu â'r safon o 90%

Mae cymhwysedd ar gyfer sgrinio'r coluddyn wedi ehangu fesul cam ers mis Hydref 2021. Mae bellach yn cynnwys pobl rhwng **50 a 74** oed, ac mae'n defnyddio prawf mwy sensitif.

Roedd y nifer a gafodd sgriniad serfigol yn **is na'r safon**

Canser y croen nad yw'n felanoma, canser y coluddyn, canser y fron, canser yr ysgyfaint a chanser y prostad yw'r **canserau mwyaf cyffredin** yng Nghymru

Ffynhonnell: Archwilio Cymru

Nodiadau: *Data Llywodraeth Cymru: Gwariant y GIG yn ôl categori cyllideb rhaglen a blwyddyn, 'canserau a thiwmorau', ar StatsCymru.

4 Negeseuon allweddol

Cyd-destun

1 Bydd un o bob dau o bobl yn y DU a anwyd ar ôl 1960 yn cael diagnosis o ryw fath o ganser yn ystod eu hoes[1]. Mae llawer o bobl yn mynd ymlaen i oroesi canser ac i fyw bywyd iach. Mae diagnosis cynnar a thriniaeth amserol yn allweddol i oroesi y rhan fwyaf o ganserau.

2 Mae llawer o sefydliadau yn y sector cyhoeddus a'r trydydd sector yn darparu gwasanaethau er mwyn canfod, rhoi diagnosis a thrin canserau a chefnogi cleifion canser. Mae rhai gwasanaethau, yn nodedig Therapi Gwrth-ganser Systemig[2] a radiotherapi, yn gwasanaethu cleifion canser yn bennaf. Fodd bynnag, mae llawer o'r capasiti cleifion allanol, diagnostig a llawfeddygol sydd ei angen ar gyfer cleifion canser yn rhan o'r system gofal a gynllunnir yn ehangach.

3 Mae Llywodraeth Cymru yn gyfrifol am osod y weledigaeth a phennu'r targedau gofal iechyd, ac am ddyrannu cyllid. Mae'n nodi amrywiaeth o ddisgwyliadau ar gyfer Gweithrediaeth y GIG, gan gynnwys cefnogi gwelliant mewn gwasanaethau canser, drwy lythyr cylch gwaith blynyddol. Mae'r Rhwydwaith Clinigol Strategol Cenedlaethol ar gyfer Canser[3] yn rhan o Weithrediaeth y GIG ac mae'n dod â chlinigwyr a gweithwyr iechyd proffesiynol at ei gilydd i gefnogi gwelliant. Mae byrddau iechyd yn gyfrifol am ddarparu gofal o ansawdd uchel i gleifion a chyflawn targedau perfformiad. Mae **Atodiad 1** yn esbonio rolau a chyfrifoldebau ar gyfer gwasanaethau canser ac elfennau allweddol o'r dull strategol.

4 Mae ein gwaith wedi archwilio cydlyniad y trefniadau cenedlaethol i sbarduno gwelliannau mewn gwasanaethau canser yng Nghymru. Mae'r adroddiad yn cynnwys trosolwg o berfformiad GIG Cymru wrth ddarparu diagnosis a thriniaeth canser ac mae'n cynnig safbwyntiau ar y rhagolygon ar gyfer gwella, gan gynnwys drwy atal. Nid yw'r adroddiad yn gwneud sylw ar berfformiad cyrff unigol y GIG oherwydd y bydd hyn yn cael ei archwilio yn rhan o raglen gwaith archwilio lleol 2025 yr Archwilydd Cyffredinol yn y cyrff hynny. Mae **Atodiad 3** yn darparu rhagor o fanylion am ein gwaith.

1 Cancer Research UK.

2 Mae Therapi Gwrth-ganser Systemig yn cynnwys cemotherapi, imiwnotherapi a therapi hormonau.

3 Rhwydwaith Canser Cymru oedd ei enw ar y pryd. Cyfeiriwn at y Rhwydwaith fel y 'Rhwydwaith Canser' drwy gydol yr adroddiad er hwylustod wrth gyfeirio.

Casgliadau cyffredinol

5 Ar y cyfan, canfuom er gwaethaf cynnydd mewn buddsoddiad, fod methiant parhaus i gyflawni'r targedau perfformiad cenedlaethol ar gyfer canser a bod lleiafrif o gleifion yn wynebu arosiadau annerbyniol o hir am ddiagnosis a/neu driniaeth. Mae canlyniadau canser yng Nghymru wedi gwella yn ystod y blynyddoedd diwethaf ond maent yn dal yn wael o'u cymharu â gwledydd eraill. Mae gwendidau mewn arweinyddiaeth strategol cenedlaethol y mae angen mynd i'r afael â hi ar frys er mwyn helpu i sbarduno'r gwelliannau angenrheidiol o ran amseroldeb a chynaliadwyedd diagnosis a thriniaeth canser.

Materion allweddol

Perfformiad ac adnoddau

6 Mae'r galw gan gleifion yr amheuir bod ganddynt ganser yn cynyddu o flaen gallu'r GIG i'w fodloni. O ganlyniad, mae'r rhestr aros ar gyfer diagnosis a thriniaeth yn tyfu. Mae ein modelu dangosol yn dangos, heb gynnydd sylweddol mewn gweithgarwch i wneud diagnosis a thrin cleifion, na fydd y rhestr aros yn dychwelyd i lefelau a oedd yn bodoli cyn y pandemig.

7 Nid yw'r targed cenedlaethol, sef y dylai 75% o gleifion canser ddechrau eu triniaeth terfynol cyntaf o fewn 62 o ddiwrnodau i'r amheuaeth gyntaf, wedi ei gyflawni gan unrhyw un o fyrddau iechyd Cymru ers mis Awst 2020. Gwaethygodd y perfformiad yn dilyn y pandemig ac mae wedi bod yn sefydlog ers dechrau 2022, gyda rhwng 52% ac 61% o'r cleifion yn dechrau eu triniaeth o fewn yr amser targed. Mae amseroedd aros ar gyfer rhai mathau o ganser yn enwedig o hir, gyda rhai cleifion yn aros dros 100 niwrnod am driniaeth[4]. Mae arosiadau cynyddol hefyd rhwng diagnosis a dechrau'r driniaeth.

8 Mae lleiafrif sylweddol o bobl yn cael eu nodi â chanser cam hwyr, sy'n effeithio ar eu tebygolrwydd o oroesi. Yn 2021, roedd cleifion a gafodd ddiagnosis o ganserau coden y bustl, y pancreas a'r ysgyfaint yn fwy tebygol na chleifion â mathau eraill o ganserau o gael diagnosis yn ystod cam pedwar (74%, 52% a 48% o'r cleifion).

9 Mae sgrinio yn chwarae rôl hanfodol wrth ganfod yn gynnar. Er bod y safon ar gyfer y nifer sy'n manteisio ar sgrinio'r coluddyn yn cael ei chyflawni, nid yw hyn yn wir ar gyfer rhaglenni sgrinio'r fron a serfigol.

4 Gweler **Arddangosyn 8**.

10 Mae canlyniadau cleifion wedi gwella dros amser. Ond Cymru sydd â'r gyfradd marwolaethau canser uchaf ond un yn y DU, ar ôl yr Alban. Mae gan y DU ei hun gyfradd waeth na llawer o wledydd y Sefydliad ar gyfer Cydweithrediad a Datblygiad Economaidd. Mae cyfraddau marwolaethau yng Nghymru yn llawer gwaeth i bobl sy'n byw mewn ardaloedd difreintiedig ac mae'r bwlch rhwng y mwyaf a'r lleiaf difreintiedig yn tyfu.

11 Mae gwariant termau real ar ofal canser dros y 13 mlynedd ddiwethaf wedi cynyddu'n llawer mwy na'r cynnydd cyffredinol yng ngwariant termau real y GIG. Fodd bynnag, nid yw'r cynnydd hwn yn troi'n weithgaredd ychwanegol o reidrwydd oherwydd bod amrywiaeth o bwysau cost chwyddiant, gan gynnwys costau cyffuriau a thriniaethau newydd. Mae heriau o ran capasiti hefyd—gan gynnwys bylchau yn y gweithlu a phryderon am brinder offer sganio modern.

Cyfeiriad strategol

12 Noda Llywodraeth Cymru ei gweledigaeth strategol lefel uchel ar gyfer gwasanaethau canser yn ei Datganiad Ansawdd ar gyfer Canser 2021. Ym mis Chwefror 2023, ar gais y Gweinidog Iechyd a Gofal Cymdeithasol ar y pryd, cyhoeddodd y Rhwydwaith Canser Gynllun Gwella Canser tair blynedd fel ymateb cyfunedig gan y GIG i'r Datganiad Ansawdd. Mae Gweithrediaeth y GIG yn datblygu Rhaglen Adfer Canser Genedlaethol yn rhan o'r dull cenedlaethol ehangach o drawsnewid gofal a gynlluniwyd. Mae Llywodraeth Cymru hefyd wedi lansio menter 'Canser: Gwella Canlyniadau' drwy ei Hwb Gwyddorau Bywyd â'r nod o feithrin arloesedd a chydweithrediad rhwng y GIG a diwydiant.

13 Er bod y datblygiadau amrywiol hyn yn dangos ymrwymiad cenedlaethol clir i wella gwasanaethau canser, fframwaith polisi a chynllunio sy'n ddiffygiol o ran cydlyniad ydynt. Mae'r fframwaith hwnnw'n cael ei danseilio gan ddryswch ynghylch statws y Cynllun Gwella Canser tair blynedd. Mae'r cynllun yn nodi camau i gyrff y GIG gyflawni rhai agweddau ar y Datganiad Ansawdd, ond nid pob un ohonynt. Fodd bynnag, gwnaed yn glir inni nad dogfen gan Lywodraeth Cymru yw'r Cynllun Gwella.

14 Felly, mae cyrff y GIG a'r trydydd sector yn ddryslyd ynghylch statws y Cynllun Gwella a'r hyn y dylent fod yn ei wneud, os o gwbl, i'w weithredu. Roedd llawer hefyd yn ddryslyd ynghylch y cysylltiadau rhwng y Cynllun Gwella, y Rhaglen Adfer Canser Genedlaethol a menter Canser: Gwella Canlyniadau.

15 Mae dryswch tebyg ynghylch rhaniad arweinyddiaeth ac atebolrwydd rhwng Llywodraeth Cymru a Gweithrediaeth y GIG ac ynghylch rolau yng Ngweithrediaeth y GIG. Ar y cyfan, gwnaethom nodi cydsyniad, gan gynnwys yn Llywodraeth Cymru a Gweithrediaeth y GIG, nad oedd y trefniadau'n darparu eto yr arweinyddiaeth gref sydd ei hangen i sbarduno gwelliant ar draws y system mewn gwasanaethau canser.

16 Gwnaethom nodi enghreifftiau o fuddsoddiad pwysig gan Lywodraeth Cymru i wella gwasanaethau canser a gofal a gynlluniwyd ehangach, gan gynnwys canolfannau diagnostig cyflym a chanolfan canser newydd ar gyfer Ymddiriedolaeth GIG Felindre. Fodd bynnag, gall y cyflymder y mae rhai datblygiadau newydd yn cael eu datblygu fod yn araf, mewn meysydd megis patholeg celloedd digidol a sgrinio canser yr ysgyfaint.

17 Mae risg hefyd na fydd Llywodraeth Cymru yn cael elw da ar ei buddsoddiad o £3.4 miliwn mewn Academi Ddelweddu Genedlaethol. Mae'r Academi yn hyfforddi mwy o radiolegwyr er mwyn mynd i'r afael â phrinder gweithlu, ond nid yw rhai cyrff GIG wedi gallu creu swyddi i bobl sydd newydd gymhwyso.

18 Mae Llywodraeth Cymru yn dibynnu'n helaeth ar ei threfniadau rheoli perfformiad i oruchwylio ac i sbarduno gwelliant. Fodd bynnag, mae'r trefniadau hyn yn canolbwyntio'n bennaf ar y targed amseroldeb o 62 o ddiwrnodau, sydd ond yn cynnwys rhan o lwybr y claf. Dywedodd Llywodraeth Cymru wrthym ei bod hefyd yn canolbwyntio ar gyflawni Llwybr Delfrydol Cenedlaethol. Er hynny, yn ystod y cam drafftio, roedd Gweithrediaeth y GIG yn dal i ddatblygu cynlluniau ar gyfer monitro cydymffurfiaeth â'r llwybrau hynny.

19 Nid yw Datganiad Ansawdd Llywodraeth Cymru yn nodi unrhyw ddisgwyliadau penodol o ran atal canser er bod modd atal oddeutu 38% o'r holl ganser. Er bod strategaethau eraill gan Lywodraeth Cymru sydd â'r nod o annog ffyrdd iachach o fyw, nid yw'r rhain yn fframwaith polisi cydlynol ar gyfer iechyd y boblogaeth ac atal clefydau.

20 Mae data a digidol yn ddau faes allweddol arall y mae angen eu gwella. Gwnaethom nodi anghywirdebau mewn data cenedlaethol a'r angen am ddata cenedlaethol mwy cyson sy'n helpu i olrhain yr hyn a gyflawnir ar draws llwybr y claf. Mae gwaith yn mynd rhagddo i ddisodli'r system wybodaeth am ganser sydd wedi dyddio. Fodd bynnag, araf y bu'r cynnydd, ac mae gwasanaethau'n parhau i ddibynnu ar systemau digidol tameidiog sy'n cymryd llawer o amser ac yn cario risgiau i ddiogelwch cleifion.

Mae Datganiad Ansawdd Llywodraeth Cymru, nodi llwybrau sydd wedi'u hoptimeiddio'n genedlaethol a chyhoeddi Cynllun Gwella Canser i gyd yn enghreifftiau o ymrwymiad clir i sicrhau gofal canser o ansawdd uchel i bobl Cymru.

Fodd bynnag, er gwaethaf hyn, a mwy o fuddsoddi yn ystod y blynyddoedd diwethaf, mae gormod o bobl yn wynebu amseroedd aros annerbyniol o hir am ddiagnosis a thriniaeth canser. Mae amrywiadau o ran perfformiad a chanlyniadau yn parhau o fewn cyrff iechyd yng Nghymru a rhwng cyrff iechyd yng Nghymru, ac nid oes digon o sylw yn cael ei roi ar atal y ffactorau ffordd o fyw a all achosi canser a chyflyrau iechyd mawr eraill.

Mae angen egluro a chryfhau'r trefniadau ar gyfer arweinyddiaeth genedlaethol a goruchwylio gwasanaethau canser yng Nghymru fel mater o frys. Mae'n rhaid i hyn gynnwys datganiad clir ar statws Cynllun Gwella Canser GIG Cymru a sut mae Llywodraeth Cymru a Gweithrediaeth y GIG yn disgwyl iddo gael ei ddefnyddio, ochr yn ochr â rhaglenni a mentrau eraill, i lunio'r gwelliannau sydd eu hangen arnom mewn gwasanaethau canser yng Nghymru.

Adrian Crompton
Archwilydd Cyffredinol Cymru



Argymhellion

Arddangosyn 2: argymhellion

Nodi dull strategol, cydlynol a hirdymor ar gyfer canser yng Nghymru, a gefnogir gan arweinyddiaeth system glir a goruchwyliaeth wybodus

A1 Dylai Llywodraeth Cymru egluro'n gyhoeddus statws y Cynllun Gwella Canser a'i gysylltiadau â'r Rhaglen Adfer Canser Genedlaethol a menter Canser: Gwella Canlyniadau. Os nad yw'r camau gweithredu yn y Cynllun Gwella Canser yn berthnasol mwyach, dylai Llywodraeth Cymru nodi sut y mae'n bwriadu sbarduno gweithrediad y weledigaeth a nodir yn ei Datganiad Ansawdd ar gyfer Canser.

A2 Dylai Llywodraeth Cymru nodi model cydlynol ar gyfer arweinyddiaeth system mewn cysylltiad â gwasanaethau canser sy'n egluro ei rôl ei hun a swyddogaeth Gweithrediaeth y GIG ac yn nodi sut y bydd yn ymgysylltu â chlinigwyr a rhanddeiliaid allweddol eraill er mwyn datblygu safbwynt cyffredin ar berfformiad, ansawdd a chyfleoedd i wella gwasanaeth canser.

A3 Dylai Llywodraeth Cymru adolygu ei fframwaith goruchwylio a pherfformiad mewn cysylltiad â gwasanaethau canser er mwyn canolbwyntio ar amrywiaeth ehangach o faterion, gan gynnwys cysondeb mwy eglur â'r uchelgeisiau a'r priodoleddau ansawdd a nodir yn y Datganiad Ansawdd ar gyfer Canser.

Datblygu'r dull strategol o wella iechyd y boblogaeth ac atal clefydau

A4 Dylai Llywodraeth Cymru ddatblygu dull mwy cydlynol o wella iechyd y boblogaeth drwy nodi sut mae'n bwriadu defnyddio ei Cyngor ar Wyddoniaeth a Thystiolaeth: Y GIG mewn 10 Mlynedd a Mwy i reoli'r cyfleoedd sy'n gysylltiedig ag atal i leihau nifer yr achosion o ganser a chyflyrau mawr eraill.

Manteisio ar gyfleoedd penodol i wella

A5 Dylai Llywodraeth Cymru weithio gydag Iechyd Cyhoeddus Cymru i gyflymu'r broses o wneud penderfyniadau ynghylch rhaglen sgrinio'r ysgyfaint cenedlaethol. Dylai gadarnhau cyn gynted â phosibl a fydd yn ariannu rhaglen sgrinio'r ysgyfaint cenedlaethol i Gymru a'r amserlen ar gyfer gweithredu rhaglen o'r fath.

A6 Yn rhan o ddull ehangach o annog gweithio rhanbarthol gwell rhwng byrddau iechyd, dylai Llywodraeth Cymru a Gweithrediaeth y GIG weithio gyda'r gwasanaeth i ddeall a helpu i fynd i'r afael ag unrhyw rwystrau allweddol i ddarparu gwasanaethau rhanbarthol. Dylai hyn gynnwys gweithio gydag Iechyd a Gofal Digidol Cymru i nodi atebion digidol er mwyn cefnogi rhestrau aros a rennir ar gyfer diagnosis a thriniaeth canser, fel y bo'n briodol.

A7 Dylai Llywodraeth Cymru weithio gyda Gweithrediaeth y GIG, Addysg a Gwella Iechyd Cymru a chyrff eraill y GIG i sicrhau bod cyfleoedd cyflogaeth ar gael i radiolegwyr sydd wedi eu hyfforddi yn yr Academi Ddelweddu Genedlaethol.

Gwella Data a Digidol

A8 Dylai Llywodraeth Cymru egluro rolau a chyfrifoldebau cenedlaethol o ran monitro, a sicrhau y cydymffurfir â'i safonau data gan gynnwys sut y bydd yn dwyn cyrff y GIG i gyfrif am gydymffurfiaeth wael.

A9 Dylai Llywodraeth Cymru weithio gyda'r Rhwydwaith Canser, Gweithrediaeth y GIG, Iechyd a Gofal Digidol Cymru ac Ymddiriedolaeth GIG Iechyd Cyhoeddus Cymru i ddatblygu set data mwy cynhwysfawr am wasanaethau canser sydd ar gael i'r cyhoedd, a ddylai gynnwys yr hyn a ganlyn, o leiaf:

- nifer y bobl sy'n aros am ddiagnosis neu driniaeth canser ar hyn o bryd (data llwybr agored).
- y perfformiad o'i gymharu â'r targed 62 o ddiwrnodau i'r bwrdd iechyd ddarparu diagnosis a thriniaeth a'r bwrdd iechyd sy'n gyfrifol am leoliad preswyl y claf, gan gynnwys pobl sy'n byw yn ardal Bwrdd Iechyd Addysgu Powys.
- y perfformiad ar draws llwybrau cleifion gan gynnwys amseroldeb adroddiadau diagnostig ar draws lleoliadau tiwmor; amseroldeb o'r penderfyniad i drin claf hyd at ddechrau'r driniaeth honno (gan gynnwys llawdriniaeth, radiotherapi a Therapi Gwrth-ganser Systemig); a diagnosis a thriniaeth ar gyfer clefyd sy'n dod drachefn a thrachefn. Dylid darparu gwybodaeth am berfformiad ar lefel isdiwmor canser pan fo hynny'n bosibl.
- amseroldeb diagnosis a thriniaeth ar gyfer cleifion a gyfeirir o raglenni sgrinio'r fron a serfigol.
- gwybodaeth gywir am degwch o ran y gallu i gael triniaeth, gan gynnwys ethnigrwydd cleifion canser yn ogystal â phrofiadau gwahanol grwpiau o gleifion (dylai hyn gynnwys plant a phobl ifanc).

A10 Dylai Llywodraeth Cymru weithio gydag Iechyd a Gofal Digidol Cymru a GIG Lloegr i rannu data rheolaidd a chyson am amseroldeb diagnosis a thriniaeth i gleifion canser Cymru sy'n cael eu trin gan GIG Lloegr.

Ffynhonnell: Archwilio Cymru

Perfformiad ac adnoddau

01

1.1 Mae'r rhan hon o'r adroddiad yn edrych ar ba mor dda y mae gwasanaethau rhoi diagnosis a thrin canser yn perfformio, gan gynnwys o'u cymharu â thargedau cenedlaethol. Mae'n ystyried perfformiad yng nghyd-destun ehangach y galw, pwysau ariannol a phwysau o ran capasiti.

Yr hyn yr oeddem yn chwilio amdano

Roeddem yn chwilio am dystiolaeth bod y GIG yn bodloni'r galw i roi diagnosis a thrin canser yn gynaliadwy; a yw'n cyflawni'r targedau perfformiad cenedlaethol o ran amseroldeb diagnosis a thriniaeth canser; ac am dystiolaeth bod canlyniadau cleifion canser yn gwella ac yn cymharu'n dda yn rhyngwladol.

Mae'r galw yn cynyddu o flaen gallu'r GIG i'w fodloni ac mae'r rhestr aros am ddiagnosis a/neu driniaeth yn tyfu

Mae nifer y bobl sy'n cael eu cyfeirio oherwydd amheuaeth o ganser wedi parhau i godi yn dilyn cwymp sydyn yn ystod y pandemig

1.2 Mae atgyfeiriadau oherwydd amheuaeth o ganser yn creu galw am wasanaethau y GIG, er bod y mwyafrif helaeth o'r atgyfeiriadau hynny (dros 84% ohonynt[5]) yn mynd rhagddynt i ddarganfod nad oes ganddynt ganser. Mae oddeutu 80% o'r cleifion yr amheuir bod ganddynt ganser yn cael eu cyfeirio gan feddygon teulu. Fodd bynnag, oherwydd eu bod yn llawer llai tebygol i fod â chanser mewn gwirionedd na'r rhai sy'n dod o lwybrau eraill[6], dim ond oddeutu 54% o'r cleifion sy'n cael eu cyfeirio gan feddygon teulu sy'n mynd rhagddynt i ddechrau triniaeth.

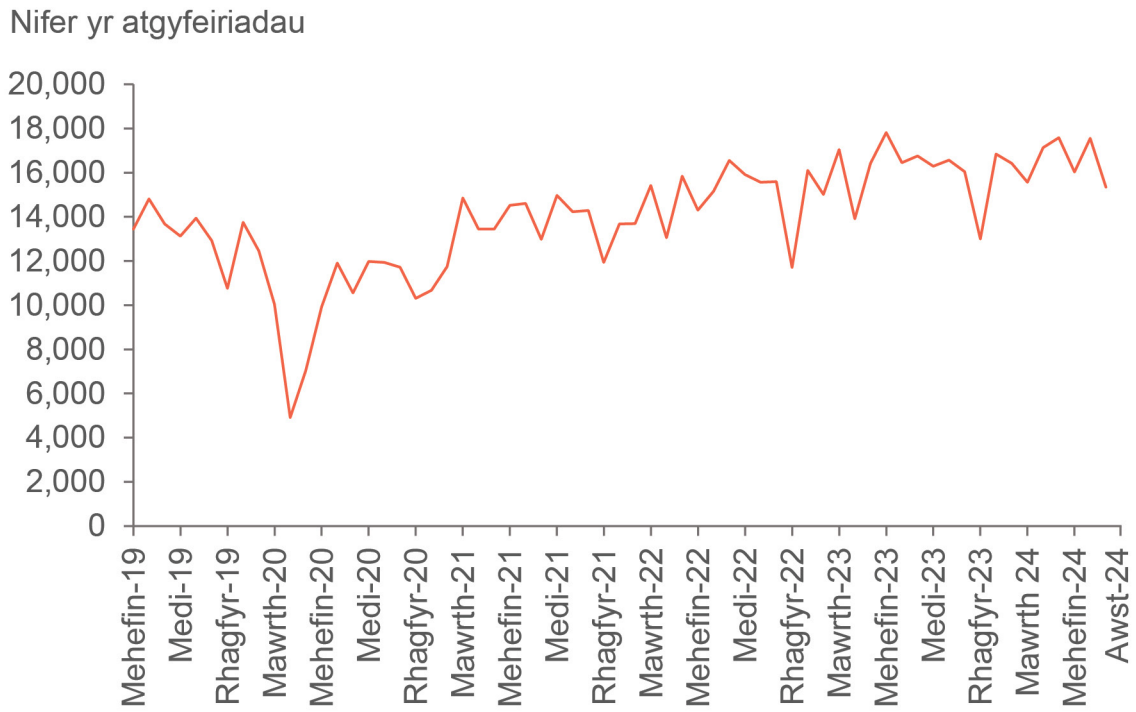
1.3 Bu cynnydd o 14% yn nifer yr atgyfeiriadau oherwydd amheuaeth o ganser rhwng mis Mehefin 2019 a mis Awst 2024 (**Arddangosyn 3**); sy'n cyfateb i dwf o oddeutu 3% pob blwyddyn. Mae atgyfeiriadau wedi cynyddu ar ôl cwymp ar ddechrau y pandemig. Roedd y nifer uchaf o atgyfeiriadau ym mis Awst 2024 ar gyfer canser y croen (ac eithrio carsinoma celloedd gwaelodol[7]) a chanser gastroberfeddol isaf (17% a 15% o atgyfeiriadau yn y drefn honno).

5 Ers mis Tachwedd 2020.

6 Mae llwybrau eraill yn cynnwys gwasanaethau sgrinio, adrannau brys, a gweithwyr proffesiynol gofal eilaidd eraill.

7 Carsinoma celloedd gwaelodol yw'r math mwyaf cyffredin o ganser y croen ac mae'n llai tebygol na chanserau eraill y croen o ledaenu i rannau eraill o'r corff. Nid yw GIG Cymru yn cyfeirio carsinoma celloedd gwaelodol a amheuir trwy'r llwybr amheuaeth o ganser oni bai bod pryder y gallai oedi wrth ymchwilio achosi effaith sylweddol i'r claf yn unol â Canllawiau NICE (NG12), a ddiweddarwyd ddiwethaf ym mis Hydref 2023.

Arddangosyn 3: atgyfeiriadau brys oherwydd amheuaeth o ganser, Mehefin 2019 – Awst 2024



Ffynhonnell: Iechyd a Gofal Digidol Cymru, Llwybr Lle'r Amheuir Canser—Set ddata Llwybrau Agored, ar StatsCymru.

Noder: mae'r data rhwng mis Mehefin 2019 a mis Tachwedd 2021 yn seiliedig ar ddadansoddiad arbrofol ar StatsCymru ac efallai na fydd modd ei gymharu'n uniongyrchol â'r data a ddilyswyd o fis Rhagfyr 2021 ymlaen.

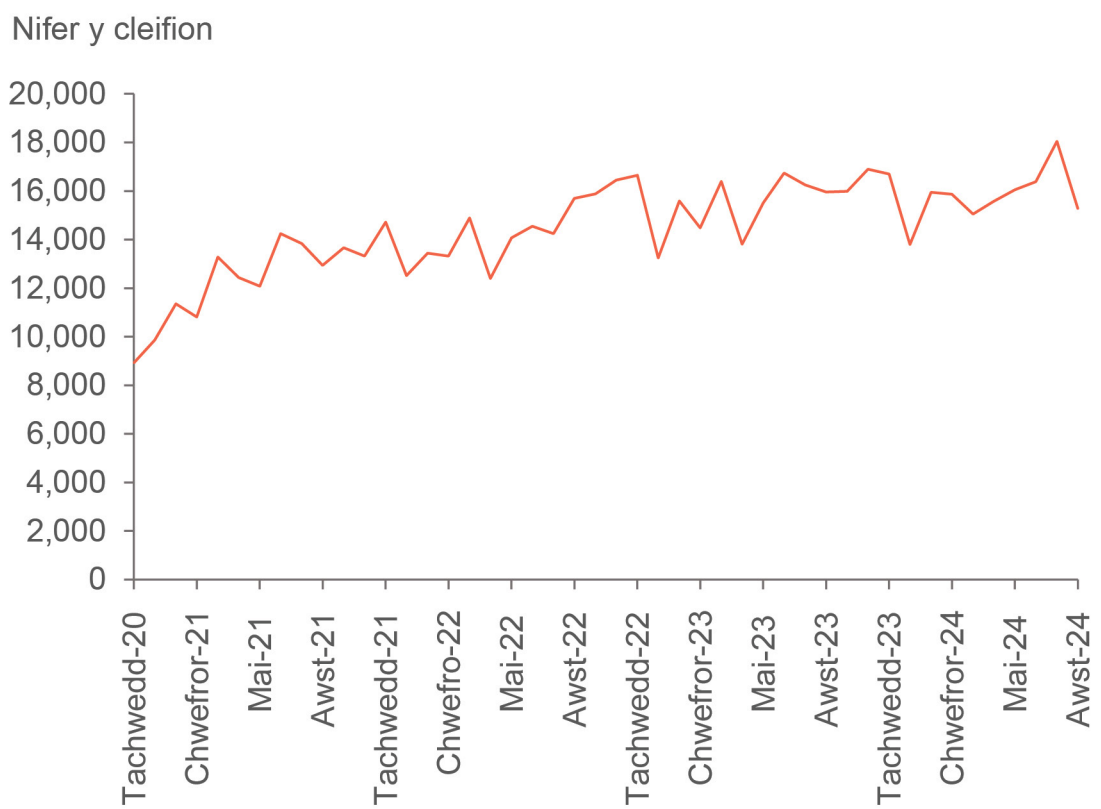
1.4 Mae nifer y cleifion canser sydd newydd gael diagnosis wedi cynyddu dros amser hefyd (cynnydd o 22% rhwng 2002 a 2021) (gweler **Atodiad 2, Arddangosyn 26**). Gostyngodd y niferoedd yn 2020, oherwydd bod llai o bobl wedi cael gofal iechyd yn ystod y pandemig yn ôl pob tebyg. Bu cynnydd niferoedd y diagnosisau newydd o ganser yn 2021, ond nid ydynt wedi dychwelyd at y lefelau a oedd yn bodoli cyn y pandemig eto. Nid yw Uned Gwybodaeth ac Arolygaeth Canser Cymru[8] wedi cyhoeddi data cofrestrfa canser clinigol y tu hwnt i 2021 eto.

8 Mae Uned Gwybodaeth ac Arolygaeth Canser Cymru yn rhan o Ymddiriedolaeth GIG Iechyd Cyhoeddus Cymru.

Mae'n ymddangos bod y cynnydd sydyn mewn gweithgarwch ar ôl y pandemig wedi llonyddu

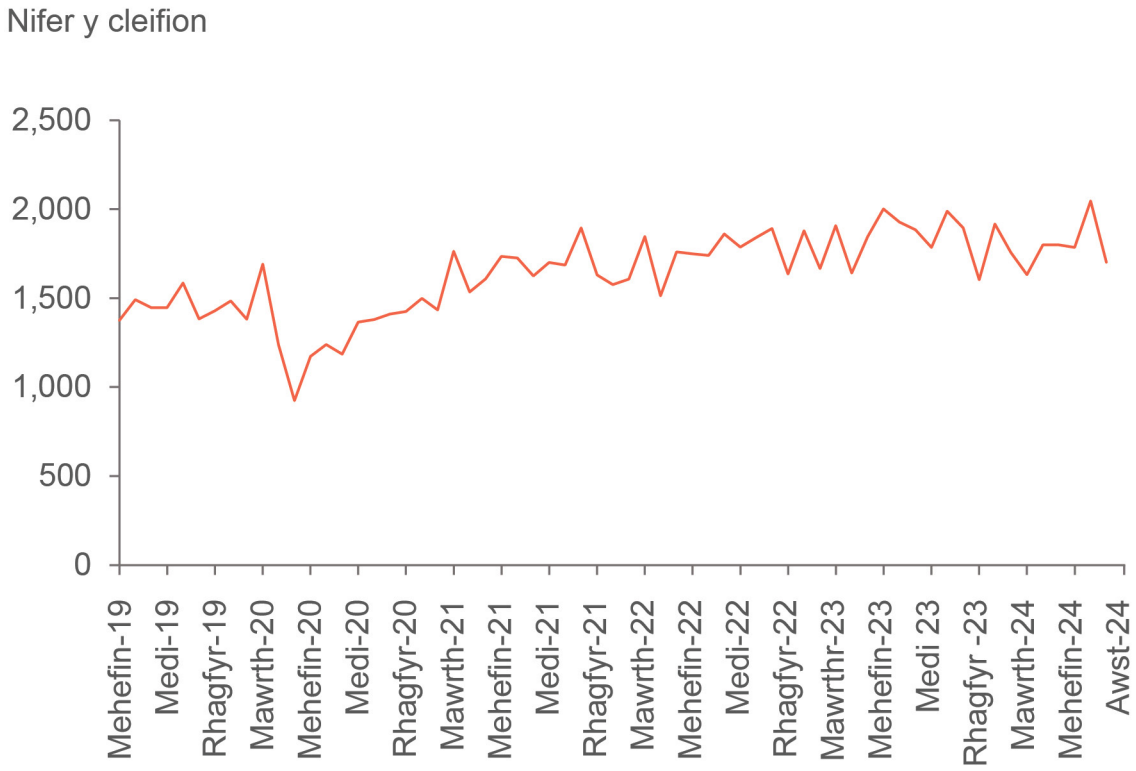
1.5 Bu cynnydd mewn gweithgarwch i roi diagnosis a thrin cleifion yr amheuir bod ganddynt ganser[9] ers y pandemig, ond mae'n ymddangos bod hyn yn llonyddu. Mae nifer cyffredinol y llwybrau a gaewyd—gan gynnwys y rhai y dywedwyd wrthynt nad oes canser arnynt a'r rhai a ddechreuodd driniaeth—wedi cynyddu ers mis Tachwedd 2020 (**Arddangosyn 4a**). Nid oes data hanesyddol cymharol i ddangos sut y mae'r lefelau gweithgarwch cyffredinol yn cymharu â'r lefelau a fodolai cyn y pandemig. Fodd bynnag, bu cynnydd yn nifer y cleifion a ddechreuodd driniaeth canser yn gyflym yn dilyn cwymp ar ddechrau'r pandemig a rhagorodd ar y ffigyrau ar gyfer y cyfnod cyn y pandemig erbyn mis Mawrth 2021 (**Arddangosyn 4b**). Mae'n ymddangos bod nifer y cleifion sy'n dechrau triniaeth wedi llonyddu i raddau helaeth o fis Tachwedd 2022.

Arddangosyn 4a: yr holl lwybrau a gaewyd Tachwedd 2020 – Awst 2024



9 Fel y'i mesurir yn ôl nifer y llwybrau a gaewyd.

Arddangosyn 4b: nifer y llwybrau a gaewyd oherwydd bod cleifion yn dechrau eu triniaeth gyntaf, Mehefin 2019 – Awst 2024



Ffynhonnell: Iechyd a Gofal Digidol Cymru, Llwybr Lle'r Amheuir Canser—Set Ddata Llwybrau Caeëdig, ar StatsCymru.

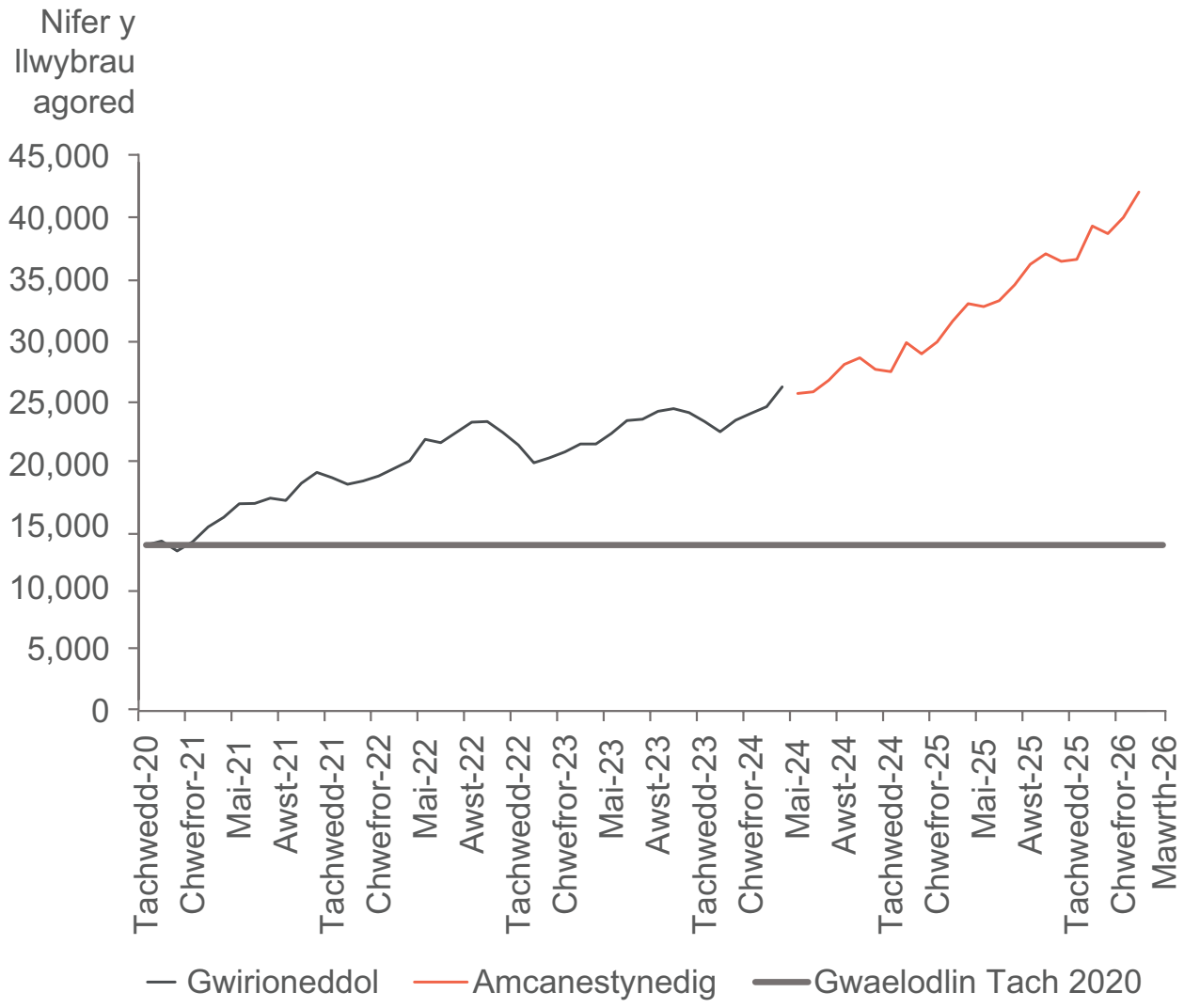
1.6 Mae'r data sydd ar gael yn tanddatgan swm y gweithgarwch oherwydd nad ydynt yn cynnwys gweithgarwch y tu hwnt i bwynt cyntaf y driniaeth. Bydd angen sawl episod o ofal ar lawer o bobl ar ôl iddynt ddechrau eu triniaeth gyntaf. Mae'n debygol bod swm y gweithgarwch ar ôl dechrau triniaeth gyntaf yn cynyddu gyda chymhlethdod cynyddol triniaethau newydd, yn enwedig ym maes imiwnotherapi. Mae'r tri chanolfan canser yng Nghymru[10] yn cadw gwybodaeth am amseroldeb y gallu i gael radiotherapi a Therapi Gwrth-ganser Systemig. Fodd bynnag, mae anghysondeb yn y ffordd y mae rhywfaint o'r data'n cael eu casglu yn golygu na allant ddarparu unrhyw fewnwelediad ar dueddiadau cenedlaethol ar hyn o bryd nac amseroldeb cymharol ar gyfer triniaeth barhaus ledled Cymru.

10 Yng ngogledd Cymru, de-orllewin Cymru, a de Cymru. Rheolir y canolfannau yn unigol gan Fwrdd Iechyd Prifysgol Betsi Cadwaladr, Bwrdd Iechyd Prifysgol Bae Abertawe ac Ymddiriedolaeth GIG Felindre.

Mae nifer y cleifion sy'n aros am ddiagnosis neu driniaeth yn cynyddu ac mae ein dadansoddiad yn awgrymu bod angen i'r GIG gynyddu gweithgarwch ymhellach os yw'n mynd i leihau'r ôl-groniad a bodloni'r galw yn gynaliadwy

1.7 Yn rhan o'i gweledigaeth ar gyfer gofal canser o safon, mae Llywodraeth Cymru yn dymuno gweld maint y rhestr aros yn dychwelyd i'r lefelau a oedd yn bodoli cyn y pandemig. Mae hefyd wedi pennu targed bod 80% o'r cleifion canser yn dechrau triniaeth o fewn 62 o ddiwrnodau erbyn mis Mawrth 2026. Fodd bynnag, mae'r rhestr aros am ddiagnosis a/neu driniaeth wedi parhau i dyfu, ac mae'n anodd gweld sut y bydd y targed hwnnw'n cael ei gyflawni (**Arddangosyn 5**). Dengys ein modelu dangosol y bydd y rhestr yn parhau i dyfu ar sail tueddiadau diweddar o ran galw a gweithgarwch. Mae'n amlwg, heb gynnydd sylweddol mewn gweithgarwch i roi diagnosis a thrin rhagor o gleifion, nad yw'n debygol y bydd y rhestr aros yn dychwelyd i'r lefelau blaenorol.

Arddangosyn 5: rhifau gwirioneddol ac wedi eu modelu ar gyfer llwybrau amheuaeth o ganser agored hyd at fis Mawrth 2026



Ffynhonnell: Dadansoddiad Archwilio Cymru o ddata Iechyd a Gofal Digidol Cymru, llwybrau amheuaeth o ganser agored ar ddiwedd y mis.

Noder: Gallai cleifion fod â mwy nag un llwybr os ydynt yn aros am ddiagnosis neu driniaeth ar gyfer mwy nag un canser.

Fel y'i mesurir gan atgyfeiriadau, roedd ein rhagamcaniad yn tybio bod cynnydd o 3% y flwyddyn yn y galw yn unol â thueddiadau diweddar a bod cynnydd o 1% y flwyddyn mewn gweithgarwch.

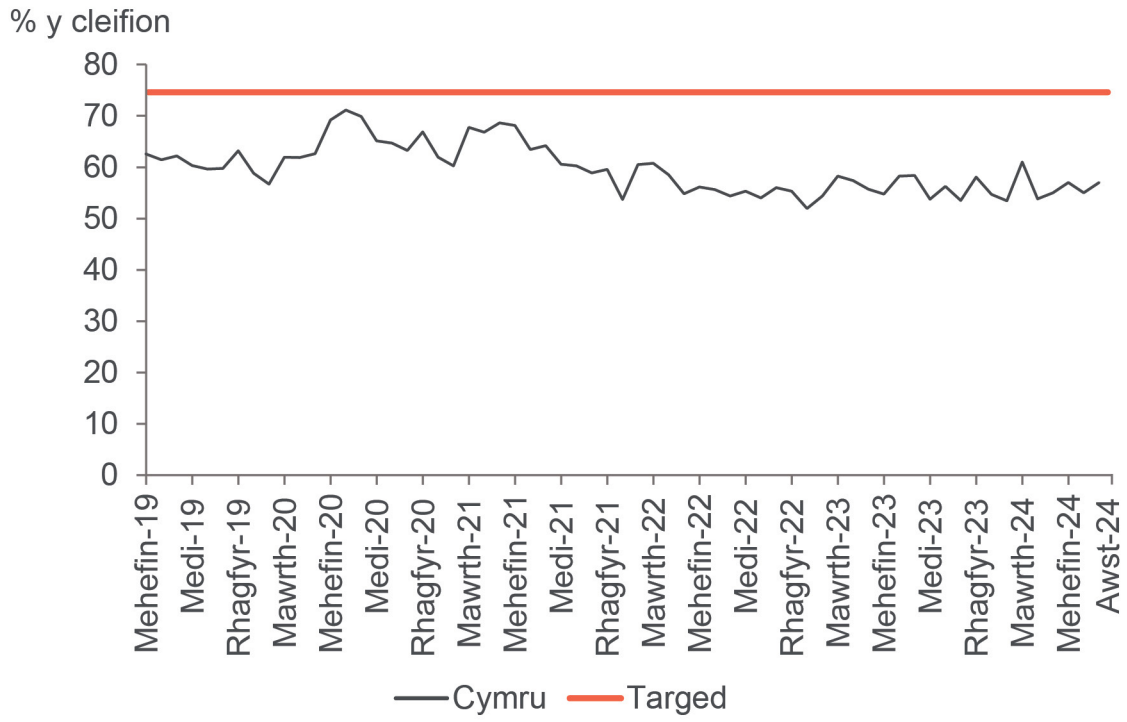
1.8 Mae llawer o'r capasiti y mae'r GIG yn ei ddefnyddio i ddiagnosio a thrin cleifion canser hefyd yn cael ei ddefnyddio ar gyfer llwybrau cleifion eraill nad ydynt yn gleifion canser. Felly, bydd cyflawni'r uchelgeisiau gwleidyddol a pholisi i wella'r gallu i gael gofal canser a gofal ehangach a gynlluniwyd yng nghapasiti presennol y system yn heriol. Bydd angen cydbwyso blaenoriaethau ar ofal canser â blaenoriaethau gofal eraill a gynlluniwyd. Bydd angen ystyried sut y gellir defnyddio neu ehangu'r capasiti presennol yn well.

Mae'r GIG yng Nghymru yn parhau i fethu'r targed perfformiad cenedlaethol ar gyfer triniaeth canser

Er bod mwyafrif y cleifion yn dechrau eu triniaeth o fewn 62 o ddiwrnodau, mae'r perfformiad ymhell o gyflawni'r targed cenedlaethol o 75%

1.9 Dechreuodd Llywodraeth Cymru weithredu ei Llwybr Amheuaeth o Ganser ym mis Mehefin 2019, gyda tharged y dylai 75% o'r cleifion canser ddechrau eu triniaeth terfynol cyntaf o fewn 62 o ddiwrnodau i'r amheuaeth gyntaf o ganser[11]. Nid oes yr un bwrdd iechyd wedi cyflawni'r targed cyffredinol o 75% ers mis Awst 2020 er bod y perfformiad wedi bod yn well ar gyfer lleoliadau tiwmor unigol (gweler **paragraffau 1.10 a 1.11**). Yn ystod haf 2020, roedd atgyfeiriadau yn is ac roedd byrddau iechyd yn blaenoriaethu gofal brys a chanser dros gleifion eraill oherwydd y pandemig. Ers hynny, er gwaethaf rhywfaint o amrywiadau o'r naill fis i'r llall, mae'r perfformiad wedi aros rhwng 52 a 61% (**Arddangosyn 6**).

Arddangosyn 6: y perfformiad o'i gymharu â'r Targed Llwybr Amheuaeth o Ganser 62 o ddiwrnodau, Mehefin 2019 – Awst 2024

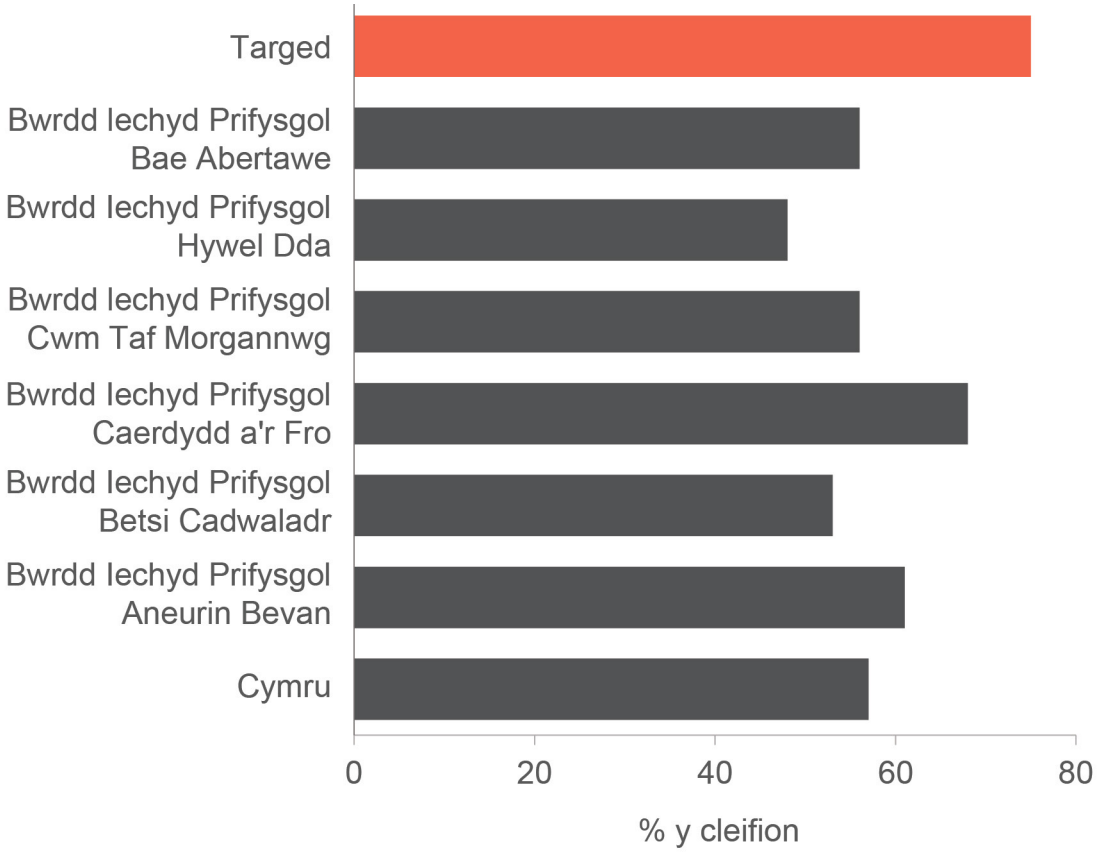


Ffynhonnell: Iechyd a Gofal Digidol Cymru, Llwybr Lle'r Amheuir Canser—Set Ddata Llwybrau Caeëdig, ar StatsCymru.

11 Mae rhywfaint o ddata am berfformiad o'i gymharu â'r targed ar gael o fis Mehefin 2019 ac roedd yn ofynnol yn swyddogol i fyrddau iechyd adrodd o'u cymharu â'r targed o fis Chwefror 2021 ymlaen.

1.10 Mae cryn amrywiaeth ac amrywiad mewn perfformiad o'i gymharu â'r targed fesul ardal bwrdd iechyd. Ym mis Awst 2024, Bwrdd Iechyd Prifysgol Caerdydd a'r Fro oedd agosaf at gyflawni'r targed ar 68%, a Bwrdd Iechyd Prifysgol Hywel Dda oedd y perfformiwr gwaethaf ar 48% (**Arddangosyn 7**). Mae perfformiad y byrddau iechyd wedi amrywio'n sylweddol ers 2019 (gweler **Atodiad 2**, **Arddangosion 27a–f**).

Arddangosyn 7: perfformiad byrddau iechyd o'u cymharu â'r Targed Llwybr Amheuaeth o Ganser 62 o ddiwrnodau, Awst 2024



Ffynhonnell: Iechyd a Gofal Digidol Cymru, Llwybr Lle'r Amheuir Canser—set ddata Llwybrau Caeëdig, ar StatsCymru.

Noder: Mae StatsCymru yn cyhoeddi data ar gyfer trigolion pob bwrdd iechyd oni bai eu bod yn cael eu trin gan GIG Lloegr. Cynhwysir trigolion Bwrdd Iechyd Addysgu Powys sy'n cael eu trin gan fyrddau iechyd eraill yng Nghymru yn ffigyrau y byrddau iechyd hynny. Nid yw StatsCymru yn gwahaniaethu rhwng trigolion Powys a thrigolion y bwrdd iechyd sy'n cael eu trin ganddo.

Mae'r amser i ddechrau triniaeth yn amrywio yn ôl math o ganser a gall rhai cleifion wynebu amseroedd aros annerbyniol o hir

1.11 Mae amseroedd aros yn amrywio gan ddibynnu ar leoliad y canser. Mae'r amseroedd aros ar gyfer canser y croen, ac eithrio carsinoma celloedd gwaelodol wedi bod yn uwch na'r targed o 75% yn gyson, ar wahân i gyfnod byr ym mis Tachwedd 2023. Fodd bynnag, yn anaml y bu'r amseroedd aros ar gyfer lleoliadau tiwmor eraill ar y targed neu'n uwch na'r targed ar lefel Cymru gyfan[12]. Mae amseroedd aros ar gyfer canserau gynaecolegol, gastroberfeddol isaf ac wrolegol, a sarcoma yn enwedig o wael, a dechreuodd llai na hanner y cleifion eu triniaeth gyntaf o fewn 62 o ddiwrnodau i'r amheuaeth gyntaf ym mis Awst 2024 (**Arddangosyn 8**). Gallai'r perfformiad amrywio yn y lleoliadau isdiwmor[13] ar gyfer y canserau hyn, ond nid oes gwybodaeth sydd ar gael yn genedlaethol i ddeall y perfformiad o'i gymharu â lleoliadau isdiwmor (**argymhelliad 9**).

12 Gwnaeth y perfformiad canser y fron a chanser yr ysgyfaint gyflawni'r targed am gyfnod byr ym mis Mehefin 2021, ond mae wedi dirywio ers hynny. Mae canser yr ymennydd a chanser y system nerfol ganolog a chanserau haematolegol, lewcemia acíwt a sarcoma i gyd wedi cyflawni'r targed ar wahanol adegau rhwng mis Tachwedd 2020 a mis Mehefin 2024, ond niferoedd isel o gleifion y mae'r rhain yn eu cynrychioli.

13 Er enghraifft, mae canser serfigol a chanser yr ofarïau yn lleoliadau isdiwmor gynaecolegol.

Arddangosyn 8: y perfformiad o'i gymharu â'r arosiadau targed, canolrif, a phymthegfed canran a thrigain y Llwybr Amheuaeth o Ganser ar gyfer canserau gynaecolegol, gastroberfeddol isaf, y croen, ac wrolegol, a sarcoma, a mis Awst 2024

	Y perfformiad o'i gymharu â'r targed o 75%	Amseroedd aros canolrifol	Amseroedd aros y 75ain ganran
Croen (ac eithrio carsinoma celloedd gwaelodol)	80%	35 o ddiwrnodau	61 o ddiwrnodau
Sarcoma	20%	Dim data	Dim data
Urological	40%	86 o ddiwrnodau	132 o ddiwrnodau
Gynaecolegol	35%	83 o ddiwrnodau	115 o ddiwrnodau
Gastroberfeddol isaf	45%	70 o ddiwrnodau	106 o ddiwrnodau

Ffynhonnell: Iechyd a Gofal Digidol Cymru, Llwybr Lle'r Amheuir Canser—Set Ddata Llwybrau Caeëdig ar StatsCymru (data am berfformiad o'i gymharu â'r targed o 75%) a data Iechyd a Gofal Digidol Cymru am y Dangosfwrdd Amheuaeth o Ganser (data am arosiadau canolrif a'r bymthegfed ganran a thrigain).

Noder: Amser aros canolrifol yw'r pwynt pan fo hanner y bobl wedi cael eu triniaeth a bod yr hanner arall yn dal i aros. Y bymthegfed ganran a thrigain yw'r amser pan fo 75% o'r bobl wedi cael eu triniaeth ond bod 25% ohonynt yn dal i aros.

Er bod arosiadau diagnostig yn mynd yn fyrrach, mae arosiadau rhwng diagnosis a dechrau triniaeth yn mynd yn hirach

1.12 Dywedodd swyddogion y bwrdd iechyd, Gweithrediaeth y GIG a Llywodraeth Cymru wrthym mai oedi yn ystod y cam diagnostig yw un o'r prif resymau dros berfformiad gwael o'i gymharu â'r targed canser o 62 o ddiwrnodau. Mae canolrif yr amseroedd aros o'r amheuaeth gyntaf o ganser i'r prawf diagnostig cyntaf wedi gostwng o 20 diwrnod ym mis Chwefror 2021 i 16 ym mis Awst 2024. Gan ddibynnu ar y math o ganser, mae cleifion yn arfer wynebu arhosiad arall rhwng cael prawf diagnostig a darganfod a oes ganddynt ganser (diagnosis). Cynyddodd yr arosiadau canolrifol rhwng yr amheuaeth gyntaf a'r diagnosis gwirioneddol o 26 o ddiwrnodau ym mis Chwefror 2021 i 36 ym mis Ionawr 2022, ond gwnaethant ostwng i 27 ym mis Awst 2024[14].

1.13 Mae ein dadansoddiad[15] yn tynnu sylw at broblemau rhwng diagnosis a dechrau triniaeth. Rhwng mis Chwefror 2021 a mis Awst 2024, bu cynnydd o 38% yn yr arosiadau canolrifol rhwng diagnosis a thriniaeth, o 21 o ddiwrnodau i 29. Mae arosiadau rhwng diagnosis a thriniaeth yn amrywio rhwng lleoliadau tiwmor, gyda chleifion a chanddynt ganser gastroberfeddol isaf a chanser y fron yn aros yn hirach na'r rhai sydd â mathau eraill o ganser ym mis Awst 2024[16] (**Arddangosyn 9**).

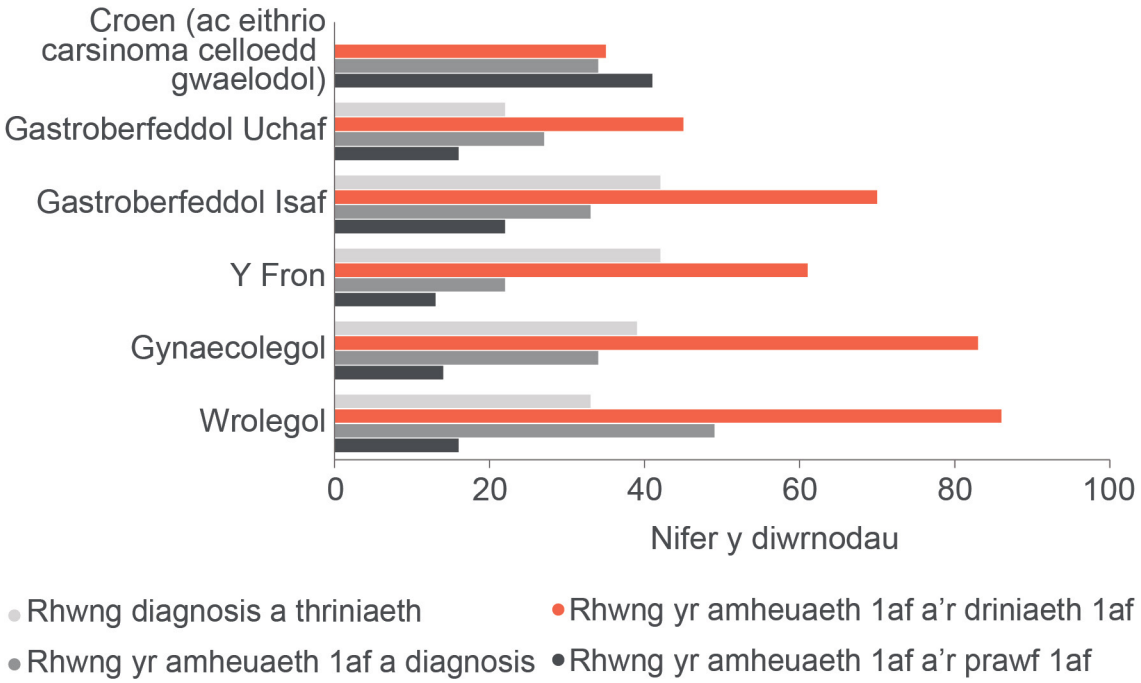
1.14 Mae amrywiadau sylweddol hefyd mewn arosiadau ar gamau eraill o'r llwybr ar draws lleoliadau tiwmor. Er enghraifft, ym mis Awst 2024, yr arhosiad canolrifol ar gyfer canserau wrolegol oedd 16 o ddiwrnodau rhwng yr amheuaeth gyntaf a'r prawf diagnostig, 49 o ddiwrnodau rhwng yr amheuaeth gyntaf a'r diagnosis, ac 86 o ddiwrnodau rhwng yr amheuaeth gyntaf a dechrau y driniaeth. Mewn cymhariaeth, yr arhosiad canolrifol ar gyfer canserau y croen oedd 41 o ddiwrnodau rhwng yr amheuaeth gyntaf a'r prawf diagnostig, 34 o ddiwrnodau rhwng yr amheuaeth gyntaf a'r diagnosis, a 35 o ddiwrnodau rhwng yr amheuaeth gyntaf a dechrau y driniaeth (**Arddangosyn 9**).

14 Mae **Atodiad 2, Arddangosyn 28** yn rhoi arosiadau canolrifol o'r amheuaeth gyntaf hyd at ddiagnosis, dros amser.

15 O ddata Iechyd a Gofal Digidol Cymru o Ddangosfwrdd y Llwybr Amheuaeth o Ganser. Dim ond arosiadau canolrifol ar gyfer y lleoliadau tiwmor a gynhwysir yn **Arddangos 9** y mae Iechyd a Gofal Digidol Cymru yn eu cyhoeddi.

16 Nid yw Llywodraeth Cymru yn cyhoeddi arosiadau canolrifol ar gyfer pob lleoliad tiwmor.

Arddangosyn 9: arhosiad canolrifol rhwng yr amheuaeth gyntaf o ganser a'r prawf gyntaf, diagnosis a dechrau y driniaeth gyntaf, mis Awst 2024



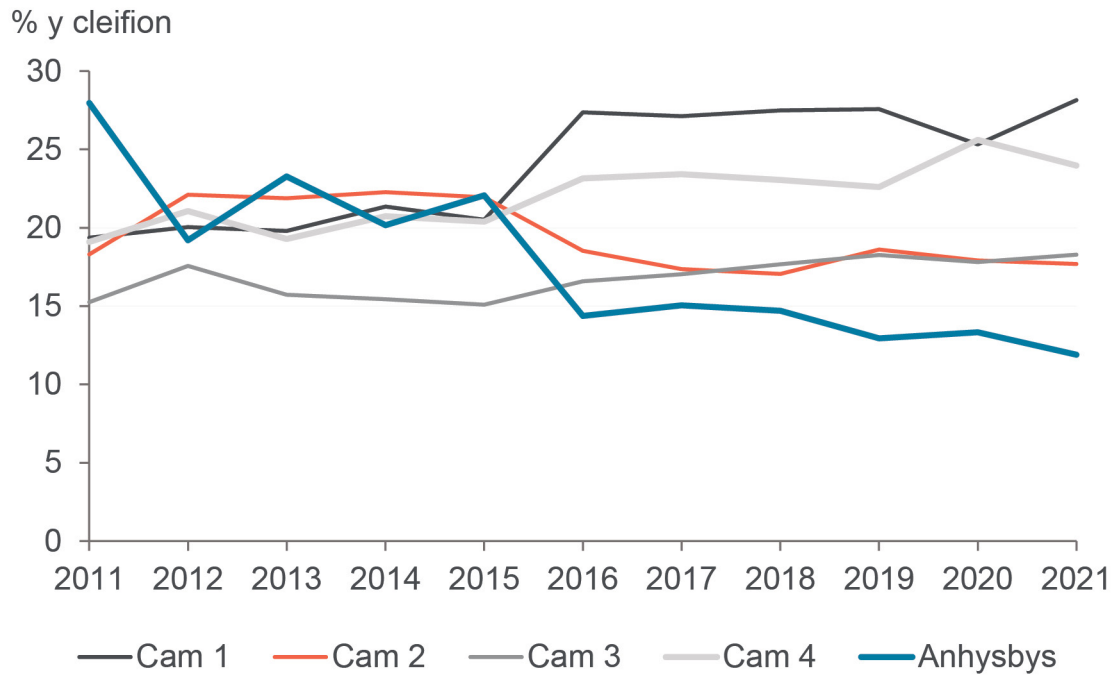
Ffynhonnell: Data Iechyd a Gofal Digidol Cymru o Ddangosfwrdd y Llwybr Ameuaeth o Ganser

Mae lleiafrif sylweddol o bobl yn cael eu nodi â chanser cam hwyr, sy'n effeithio ar eu tebygolrwydd o oroesi

1.15 Ar gyfer pob math o ganser, mae gostyngiad yn y nifer sy'n goroesi wrth i gam y diagnosis fynd rhagddo[17]. Yn 2021, cafodd 24% o'r cleifion canser ddiagnosis yn ystod cam 4, a 18% ohonynt yn ystod cam 3 (**Arddangosyn 10**). Mae'r cynnydd yng nghyfran y cleifion canser a gafodd ddiagnosis yn ystod cam 1 rhwng 2011 a 2021 yn cyfateb i ostyngiad mewn cleifion a gafodd ddiagnosis yn ystod cam 2 a chleifion nad yw eu cam yn hysbys ar adeg y diagnosis. Ac eithrio cynnydd yn 2020, mae cyfran y cleifion canser a gafodd ddiagnosis yn ystod cam 4 wedi amrywio rhwng 19% a 24% yn ystod yr un cyfnod. Yn gadarnhaol, bu gostyngiad sylweddol ers 2011 yng nghyfran gyffredinol y cleifion canser yr oedd eu cam ar adeg y diagnosis yn 'anhysbys'.

17 Uned Gwybodaeth ac Arolygaeth Canser Cymru, Goroesi canser ymhlith preswylwyr Cymru a gafodd ddiagnosis rhwng 2002 a 2020, Tachwedd 2023.

Arddangosyn 10: cyfran y cleifion canser fesul cam ar adeg y diagnosis, 2011–2021



Ffynhonnell: Data achosion canser Uned Gwybodaeth ac Arolygaeth Canser Cymru.

Noder: Mae ein dadansoddiad yn seiliedig ar ddata achosion canser Uned Gwybodaeth ac Arolygaeth Canser Cymru nad yw'n cynnwys canser na ellir darganfod ei gam, canser y croen nad yw'n felanoma, a rhai mathau prin o ganser.

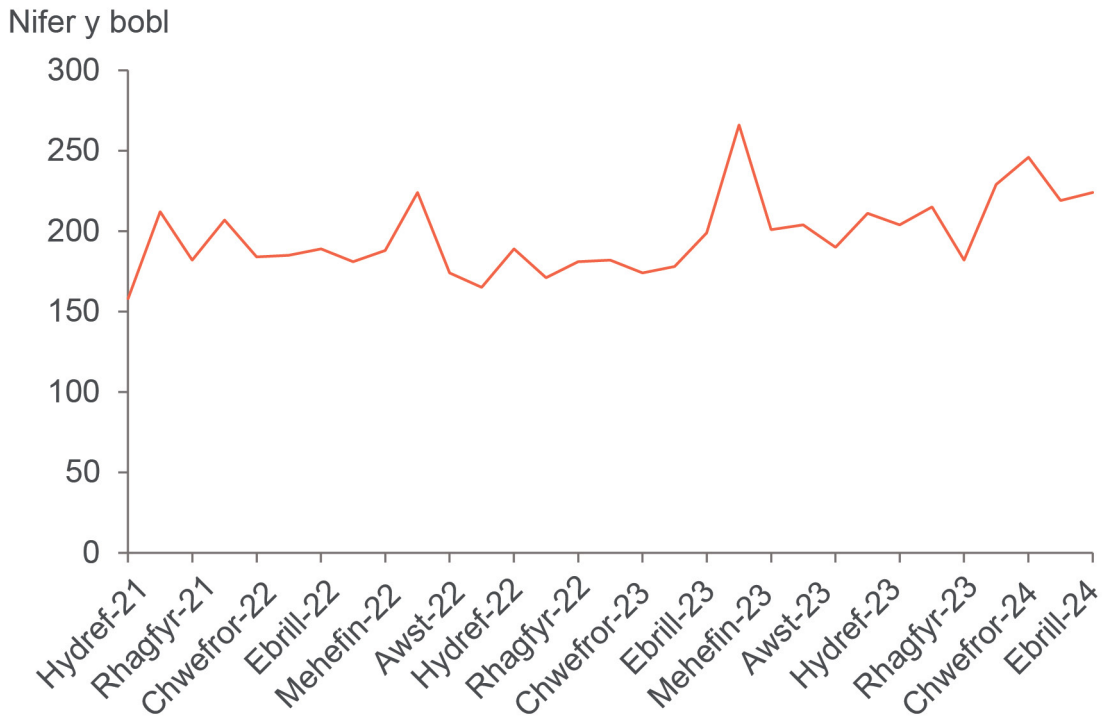
1.16 Mae rhai canserau yn fwy tebygol nag eraill o gael diagnosis ar gam hwyr, yn enwedig canserau asymptomatig. Yn 2021, roedd cleifion â chanser coden y bustl, canser pancreatig a chanser yr ysgyfaint yn fwy tebygol na chleifion canser eraill o gael diagnosis yn ystod cam 4[18]. Cafodd 48% o gleifion canser yr ysgyfaint ddiagnosis yn ystod cam 4 yn 2021 (1,175 o bobl). Er mwyn dangos pwysigrwydd diagnosis cynnar, goroesiad pum mlynedd ar gyfer canser yr ysgyfaint a gafodd ddiagnosis yn ystod 2016–2020 oedd 55% yn ystod cam 1, 30% yn ystod cam 2, 13% yn ystod cam 3, a dim ond 3% yn ystod cam 4[19].

1.17 Er bod y niferoedd yn gymharol fach, bu cynnydd o 40% yn nifer y bobl y canfuwyd eu hamheuaeth o ganser drwy adrannau brys rhwng mis Hydref 2021 a mis Ebrill 2024 (**Arddangosyn 11**).

18 Cafodd 74% o'r cleifion â chanser coden y bustl a 52% o'r cleifion â chanser pancreatig eu diagnosis yn ystod cam 4 yn 2021.

19 Uned Deallusrwydd a Gwyliadwriaeth Canser Cymru (WCISU), Goroesi canser ymhlith preswylwyr Cymru a gafodd ddiagnosis rhwng 2002 a 2020, Tachwedd 2023.

Arddangos 11: nifer yr atgyfeiriadau brys oherwydd amheuaeth o ganser drwy adrannau brys rhwng mis Hydref 2021 a mis Ebrill 2024.



Ffynhonnell: Dadansoddiad Archwilio Cymru o Ddata Llwybr Amheuaeth o Ganser gan Iechyd a Gofal Digidol Cymru—llwybrau caeëdig fesul ffynhonnell yr amheuaeth.

1.18 Canfu ymchwil gan y Bartneriaeth Meincnodi Canser Rhyngwladol[20] fod gan wledydd a chanddynt gyfraddau uwch o ddiagnosisau canser yn sgil cyflwyno argyfwng gyfraddau goroesi gwaeth[21]. Mae'n egluro fod gan Gymru a'r Alban rai o'r cyfraddau uchaf ymhlith gwledydd tebyg. Canfu ein dadansoddiad ein hunain fod cleifion yr amheuwyd bod ganddynt ganser a gyfeiriwyd o adrannau brys yn fwy tebygol na'r rhai a gyfeiriwyd trwy lwybrau eraill o farw cyn cael diagnosis neu ddechrau triniaeth[22]. Er bod angen rhywfaint o rybudd oherwydd y niferoedd bach, mae tuedd at i fyny ymhlith cleifion a gyfeirir o adrannau brys sy'n marw cyn cael triniaeth neu ddiagnosis.

20 Mae'r Bartneriaeth yn dwyn ynghyd glinigwyr, gwneuthurwyr polisïau ac ymchwilwyr rhyngwladol i nodi arferion gorau ac i gefnogi gwell canlyniadau canser i gleifion.

21 Abd Elkader, Alv, R; Barclay, M; Johnson, S; McPhail, S; Swann, R, Risk Factors and Prognostic Implications of Diagnosis of Cancer Within 30 Days After and Emergency Admission (Emergency Presentation): An International Cancer Benchmarking Partnership Population Based Study, 2022.

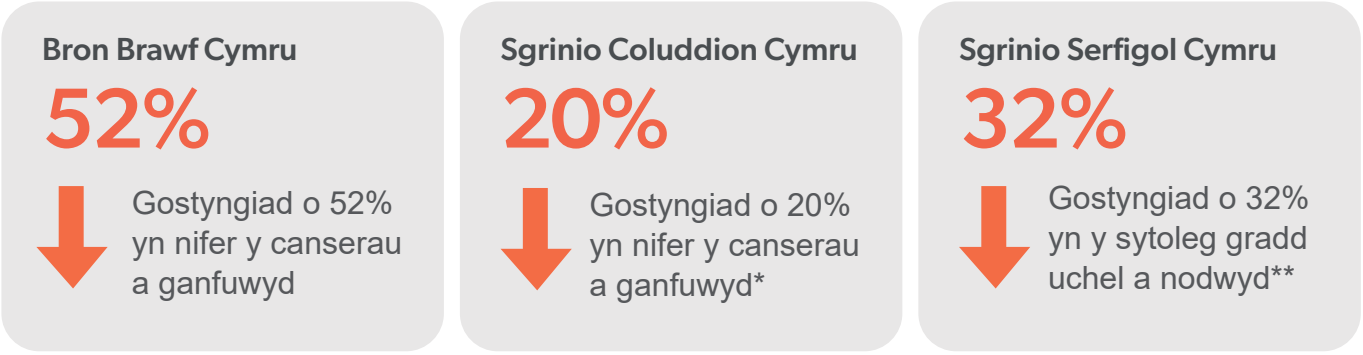
22 Yn seiliedig ar ein dadansoddiad o Ddata Llwybr Amheuaeth o Ganser gan Data Iechyd a Gofal Digidol Cymru. Ym mis Ebrill 2024, bu farw 4% o'r cleifion yr amheuwyd bod ganddynt ganser a atgyfeiriwyd o adran frys cyn dechrau triniaeth neu ddarganfod nad oedd ganddynt ganser o'u cymharu ag 1% o'r holl atgyfeiriadau oherwydd amheuaeth o ganser.

Mae lle i gynyddu'r nifer sy'n manteisio ar sgriniad er mwyn canfod canserau yn gynharach

1.19 Mae sgrinio yn chwarae rôl hanfodol wrth ganfod yn gynnar. Mae Ymddiriedolaeth GIG Iechyd Cyhoeddus Cymru yn rhedeg tair rhaglen sgrinio canser Cymru: Bron Brawf Cymru, Sgrinio Coluddion Cymru a Sgrinio Serfigol Cymru. Mae'r Ymddiriedolaeth yn amcangyfrif bod seibiannau byr i'w rhaglenni sgrinio[23] ar ddechrau'r pandemig wedi lleihau nifer y canserau a ganfuwyd yn 2021 o'i chymharu â blynyddoedd blaenorol (**Arddangosyn 12**).

23 Archwilio Cymru - Adolygiad o'r Trefniadau i Adfer Gwasanaethau Sgrinio, Awst 2023, yn rhoi mwy o wybodaeth am y gwasanaethau saib ac adfer sgrinio gan gynnwys mesurau perfformiad, cymhwysedd a safonau cwmpas ar gyfer pob rhaglen.

Arddangosyn 12: gostyngiad yn y canserau a ddarganfuwyd trwy sgrinio, rhwng mis Ebrill 2020 a mis Mawrth 2021 o'i chymharu â'r flwyddyn flaenorol



Ffynhonnell: Iechyd Cyhoeddus Cymru, Update on Population Based Screening Programmes in Wales to the Quality, Safety and Improvement Committee, Mehefin 2021.

Noder: * rhwng mis Ebrill 2020 a mis Chwefror 2021.

** celloedd annormal sydd â'r potensial i ddatblygu i fod yn ganser serfigol.

1.20 Er bod sgrinio'r coluddyn yn cyflawni ei safonau derbyn, mae cyfleoedd i gynyddu'r nifer sy'n cael eu sgrinio ar gyfer rhaglenni sgrinio'r fron a serfigol yr oedd y ddwy ohonynt islaw'r safon ym mis Awst ac ym mis Ebrill 2024 yn y drefn honno (**Arddangosyn 13**). Yn 2022, adroddodd yr Ymddiriedolaeth wahaniaethau yn y nifer sy'n cael eu sgrinio ar y tair rhaglen gan ddibynnu ar oedran, ardal y bwrdd iechyd y mae pobl yn byw ynddi, ac a yw'r ardal yn ddifreintiedig ai peidio[24]. Mae'n gweithio i fynd i'r afael ag annhegwch yn y niferoedd sy'n derbyn sgriniad drwy ei Strategaeth Ecwiti Sgrinio, ond nid yw wedi cyhoeddi adroddiad cynnydd ar degwch sgrinio ers mis Mehefin 2022.

24 Ymddiriedolaeth GIG Iechyd Cyhoeddus Cymru, Screening Division Inequities Report 2020–21, Mehefin 2022.

Arddangosyn 13: y cwmpas sgrinio o'i gymharu â'r targed, mis Ebrill a mis Awst 2024

	Cymhwystra	Safon	Cyfradd sgrinio
Bron Brawf Cymru	Gwahoddir menywod rhwng 50 a 70 oed i gael sgriniad pob tair blynedd	70%	68%*
Sgrinio Coluddion Cymru	Gwahoddir pobl rhwng 50 a 74 oed i gael sgriniad pob dwy flynedd	60%	65%**
Sgrinio Serfigol Cymru	Gwahoddir menywod a phobl sydd â cheg y groth rhwng 25 a 64 oed i gael sgriniad pob 5 mlynedd os ydynt yn cael canlyniad negatif mewn cysylltiad â'r firws papiloma dynol, neu'n amlach os ydynt yn cael canlyniad positif mewn cysylltiad â'r firws papiloma dynol	80%	69%***

Ffynhonnell: Archwilio Cymru, yn seiliedig ar wybodaeth a geiriad gan Iechyd Cyhoeddus Cymru, Hydref 2024.

Noder:

*Y gyfradd flynyddol dreigl ym mis Awst 2024
**Cyfartaledd dros y flwyddyn flaenorol ym mis Awst 2024
***Cwmpas sy'n briodol i oedran ym mis Ebrill 2024.

1.21 Roedd atgyfeiriadau o raglenni sgrin'r fron a'r coluddyn ymhlith y rhai mwyaf tebygol o fynd ymlaen i ddehrau triniaeth canser (92% a 28% yn y drefn honno yn 2023–24 o'u cymharu â 12% yn gyffredinol)[25]. Fodd bynnag, nid oes data cenedlaethol am amseroldeb diagnosis na thriniaeth canser dilynol ar gyfer pobl a gyfeiriwyd o sgrinio'r fron neu sgrinio serfigol. Rhwng mis Gorffennaf 2023 a mis Gorffennaf 2024, dim ond 21% o'r bobl gymwys a gyfeiriwyd o sgrinio'r coluddyn a gafodd gynnig colonosgopi gan y bwrdd iechyd perthnasol o fewn pedair wythnos i ffonio i'w drefnu[26]. Deg a phedwar ugain y cant yw'r targed. Roedd amseroedd aros ar gyfer colonoscopïau yn amrywio rhwng byrddau iechyd o bedair i 14 wythnos.

Mae data yr arolwg yn awgrymu bod cleifion yn fodlon â'u gofal canser ar y cyfan, er bod yr arolwg diweddaraf yn rhagddyddio'r dirywiad diweddar mewn perfformiad

1.22 Cesglir data am brofiad cleifion drwy Arolwg Profiad Cleifion Canser Cymru blynyddol a gomisiynwyd gan y Rhwydwaith Canser a Chymorth Canser Macmillan. Daw'r data diweddaraf o 2021 ac maent yn rhagddyddio'r dirywiad mewn perfformiad o'u cymharu â'r targed o 62 o ddiwrnodau.

1.23 Mae'r mwyafrif helaeth o gleifion canser a ymatebodd i'r arolwg yn sgorio eu gofal cyffredinol yn uchel. Y sgôr gyfartalog ar gyfer gofal cyffredinol oedd naw allan o 10 ledled Cymru, ar sail 5,859 o ymatebion. Mae'r canlyniadau cadarnhaol yn adlewyrchu gwaith caled a gofal tosturiol y nifer mawr o staff sy'n gweithio ar draws y GIG i gefnogi a gofalu am gleifion canser. Dywedodd 87% o'r ymatebwyr fod y gwahanol weithwyr proffesiynol sy'n eu trin ac yn gofalu amdanynt yn gweithio'n dda gyda'i gilydd i roi'r gofal gorau posibl iddynt naill ai 'bob amser' neu 'y rhan fwyaf o'r amser'. Nid yw'r arolwg yn gofyn i gleifion sut yr oeddent yn teimlo am y cyfnod cyfan o amser y buont yn aros rhwng yr amheuaeth gyntaf a dechrau'r driniaeth.

25 Yn seiliedig ar Ddata Llwybr Amheuaeth o Ganser gan Data Iechyd a Gofal Digidol Cymru. Rydym wedi eithrio atgyfeiriadau sgrinio serfigol o'n dadansoddiad oherwydd niferoedd isel. Mae llai na phump o bobl yn cael eu hatgyfeirio pob mis gydag amheuaeth o ganser yn dilyn sgrinio serfigol.

26 Ymddiriedolaeth GIG Iechyd Cyhoeddus Cymru, Hydref 2024.

Yn gyffredinol, mae canlyniadau i gleifion canser yn gwella, ond maent ar ei hôl hi o'u cymharu â gwledydd cymharol ac yn waeth i bobl sy'n byw mewn ardaloedd difreintiedig

1.24 Canser yw prif achos marwolaeth[27] yng Nghymru, gan gyfrif am 25% o'r holl farwolaethau yn 2022. Mae canser yr ysgyfaint, canser y coluddyn a chanser y prostad yn cyfrif am y cyfrannau mwyaf o farwolaethau canser[28]. Mae nifer y marwolaethau canser wedi cynyddu o 8,295 yn 2002 i 9,154 yn 2022, a rhagwelir y bydd cynnydd o 27% erbyn 2040 (ar sail lefelau 2021)[29]. Esbonnir y cynnydd mewn marwolaethau canser yn bennaf gan strwythur oedran newidiol y boblogaeth. Yn gyffredinol, mae'r gyfradd wedi ei safoni yn ôl oedran[30] ar gyfer marwolaethau canser wedi gostwng ers 2011, er bod cynnydd bach yn 2022 (**Arddangosyn 14**).

1.25 Mae'r gyfradd marwolaethau canser yng Nghymru yn cymharu'n wael â chenhedloedd eraill y DU ac yn rhyngwladol[31]. Cymru sydd â'r gyfradd wedi ei safoni yn ôl oedran uchaf ond un ar gyfer marwolaethau canser yn y DU, bron yn gyson ers 2010 (**Arddangosyn 14**). Cymharodd y Sefydliad ar gyfer Cydweithrediad a Datblygiad Economaidd gyfraddau wedi eu safoni yn ôl oedran ar gyfer marwolaethau canser yn 2023, ar sail data 2021. Rhoddodd y Deyrnas Unedig yn yr 35fed safle allan o 45 o wledydd[32].

27 Yn 2022, achoswyd 24% o'r marwolaethau gan glefydau system cylchrediad y gwaed, 12% gan glefydau y system anadlol, 10% gan ddementia a chlefyd Alzheimer, a 29% gan achosion eraill.

28 Data marwolaethau canser gan Uned Gwybodaeth ac Arolygaeth Canser Cymru.

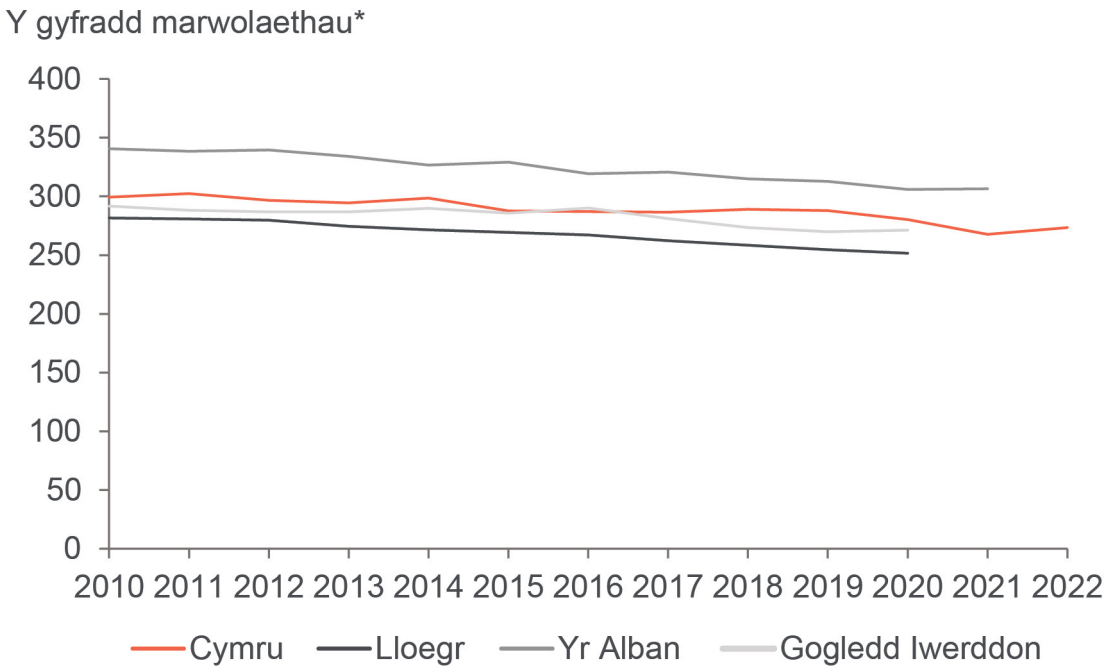
29 Y Rhwydwaith Clinigol Strategol Cenedlaethol ar gyfer Canser, Cynllun Gwella Canser ar gyfer GIG Cymru 2023–26, 2023.

30 Marwolaethau fesul 100,000 o'r boblogaeth gan ystyried gwahaniaethau strwythur oedran mewn gwahanol rannau o Gymru.

31 Mae llawer o ffactorau sy'n effeithio ar incwm canser, gan gynnwys cyfoeth cymharol a'r gwariant ar ofal iechyd ym mhob gwlad, iechyd sylfaenol y boblogaeth, ac amddifadedd.

32 OECD, Health At A Glance 2023: OECD Indicators, OECD, 2023.

Arddangosyn 14: cyfraddau wedi eu safoni yn ôl oedran ar gyfer marwolaethau canser yng ngwledydd y DU (ac eithrio canser y croen nad yw'n felanoma), 2010–2022



Ffynhonnell: Data marwolaethau canser gan Uned Gwybodaeth ac Arolygaeth Canser Cymru.

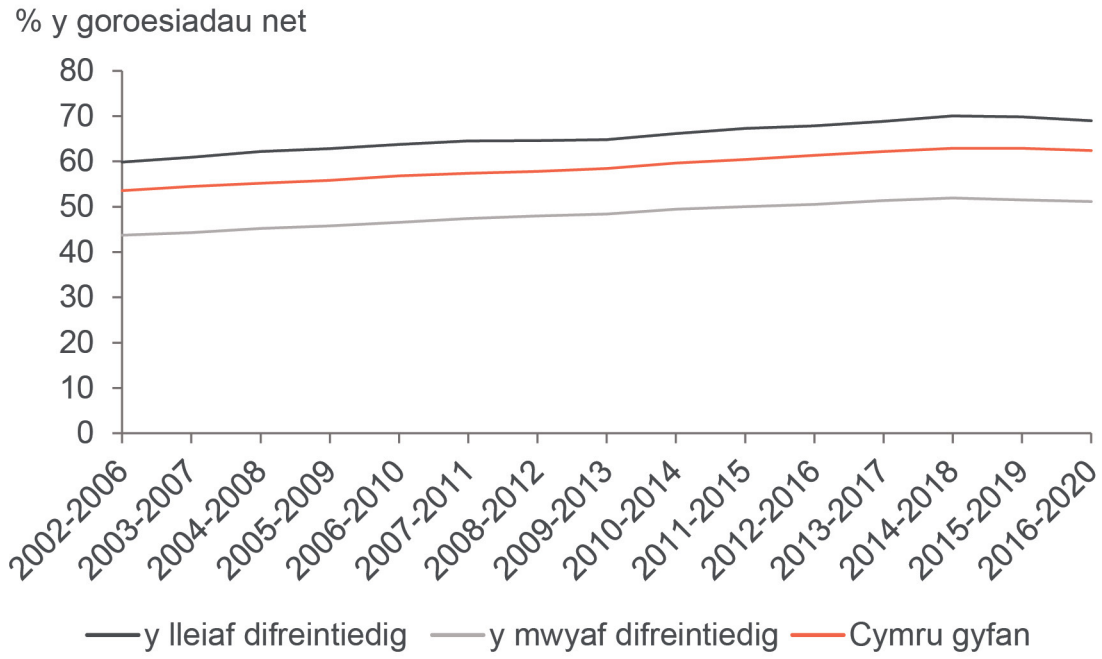
Noder: * fesul 100,000, wedi'i addasu i adlewyrchu oedran y boblogaeth

1.26 Bu cynnydd yn y cyfraddau[33] goroesi canser rhwng 2002 a 2020. Goroesodd 54% o'r cleifion a gafodd ddiagnosis o ganser rhwng 2002–2006 eu canser bum mlynedd bum mlynedd ar ôl eu diagnosis o'u cymharu â 62% o'r cleifion a gafodd ddiagnosis rhwng 2016 a 2020. Nid oes data ar gael eto i olrhain effaith y pandemig ar gyfraddau goroesi. Mae gwahaniaethau mewn dulliau casglu data yn ei gwneud yn anodd cymharu'r ffigurau goroesi cyffredinol ar draws gwledydd y DU.

1.27 Mae bwlch amddifadedd sylweddol yn y cyfraddau goroesi. Er bod 69% o'r cleifion canser sy'n byw yn rhannau mwyaf cyfoethog o Gymru yn goroesi canser bum mlynedd ar ôl eu diagnosis, mae hynny'n gostwng i 51% ar gyfer y rhai yn yr ardaloedd mwyaf difreintiedig (**Arddangosyn 15**). Mae'n peri pryder bod y bwlch amddifadedd wedi ehangu o wahaniaeth o 16 pwynt canran ar gyfer y bobl a gafodd ddiagnosis rhwng 2002–06 i 18 pwynt canran ar gyfer y bobl a gafodd ddiagnosis rhwng 2016–2020.

33 Mae ffigyrau marwolaethau canser yn dangos nifer y marwolaethau pan oedd canser yr achos sylfaenol, ac mae ffigurau goroesi yn dangos faint o bobl sydd wedi cael canser a'u bod yn dal yn fyw ar ôl cyfnod penodol o amser, felly mae'n cymryd sawl blwyddyn i gyhoeddi data cywir.

Arddangosyn 15: canran y goroesiadau net treigl heb eu safoni bum mlynedd ar ôl cael diagnosis o'i chymharu â'r ardaloedd mwyaf a lleiaf difreintiedig â ffigur Cymru gyfan ar gyfer cleifion a gafodd ddiagnosis rhwng cyfnodau 2002–2006 a 2016–2020 (ac eithrio canser y croen nad yw'n felanoma).



Ffynhonnell: Data goroesi canser gan Uned Gwybodaeth ac Arolygaeth Canser Cymru.

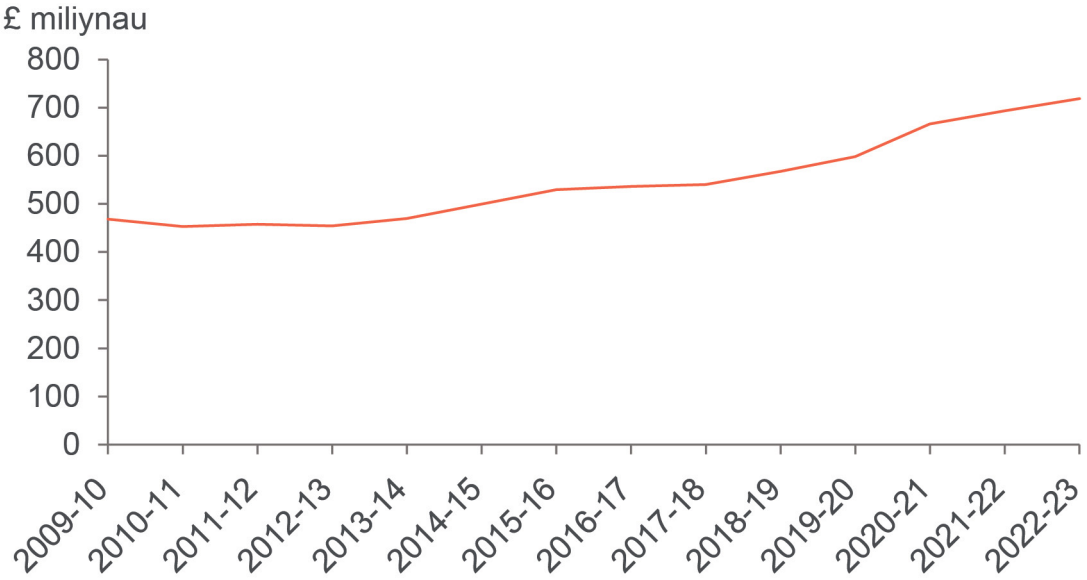
Mae gwariant ar wasanaethau rhoi diagnosis, trin a chefnogi cleifion canser wedi codi'n gyflymach na gwariant cyffredinol y GIG, ond mae bylchau yn y capasiti staffio

Mae gwariant termau real ar wasanaethau rhoi diagnosis, trin a chefnogi cleifion canser wedi tyfu yn fwy na'r twf cyffredinol yng ngwariant GIG Cymru, ond mae pwysau cost sylweddol ar y gwasanaethau hynny

1.28 Bu cynnydd o 54% mewn gwariant termau real ar wasanaethau rhoi diagnosis, trin a chefnogi cleifion canser, o ychydig dros £450 miliwn yn 2009–10 i bron i £720 miliwn yn 2022–23 (**Arddangosyn 16**). Mae'r cynnydd hwn yn llawer uwch na'r twf cyffredinol o 33% mewn termau real yng ngwariant GIG Cymru[34]. Fel cyfran o wariant cyffredinol y GIG, mae'r gwariant ar wasanaethau rhoi diagnosis, trin a chefnogi cleifion canser wedi cynyddu ychydig, o 7% yn 2009–10 i 8% yn 2022–23. Nid yw cynnydd mewn gwariant yn trosi'n gapasiti neu'n weithgarwch ychwanegol o reidrwydd. Mae llawer o bwysau cost ar wasanaethau, gan gynnwys costau gweithlu cynyddol sy'n gysylltiedig â thwf cyflog a'r defnydd o staff asiantaeth; costau cynyddol ar gyfer cyffuriau presennol; cyffuriau newydd a thechnolegau newydd i wella triniaeth.

34 Ar sail gwariant refeniw yng ngwariant Llywodraeth Cymru ar y GIG, fesul data categoreiddio cyllideb rhaglenni ar StatsCymru er cysondeb â ffigyrau gwariant ar ganser. Mae Offeryn Data Cyllid y GIG ar ein gwefan yn seiliedig ar gyllidebau cyhoeddedig Llywodraeth Cymru ac mae'n rhoi ffigur ychydig yn wahanol.

Arddangosyn 16: gwariant y GIG ar ganser mewn termau real, 2009–10 i 2022–23



Ffynhonnell: Llywodraeth Cymru, Gwariant y GIG yn ôl categori cyllideb rhaglen a blwyddyn, 'canserau a thiwmorau', ar StatsCymru.

Noder: Addesir ffigurau termau real i ystyried chwyddiant. Gwnaethom ddefnyddio GDP deflators at market prices and money Trysorlys EF ar gyfer 2022–23, Mawrth 2024.

Cadarnhaodd Llywodraeth Cymru fod y data hyn yn seiliedig ar gostau gweithgarwch cleifion GIG Cymru gan gynnwys staff, nwyddau traul, meddyginiaethau a chostau gorbenion megis ystadau, arlwyo, costau Adnoddau Dynol a chyllid.

1.29 Yn 2022–23, gwariodd GIG Cymru £230 fesul pen o'r boblogaeth ar wasanaethau rhoi diagnosis, trin a chefnogi cleifion canser[35]. Roedd y gwariant fesul pen yn amrywio o £206 yng Nghaerdydd a'r Fro i £270 ym Mwrdd Iechyd Prifysgol Bae Abertawe. Roedd archwiliad o'r rhesymau dros y gwahanol ffigurau gwariant ar draws ardaloedd byrddau iechyd y tu hwnt i gwmpas yr adolygiad hwn, ond mae'n debygol o adlewyrchu gwahanol fodelau gofal lleol a ffactorau poblogaeth, gan gynnwys demograffeg ac amddifadedd.

35 Nid oes unrhyw ddata tebyg o wledydd eraill y DU nac o wledydd tebyg.

1.30 Er bod gwelliannau mewn amseroedd aros canser yn un o'r blaenoriaethau allweddol ar gyfer GIG Cymru, mae'r rhagolygon ar gyfer gwariant ar wasanaethau rhoi diagnosis, trin a chefnogi cleifion canser yn ansicr. Mae cyllid cyhoeddus y Deyrnas Unedig dan bwysau. Mae cyrff y GIG yng Nghymru eisoes dan straen ariannol, gyda chwech o saith bwrdd iechyd yn gorwario yn 2023–24 ac mae'r mwyafrif ohonynt yn rhagweld diffyg ariannol yn 2024–25. Nid yw'n glir a fyddant yn gallu blaenoriaethu gwasanaethau brys ar gyfer cleifion yr amheuir bod ganddynt ganser er mwyn cynyddu'r gweithgarwch yn ddigonol i fodloni'r galw a lleihau amseroedd aros. Mae byrddau iechyd hefyd o dan bwysau i flaenoriaethu rhannau eraill o'r system lle mae perfformiad yn wael, gan gynnwys arosiadau hir am ofal heb ei drefnu a gofal a gynlluniwyd.

Mae capasiti y gweithlu yn her sylweddol ac mae diffyg gwybodaeth am argaeledd a chyflwr offer

1.31 Er gwaethaf cynnydd mewn gwariant, mae capasiti y gweithlu yn parhau i fod yn her sylweddol ac mae prinder gweithlu yn lleihau capasiti y gwasanaethau[36]. Mae Cynllun Addysg a Hyfforddiant 2025–26[37] AaGIC yn disgrifio 'prinder cenedlaethol sylweddol a bylchau hirsefydlog' mewn rolau proffesiynol arbenigol sy'n effeithio ar ddiagnostig, canser, gofal brys ac iechyd meddwl. Mae'n amlygu prinder penodol mewn dermatolegwyr, oncolegwyr clinigol, llawfeddygon wroleg ymgynghorol, a histopatholegwyr. Mae'n cyfeirio at bwysau o adroddiadau canser sy'n fwyfwy cymhleth a maes genomeg sy'n datblygu o ran histopatholeg, a'r galw ar wroleg gan gleifion canser.

1.32 Mae Coleg Brenhinol y Radiolegwyr yn disgrifio diffygion o 34% a 12% yn y gweithlu radioleg ac oncoleg glinigol, sy'n debygol o ddirywio i 38% a 28% yn y drefn honno erbyn 2028[38]. Clywsom hefyd fod prinder ffisegwyr meddygol, nyrsys arbenigol ac ardal, a phrinder yn y gweithlu genomeg, Therapi Gwrth-ganser Systemig a radiotherapi.

36 Archwilio Cymru, Adroddiad briffio ar ddata ynghylch Gweithlu'r GIG, 2023. Mae'n nodi materion gweithlu eang gyda nifer ohonynt yn effeithio ar wasanaethau i gleifion canser ond ble nad yw'r gwasanaethau'n benodol i gleifion canser (megis diagnostig a llawdriniaeth).

37 Mae'r Cynllun yn nodi argymhellion comisiynu a hyfforddi ar gyfer y gweithlu gweithwyr iechyd proffesiynol yng Nghymru.

38 Coleg Brenhinol y Radiolegwyr, Radiology Workforce Census 2023, Mehefin 2024.

1.33 Nododd AaGIC ei gynlluniau i fynd i'r afael â phrinder gweithlu yn ei Gynllun Addysg a Hyfforddiant a'i Gynllun Tymor Canolig Integredig 2024–27. Yn unol â'i hymrwymiad yn y Cynllun Gwella Canser, mae AaGIC wedi cyhoeddi ei chynlluniau gweithlu ar gyfer fferylliaeth a geonomeg, ac mae'n bwriadu cyhoeddi ei chynllun ar gyfer nyrsio yn gynnar yn 2025. Mae Strategaeth Gweithlu 10 Mlynedd ar gyfer Iechyd a Gofal Cymdeithasol 2020 yn nodi'r dull strategol ehangach.

1.34 Yn ogystal â digon o staff, mae angen digon o offer ar GIG Cymru i roi diagnosis a thriniaeth amserol ac effeithiol. Mae Gweithrediaeth y GIG yn datblygu darlun o'r capasiti sy'n gysylltiedig ag oedran ac argaeledd offer delweddu diagnostig. Clywsom dystiolaeth anecdotaidd bod gan Gymru lai o beiriannau delweddu na gwledydd cyffelyb, a bod rhai peiriannau yn hen ac yn dueddol o dorri. Er ei bod y tu hwnt i gwmpas yr adolygiad hwn yn archwilio'r honiadau hynny, clywsom fod cyfyngiadau o ran y gallu i gael gafael ar offer diagnostig yn rhoi pwysau ar staff, yn effeithio ar recriwtio a chadw, ac yn cyfyngu ar allu AaGIC i gynnig lleoedd hyfforddi i fyfyrwyr diagnostig[39].

39 Mae'n archwilio defnyddio efelychiad amgylchedd hyfforddi fel dewis arall.

Cyfeiriad strategol

02

2.1 Mae'r rhan hon o'r adroddiad yn edrych ar gyfeiriad ac arweinyddiaeth strategol cenedlaethol er mwyn gwella gofal canser yng Nghymru. Mae **Atodiad 1** yn esbonio elfennau allweddol o'r dull strategol a rolau a chyfrifoldebau ar gyfer gwasanaethau canser.

Yr hyn yr oeddem yn chwilio amdano

Gwnaethom chwilio am dystiolaeth o gyfeiriad strategol clir er mwyn gwella canlyniadau a gwasanaethau canser, ac am leihau'r galw am wasanaethau canser drwy atal canser rhag digwydd yn y lle cyntaf. Gwnaethom chwilio hefyd am dystiolaeth o strwythurau arweinyddiaeth priodol a chlir er mwyn cyfarwyddo, goruchwylio a chefnogi gwelliant a mynd i'r afael â rhwystrau ar lefel genedlaethol.

Mae diffyg eglurder ynghylch statws y Cynllun Gwella Canser a sut y mae'n gyson â mentrau gwella canser eraill

Nid yw'r Cynllun Gwella Canser wedi ei integreiddio'n ddigonol i'r dull strategol ehangach o wella gwasanaethau canser

2.2 Noda Llywodraeth Cymru ei gweledigaeth o sut y dylai gwasanaethau canser 'da' edrych yn y Datganiad Ansawdd ar gyfer Canser (2021). Mae'r Datganiad ar lefel uchel ar y cyfan, ond mae'n cael ei danategu gan lwybrau delfrydol cenedlaethol sy'n benodol i diwmorau. Mae'r llwybrau'n nodi'r hyn a ddylai ddigwydd ar wahanol gamau o daith y claf yn unol â chanllawiau proffesiynol. Dywedodd Llywodraeth Cymru wrth fyrddau iechyd ddechrau gwreiddio'r llwybrau erbyn mis Medi 2022[40]. Pan gyhoeddodd y Datganiad, dywedodd Llywodraeth Cymru y byddai'r Rhwydwaith Canser yn datblygu cynllun treigl tair blynedd i gyflawni'r weledigaeth genedlaethol.

40 Trwy Gylchlythyr Iechyd Cymru (2022) (021).

Arddangosyn 17: y weledigaeth a nodir yn y Datganiad Ansawdd ar gyfer Canser

Noda'r Datganiad Ansawdd Canser mai ei nod sylfaenol yw gwella cyfraddau goroesi y boblogaeth a lleihau'r cyfraddau marwolaethau canser. Mae'n nodi meysydd allweddol ar gyfer gweithredu:

- bod canser yn cael ei atal yn effeithiol pan fo hynny'n bosibl,
- bod achosion canser yn cael eu canfod yn ystod camau cynharach pan maent yn fwy triniadwy,
- bod llwybrau triniaeth cymhleth yn cael eu hoptimeiddio, tra bod pobl yn cael eu cefnogi'n briodol ac yn cydgynhyrchu eu gofal drwy gydol y broses.

Mae'r datganiad yn nodi cyfres o briodoleddau, sy'n nodi sut mae gofal o ansawdd da yn edrych, o dan chwe phennawd:

- Teg
- Diogel
- Effeithiol
- Effeithlon
- Canolbwyntio ar yr unigolyn
- Amserol.

Ffynhonnell: Llywodraeth Cymru, Datganiad Ansawdd ar gyfer Canser, 2021.

2.3 Yn 2023, cyhoeddodd y Rhwydwaith Gynllun Gwella Canser ar gyfer Cymru 2023–26 (y Cynllun) ar gais y Gweinidog Iechyd a Gwasanaethau Cymdeithasol ar y pryd. Mae'r Cynllun yn cwmpasu amrywiaeth eang o gamau gweithredu traws-sector er mwyn gwella canlyniadau i gleifion canser a lleihau anghydraddoldeb iechyd. Roedd ei orwel tair blynedd wedi ei gysoni â chylchoedd cynllunio byrddau iechyd lleol yn fwriadol. Fodd bynnag, mae hyn yn golygu nad oes gan y Cynllun bwyslais digonol ar gamau tymor hwy i ddatblygu gwasanaethau canser cynaliadwy. Mae hefyd yn brin o fanylion am atal, gofal lliniarol a diwedd oes, ac am wasanaethau i blant a phobl ifanc, ac nid yw'n cwmpasu'r amrywiaeth lawn o uchelgeisiau yn y Datganiad Ansawdd.

2.4 Defnyddiodd y Gweinidog ar y pryd y Cynllun i osod y disgwyliad newydd erbyn mis Mawrth 2026, y byddai 80% o'r cleifion yn dechrau eu triniaeth gyntaf o fewn 62 o ddiwrnodau. Cyhoeddodd y Gweinidog y Cynllun mewn datganiad llafar, gan ei ddisgrifio fel dull gweithredu ar y cyd i GIG Cymru gyflawni'r bwriadau polisi a nodir yn y Datganiad Ansawdd ar gyfer Canser. Dywedodd Llywodraeth Cymru wrthym nad Cynllun Llywodraeth Cymru mohono. Mae'n ystyried nad oes angen cynllun cenedlaethol arni i weithredu'r Datganiad Ansawdd oherwydd bod byrddau iechyd ac ymddiriedolaethau yn gyfrifol am weithredu'r weledigaeth drwy eu cynlluniau lleol eu hunain.

2.5 Er hynny, mae'r Cynllun yn bodoli ar gais y Gweinidog ac mae llawer o'r camau gweithredu yn gofyn am gyfarwyddyd ac arweiniad cenedlaethol i gefnogi gweithrediad llwyddiannus. Byddai hyn yn cynnwys ystyried y cyllid sydd ei angen i gefnogi camau gweithredu y Cynllun a defnyddio fframweithiau cynllunio a rheoli perfformiad cenedlaethol i egluro'r gofynion o ran cyflawni'r Cynllun (**argymhelliad 1**).

2.6 Mae'r Cynllun Gwella Canser yn ymrwymo Llywodraeth Cymru i fonitro cyflawniad y Cynllun drwy ei threfniadau perfformiad presennol. Fodd bynnag, yn ystod ein gwaith maes, dywedodd swyddogion Llywodraeth Cymru wrthym nad oedd monitro o'r fath yn digwydd. Ers hynny, ar gais y Gweinidog ar y pryd, mae'r Rhwydwaith Canser wedi coladu 'diweddariad' cynnydd ôl-weithredol ar y broses o gyflawni'r Cynllun. Fodd bynnag, nid yw Llywodraeth Cymru yn monitro'r gweithrediad yn rheolaidd yn unol â'i hymrwymiad yn y Cynllun Gwella Canser.

Mae rhinwedd i fentrau cenedlaethol newydd i wella gwasanaethau canser, ond mae rhanddeiliaid yn ddryslyd ynghylch sut y maent yn gysylltiedig â'r Cynllun Gwella Canser

2.7 Ers cyhoeddi'r Cynllun yn 2023, mae Llywodraeth Cymru a Gweithrediaeth y GIG wedi sefydlu rhaglenni newydd a'r nod o wella gwasanaethau canser (**Arddangosyn 18**). Er bod rhinweddau ym mhob rhaglen, mae rhanddeiliaid yn ansicr sut y maent yn gyson â'r Cynllun Gwella Canser.

Arddangosyn 18: rhaglenni newydd i wella gwasanaethau canser

Rhaglen	Disgrifiad
Canser: Menter Gwella Canlyniadau	Comisiynodd Llywodraeth Cymru Hwb Gwyddorau Bywyd Cymru i ddatblygu'r fenter, sydd â'r nod o ganolbwyntio arloesedd ar feysydd problemus allweddol a chael gwared ar y rhwystrau i gyflawni arloesedd yn gyflym.
Rhaglen Adfer Canser Genedlaethol	Sefydlwyd y rhaglen gan Weithrediaeth y GIG a'r nod o leihau arosiadau hir er mwyn cyflawni targed bod 80% o'r cleifion yr amheuir bod ganddynt ganser yn dechrau triniaeth o fewn 62 o ddiwrnodau erbyn 31 Mawrth 2026.

Ffynhonnell: Archwilio Cymru.

2.8 Ar hyn o bryd, mae Gweithrediaeth y GIG yn cwblhau trefniadau ar gyfer ei Rhaglen Adfer Canser Genedlaethol. Mae'r Rhaglen yn canolbwyntio ar bum lleoliad tiwmor penodol[41] gyda rhai camau trawsbynciol i wella gwasanaethau mwy cyffredinol i roi diagnosis a thrin cleifion canser. Yn hytrach na thrawsnewid y system gyfan ar raddfa fawr, nod y Rhaglen yw gwella'r perfformiad a gwella cydymffurfiaeth â'r Llwybrau Delfrydol Cenedlaethol o fewn y cyllidebau presennol.

2.9 Mae Llywodraeth Cymru wedi addasu cyllid y Rhwydwaith Canser ar ddibenion gwahanol er mwyn darparu £2 miliwn y flwyddyn ar gyfer 2024–25 i 2026–27 fel y gall Gweithrediaeth y GIG weithredu'r Rhaglen. Bydd oddeutu hanner y cyllid hwn yn talu am gostau staff yn unol â nodau y Rhaglen o ran annog gwelliant o fewn y cyllidebau presennol. Dywedodd swyddogion Gweithredol y GIG wrthym y gallai'r Rhaglen nodi cyfleoedd am welliannau a fyddai wedyn yn cael eu costio a'u datblygu'n achosion busnes ar gyfer cyllid ychwanegol gan Lywodraeth Cymru.

41 Canser y fron, canser gynaecolegol, canser gastroberfeddol isaf, canser y croen a chanser wrolegol.

Mae llawer o gyrff y GIG a phartneriaid trydydd sector yn ddryslyd ynghylch y cyfeiriad strategol

2.10 Dywedodd sefydliadau y GIG a'r trydydd sector wrthym eu bod wedi drysu ynghylch cyfeiriad strategol gwasanaethau canser yng Nghymru. Mae rhai cyrff GIG Cymru gyfan wedi croesawu'r ymrwymiadau yn y Cynllun (er enghraifft **paragraff 1.33**). Mae eraill wedi gwrthod gweithredoedd a briodolir i'w sefydliad a gweld rhai camau gweithredu sydd yn y Cynllun fel rhai amherthnasol (er enghraifft **paragraff 2.37**).

2.11 Mae byrddau iechyd wedi datblygu mentrau lleol i wella diagnosis, triniaeth a chymorth i gleifion canser, ond nid yw'n glir sut y maent yn cysylltu â'r Cynllun Gwella Canser. Yn ystod ein gwaith, maes roedd yn amlwg nad oedd cyrff y GIG yn glir ynghylch statws y Cynllun na sut y dylai fod yn llywio eu gweithgareddau. Dywedodd cyrff y GIG a'r trydydd sector wrthym fod datblygu'r mentrau a'r rhaglenni newydd mor fuan ar ôl cyhoeddi'r Cynllun Gwella Canser wedi cynyddu eu dryswch ynghylch y cyfeiriad strategol.

Nid yw arweinyddiaeth, penderfyniadau na threfniadau goruchwylio cenedlaethol yn effeithiol ac mae gorddibyniaeth ar reoli perfformiad cul

Mae diffyg eglurder ynghylch pwy sy'n gyfrifol ac yn atebol am sbarduno gwelliant system gyfan yn y gwasanaethau canser

2.12 Sefydlodd Llywodraeth Cymru Weithrediaeth y GIG er mwyn sbarduno gwelliannau yn ansawdd a diogelwch y gofal. Mae'n dwyn ynghyd sefydliadau gwella presennol er mwyn cydgysylltu a sbarduno gwelliannau ansawdd a diogelwch y gofal yn well[42]. Fodd bynnag, roedd y swyddogion yng nghyrff y GIG a'r cynrychiolwyr trydydd sector y gwnaethom eu cyfweld yn ddryslyd ynghylch rolau gwahanol Llywodraeth Cymru a Gweithrediaeth y GIG. Clywsom hefyd fod dryswch ynghylch y gwahanol rolau a swyddogaethau yng Ngweithrediaeth y GIG. Ar adeg ein hadolygiad, roedd gan dair o swyddogaethau Gweithrediaeth y GIG gyfrifoldeb am sbarduno gwelliant canser;

- roedd gan y Rhaglen Strategol ar gyfer Gofal a Gynlluniwyd gyfrifoldeb am gefnogi gwelliant o ran amseroldeb diagnosis a thriniaeth canser;
- darparodd y Gyfarwyddiaeth Sicrhau Perfformiad gymorth uniongyrchol i gyrff y GIG er mwyn gwella'r perfformiad canser; a
- gweithiodd y Rhwydwaith Canser gyda chlinigwyr, gweithwyr iechyd proffesiynol, a sefydliadau trydydd sector a chynrychioli cleifion er mwyn gwella canlyniadau a gofal i gleifion canser.

2.13 Canfuom gonsensws cyffredinol, gan gynnwys yn Llywodraeth Cymru a Gweithrediaeth y GIG, nad yw'r Weithrediaeth yn darparu'r arweinyddiaeth gref a fwriadwyd hyd yn hyn i sbarduno gwelliant. Disgrifiodd llawer o gyrff y GIG a'r trydydd sector y trefniadau ar ôl sefydlu'r Weithrediaeth fel 'cam yn ôl' neu 'waeth nag erioed'.

42 Uned Cyflawni GIG Cymru, Uned Cyflawni Ariannol GIG Cymru, Cydweithrediaeth Iechyd GIG Cymru; a Gwelliant Cymru.

2.14 Cododd rhanddeiliaid bryderon amrywiol am y trefniadau arweinyddiaeth ac atebolrwydd cenedlaethol ar gyfer gwasanaethau canser, gan gynnwys:

- nid oes gan y Rhwydwaith Canser awdurdod i wneud penderfyniadau ac i ymrwymo lefel yr adnoddau sydd eu hangen i sicrhau newid;
- diffyg wrth integreiddio'r Rhwydwaith Canser yn arweinyddiaeth Gweithrediaeth y GIG a chyda'r GIG ehangach, a bylchau mewn trefniadau i rannu mewnwelediad rheng flaen gan glinigwyr;
- mae cyrff trydydd sector yn ei chael hi'n anodd gwybod â phwy i ymgysylltu a sut i rannu gwybodaeth bwysig ac, yn fwy cyffredinol, maent yn teimlo nad ydynt yn cael eu gwerthfawrogi yn ddigonol am y cymorth helaeth y maent yn ei ddarparu i'r system[43] ac i unigolion a'u teuluoedd (**argymhelliad 2**);
- gorgyffyrddiad a dyblygiad rhwng y gwaith adfer canser a wneir gan y Rhaglen Strategol ar gyfer Gofal a Gynlluniwyd a'r gwaith ymyrryd dan arweiniad y Gyfarwyddiaeth Sicrhau Perfformiad; a
- diffyg cyfathrebu rhwng Llywodraeth Cymru a Gweithrediaeth y GIG i asesu a yw cyllid ar gyfer capasiti ychwanegol yn cael ei ddyrannu i'r meysydd sydd â'r angen mwyaf.

2.15 Ers ein gwaith maes, mae Gweithrediaeth y GIG wedi sefydlu Grŵp Arwain Rhwydwaith Clinigol i gefnogi gweithio agosach rhwng clinigwyr ac uwch-arweinwyr ehangach Gweithrediaeth y GIG. Er bod hyn yn ddatblygiad cadarnhaol, mae angen gweithredu ehangach i gryfhau'r trefniadau arweinyddiaeth cenedlaethol. Mae'r bylchau, y diffyg eglurder a'r dyblygu a ddisgrifir uchod wedi arwain at sefyllfa lle dywedodd llawer o randdeiliaid o'r tu mewn a'r tu allan i'r GIG wrthym: 'nid ydym yn gwybod pwy sy'n gyfrifol' (**argymhelliad 2**). Coda adroddiad Pwyllgor Iechyd a Gofal Cymdeithasol y Senedd ar ganserau gynaecolegol[44] bryderon tebyg ac mae'n galw ar Lywodraeth Cymru i fod yn 'fwy atebol' am sbarduno gwell gwasanaethau canser.

43 Mae'r trydydd sector yn llawn gwybodaeth a mewnwelediad, ac mae'n darparu cyllid ar gyfer rhai gwasanaethau yng Nghymru (megis ward canser Ymddiriedolaeth Canser yr Arddegau yng Nghaerdydd). Canfuom enghreifftiau hefyd o sefydliadau y trydydd sector yn denu cyllid y sector preifat i sbarduno arloesedd ac yn datblygu adnoddau data sydd bellach yn cael eu defnyddio gan GIG Cymru.

44 Pwyllgor Iechyd a Gofal Cymdeithasol Cymru, Heb lais: Taith menywod drwy ganser gynaecolegol, Rhagfyr 2023.

Nid yw trefniadau gwneud penderfyniadau ac arweinyddiaeth cenedlaethol yn ddigon cadarn i nodi a blaenoriaethu cyfleoedd yn systematig i wella gwasanaethau canser

2.16 Mae triniaeth canser yn faes o arloesedd sylweddol, gyda chyfleoedd i wella canlyniadau ac effeithlonrwydd. Gwnaethom nodi enghreifftiau o fuddsoddiad a phroses o wneud penderfyniadau Llywodraeth Cymru i wella canser a gofal a gynlluniwyd. Er enghraifft, mae wedi gweithio gyda byrddau iechyd a Gweithrediaeth y GIG i gyflwyno canolfannau diagnostig cyflym; cefnogi gwelliannau i'r rhaglen sgrinio'r coluddyn ac mae'n ariannu canolfan canser newydd ar gyfer Ymddiriedolaeth GIG Felindre[45].

2.17 Fodd bynnag, mae Llywodraeth Cymru yn cydnabod nad oes ganddi ddull cadarn o nodi, asesu a blaenoriaethu cyfleoedd o'r fath. Mae angen cryfhau'r trefniadau presennol i sicrhau bod capasiti digonol i asesu a blaenoriaethu mentrau cyllid. Dylai trefniadau fynd i'r afael â bylchau mewn strwythurau gwneud penderfyniadau er mwyn blaenoriaethu buddsoddiad mewn meysydd megis digidol, gweithlu a diagnostig (**argymhelliad 2**). Mae **Arddangosyn 19** yn nodi dau faes cyfle i wella effeithlonrwydd a chanlyniadau, lle mae'r broses o wneud penderfyniadau wedi bod yn araf.

45 Rydym yn cynnal archwiliad ar wahân o'r broses o wneud penderfyniadau mewn cysylltiad â datblygu Canolfan Canser newydd Felindre. Rydym yn bwriadu cyhoeddi'r adroddiad hwn yn 2025.

Arddangosyn 19: datblygiadau arloesol posibl lle mae'r broses o wneud penderfyniadau wedi bod yn araf

Rhaglen	Disgrifiad
Patholeg celloedd digidol	Yn ystod ein hadolygiad, cyfeiriodd cyrff y GIG a sefydliadau y trydydd sector at rwystredigaeth gyda chyflymder y broses o wneud penderfyniadau cenedlaethol ynghylch defnyddio patholeg celloedd digidol. Roedd Bwrdd Iechyd Prifysgol Betsi Cadwaladr yn arloeswr yn y dull gweithredu a thrawsnewidiodd ei wasanaeth patholeg yn 2014. Gallai labordai sganio a lanlwytho delweddau ar systemau digidol i'w dadansoddi o bell yn hytrach na chludo samplau rhwng lleoliadau. Ochr yn ochr â rhaglen trawsnewid ehangach*, gwnaeth y dull gweithredu wella amseroldeb canlyniadau patholeg yn ddramatig a helpu'r bwrdd iechyd i recriwtio a chadw staff oherwydd ei fod yn hwyluso trefniadau gweithio hyblyg. Mae'r Rhaglen Genedlaethol Patholeg wedi bod yn gweithio gyda Llywodraeth Cymru a byrddau iechyd i ddatblygu dull cyson ar gyfer Cymru gyfan o ymdrin â phatholeg celloedd digidol ers 2019. Er gwaethaf consensws cyffredinol ar fanteision y dull gweithredu, cyfyngwyd ar y cynnydd gan ansicrwydd ynghylch pwy fyddai'n ariannu offer sganio modern a'r storfa ddigidol. Mae byrddau iechyd wedi bod yn amharod i ymrwymo arian heb eglurder am gyfraniad ariannol Llywodraeth Cymru. Er iddi fuddsoddi mewn agweddau eraill ar batholeg celloedd digidol, ni fu Llywodraeth Cymru erioed yn glir ynghylch a fyddai'n ariannu'r offer a'r storfa er mwyn sefydlu dull Cymru gyfan. Ar adeg ein hadolygiad, roedd y Rhaglen Genedlaethol Patholeg yn dal i weithio gyda byrddau iechyd i gytuno ar gyfran achos busnes sy'n rhannu costau blynyddol parhaus o oddeutu £3 miliwn ar gyfer yr offer sganio a'r storfa. Mae Cymru bellach ar ôl gweddill y DU o ran capasiti patholeg celloedd digidol, sy'n ei wneud yn ddewis cyflogaeth llai deniadol i batholegwyr newydd gymhwyso mewn marchnad sydd eisoes yn gystadleuol.

Rhaglen	Disgrifiad
Sgrinio'r Ysgyfaint	Yn 2019, dechreuodd y Rhwydwaith Canser archwilio tystiolaeth am effeithiolrwydd y broses o sgrinio'r ysgyfaint. Daeth i'r casgliad y gallai sgrinio gynyddu canran y canserau a nodir yn ystod cam cynnar a bod ganddo'r potensial i gyflawni lleihad o 20% yn nifer marwolaethau canser yr ysgyfaint. Llywiodd y gwaith raglen beilot i wirio iechyd yr ysgyfaint ym Mwrdd Iechyd Prifysgol Cwm Taf Morgannwg a ddechreuodd yn 2022 ac a ariannwyd gan sefydliadau trydydd sector a diwydiant preifat. Argymhellodd Pwyllgor Sgrinio Cenedlaethol y DU y dylai cenhedloedd y DU ddatblygu dull sgrinio'r ysgyfaint wedi ei dargedu ar gyfer pobl 55–74 oed a chanddynt hanes o ysmygu ym mis Mehefin 2022. Er gwaethaf cymeradwyaeth Pwyllgor Sgrinio Cymru ym mis Tachwedd 2022, ni roddodd Llywodraeth Cymru y dasg i Iechyd Cyhoeddus Cymru o ddatblygu dewisiadau ar gyfer rhaglen genedlaethol tan fis Gorffennaf 2023. Mae Llywodraeth Cymru wedi gofyn i Iechyd Cyhoeddus Cymru ddarparu cynigion interim ar gyfer rhaglen sgrinio'r ysgyfaint cenedlaethol erbyn mis Mai 2025. Os yw Iechyd Cyhoeddus Cymru yn cyflawni targed 2025, bydd wedi cymryd tair blynedd ar ôl argymhelliad Pwyllgor Sgrinio Cenedlaethol y DU dim ond i ddatblygu cynigion interim. Byddai cwblhau cynigion a gweithredu rhaglen genedlaethol yn cymryd mwy o amser ar ôl y pwynt hwn (**argymhelliad 5**).

Ffynhonnell: Archwilio Cymru.

Nodyn: *Roedd y dull patholeg celloedd digidol yn rhan o raglen trawsnewid ehangach, gan gynnwys cyfuno gwasanaethau rhanbarthol yn un Gwasanaeth Patholeg Cellog sengl ym Mwrdd Iechyd Prifysgol Betsi Cadwaladr.

2.18 Clywsom bryderon hefyd am allu Llywodraeth Cymru i sicrhau'r manteision o'i buddsoddiad mewn capasiti a ffyrdd newydd o weithio. Yn benodol, cyfeiriodd rhanddeiliaid yn aml at ddull anghyson sydd wedi gweld Llywodraeth Cymru yn buddsoddi mewn hyfforddi a recriwtio radiolegwyr, dim ond i lawer ohonynt fethu dod o hyd i waith yn GIG Cymru (**Arddangosyn 20**).

Arddangosyn 20: buddsoddi mewn hyfforddiant a radiolegwyr

Agorodd yr Academi Ddelweddu Genedlaethol yn 2019, ar ôl i Lywodraeth Cymru ddarparu £3.4 miliwn i AaGIC i sefydlu'r cyfleuster er mwyn helpu i lenwi bylchau a nodwyd yn y gweithlu radiolegwyr a gweithwyr delweddu proffesiynol.

Fodd bynnag, mae llawer o'r radiolegwyr newydd gymhwyso yn gadael Cymru, er gwaethaf bylchau yn y gweithlu, oherwydd nad oes swyddi ar eu cyfer. Dywedodd rhai byrddau iechyd wrthym fod pwysau ariannol wedi arwain at roi'r gorau i recriwtio, a gyfyngodd ar eu gallu i recriwtio staff diagnostig. Clywsom hefyd fod gwendidau wrth gynllunio gweithlu byrddau iechyd, gan gynnwys rhagamcaniadau o'r angen yn y dyfodol a phrosesau recriwtio araf yn rhan o'r broblem*.

Mae Cynllun Gweithredu Diagnostig Cenedlaethol Gweithrediaeth y GIG** yn cynnwys ymrwymiad gwan i weithio gydag AaGIC i 'eirioli' dros ymrwymiad i gyflogaeth gan fyrddau iechyd wrth ofyn am rifau hyfforddiant. Nid yw'n glir pa rôl y mae Llywodraeth Cymru yn bwriadu ei chwarae i sicrhau na chollir manteision ei buddsoddiad mewn hyfforddi gweithlu y dyfodol i Gymru (**argymhelliad 7**).

Ffynhonnell: Archwilio Cymru

Nodiadau:

* Gwnaeth ein hadolygiad o'r broses o gynllunio'r gweithlu argymhellion penodol i fyrddau iechyd er mwyn gwella'r broses o gynllunio'r gweithlu. Mae adroddiadau unigol ar gyfer pob corff GIG ar gael ar ein gwefan www.Archwilio.Cymru.

** Gweithrediaeth y GIG, Cynllun Gweithredu Diagnostig Cenedlaethol 2023–25.

2.19 Gall gweithio rhanbarthol ar draws ardaloedd byrddau iechyd helpu i rannu capasiti a chryfhau gwasanaethau bregus. Mae byrddau iechyd yn datblygu dulliau rhanbarthol mewn rhai meysydd a all gynyddu capasiti yn y system[46]. Mae Gweithrediaeth y GIG hefyd yn datblygu cynlluniau am ddau ganolfan diagnostig rhanbarthol yn y de, er mwyn darparu capasiti diagnostig ar y cyd ychwanegol ar gyfer y rhanbarth. Fodd bynnag, mae cyflymder cyffredinol y cydweithrediad rhanbarthol yn araf. Er bod cyfrifoldeb clir ar fyrddau iechyd i fynd rhagddynt â gwaith rhanbarthol, mae angen arweinyddiaeth a chydgysylltiad cenedlaethol gan Lywodraeth Cymru a Gweithrediaeth y GIG hefyd. Yn hynny o beth, mae creadigaeth ddiweddar uwch-rôl ymroddedig ym Mhwyllgor Gweithredol y GIG i gefnogi gweithio rhanbarthol yn ddatblygiad y dylid ei groesawu. Fodd bynnag, bydd llwyddiant hefyd yn dibynnu ar gamau i fynd i'r afael â rhwystrau i weithio rhanbarthol megis diffyg integreiddiad rhwng systemau digidol, sy'n ei gwneud yn anodd rhannu rhestrau aros ar draws byrddau iechyd[47] (**argymhelliad 6**).

Mae goruchwyliaeth Llywodraeth Cymru yn canolbwyntio yn rhy gyfyng ar y targed 62 o ddiwrnodau

2.20 Mae Fframwaith Perfformiad y GIG (2024–25) Llywodraeth Cymru yn nodi'r mesurau (ond nid y targedau) y mae cyrff y GIG yn atebol yn i'w cyflawni. Y mesur 62 o ddiwrnodau yw'r prif fesur sy'n benodol i ganser. Mae mesur amseroldeb colonosgopi ar gyfer atgyfeiriadau sgrinio'r coluddyn (**paragraff 1.21**), ond nid oes mesurau ar gyfer atgyfeiriadau sgrinio'r fron neu serfigol. Fframweithiau perfformiad blaenorol,[48] gan gynnwys mesurau cwmpas ar gyfer y tair rhaglen sgrinio canser. Mae mesur hefyd ar gyfer y nifer sy'n derbyn brechlyn firws papiloma dynol (**paragraff 2.24**).

2.21 Nid yw'r Fframwaith Perfformiad yn cynnwys unrhyw fesurau ar achosion o ganser, marwolaethau na chyfraddau goroesi canser. Nid yw'n cysylltu'n glir â'r chwe phriodoledd ansawdd a nodir yn y Datganiad Ansawdd ar gyfer Canser ac nid yw'r Fframwaith yn cyfeirio at gydymffurfio â'r Llwybrau Delfrydol Cenedlaethol sy'n tanategu'r Datganiad Ansawdd. Er bod Llywodraeth Cymru wedi gwneud Gweithrediaeth y GIG yn gyfrifol am fonitro cydymffurfiaeth â'r llwybrau, mae'n dal i ddatblygu dulliau ar gyfer gwneud hynny.

46 Gan gynnwys datblygu dulliau rhanbarthol o ymdrin â diagnostig a thriniaeth yn y gogledd, y de-ddwyrain a'r de-orllewin, gan ddefnyddio cyllid adfer gofal a gynlluniwyd gan Lywodraeth Cymru.

47 Pwyllgor Iechyd a Gofal Cymdeithasol Cymru, Heb lais: Taith menywod drwy ganser gynaecolegol, Rhagfyr 2023.

48 Fframwaith Perfformiad GIG Cymru 2022–2023.

2.22 Mae fframwaith sefydledig ar gyfer goruchwylio gwaith cynllunio a pherfformiad cyrff y GIG drwy weithgareddau megis craffu ar gynlluniau blynyddol neu dymor canolig cyrff y GIG, cyfarfodydd Ansawdd Integredig, Cynllunio a Chyflawni misol a chyfarfodydd chwemisol y Cyd-dîm Gweithredol rhwng Llywodraeth Cymru, Gweithrediaeth y GIG a chyrff unigol y GIG. Hefyd, mae cyfarfodydd perfformiad canser misol yn rhoi pwyslais penodol ar roi diagnosis a thrin cleifion canser. Gyda'i gilydd, mae hyn yn cynrychioli llawer iawn o weithgarwch rheoli perfformiad ac mae'n cynnwys datblygiadau cadarnhaol o ran cydweithredu a rhannu gwybodaeth rhwng Llywodraeth Cymru a Gweithrediaeth y GIG. Fodd bynnag, mae'r pwyslais i raddau helaeth ar gyflawni'r targed perfformiad canser 62 o ddiwrnodau yn y tymor byr, yn hytrach na newid system ehangach a chyflawni'r weledigaeth yn y Datganiad Ansawdd yn ehangach (**argymhelliad 3**).

Nid oes gan y dull strategol bwyslais cydlynol ar atal canser, ac mae'n cael ei danseilio gan fylchau mewn data a gwasanaethau digidol tameidiog

Nid oes unrhyw ddull strategol cydlynol o atal, er bod modd atal llawer o ganserau a gallai gwneud hynny achub bywydau a lleihau'r galw am wasanaethau y GIG

2.23 Mae'r Cynllun Gwella Canser yn dweud bod modd atal 38% o'r canserau yng Nghymru bob blwyddyn. Mae cyfleoedd sylweddol i fynd i'r afael â ffactorau ffordd o fyw sy'n cynyddu'r risg o rai canserau. Mae llawer o ffactorau risg ffordd o fyw ar gyfer canser yn debyg ar draws cyflyrau mawr, ac maent yn cyfrif am y rhan fwyaf o'r gofal a gynlluniwyd a'r gofal brys yn y DU. Dangosodd data o Fframwaith Canlyniadau Iechyd Cyhoeddus Iechyd Cyhoeddus Cymru[49], yn 2022–2023, fod 13% o'r oedolion yng Nghymru yn ysmygu; fod 17% ohonynt yn yfed mwy o alcohol na'r hyn a argymhellir[50]; ac mai dim ond 36% o'r oedolion o oedran gweithio oedd yn bwysau iach[51].

2.24 Mae cyfleoedd hefyd yn gysylltiedig â chynyddu'r nifer sy'n derbyn brechlyn firws papiloma dynol. Ers ei gyflwyno yn 2008, mae'r brechlyn wedi cyflawni gostyngiad o bron i 90% yn y cyfraddau canser ar gyfer menywod yn eu hugeiniau, a disgwylir iddo achub cannoedd o fywydau fesul blwyddyn yn y DU[52]. Adroddodd Iechyd Cyhoeddus Cymru fod 74% o'r plant ym mlwyddyn 9 yn yr ysgol yn ystod 2023–2024 wedi cael y brechlyn. Roedd cryn amrywiaeth yn y nifer a gafodd y frechlyn, gan amrywio o 60% ym Mwrdd Iechyd Prifysgol Caerdydd a'r Fro i 88% ym Mae Abertawe. Mae newidiadau mewn cymhwysedd ar gyfer y brechlyn yn ei gwneud yn anodd cymharu newidiadau yn y nifer sy'n ei dderbyn dros amser[53].

49 Arsyllfa Ymddiriedolaeth GIG Iechyd Cyhoeddus Cymru, Fframwaith Canlyniadau Iechyd y Cyhoedd.

50 Ar sail oedolion a nododd eu bod yn yfed dros 14 uned o alcohol yr wythnos.

51 Mae data ysmygu ac yfed alcohol yn defnyddio cyfraddau wedi eu safoni yn ôl oedran i gyfrif am wahaniaethau mewn strwythurau oedran gwahanol rannau o Gymru. Mae data am bwysau iach yn benodol i oedran.

52 Ymddiriedolaeth GIG Iechyd Cyhoeddus Cymru: imiwneiddio a brechlynnau.

53 Iechyd Cyhoeddus Cymru, Niferoedd y plant yng Nghymru a gafodd eu himiwneiddio, Adroddiad Chwarterol, Mis Ionawr i fis Mawrth 2024, Mai 2024.

2.25 Dywed Sefydliad Iechyd y Byd fod atal yn cynnig y strategaeth hirdymor mwyaf cost-effeithiol ar gyfer rheoli canser[54]. Mae Cyngor ar Wyddoniaeth a Thystiolaeth Llywodraeth Cymru[55] yn cytuno bod cyfleoedd sylweddol i leihau baich clefydau ar y GIG drwy atal canser a chyflyrau mawr eraill. Mae'n nodi cwmpas am arbedion ariannol hirdymor ac yn galw am 'weithredu llym' i fynd i'r afael â chynnydd mewn ffactorau risg ffordd o fyw, gan wneud llawer o awgrymiadau er mwyn ail-lunio gwasanaethau o amgylch atal.

2.26 Mae Fframwaith Cynllunio'r GIG 2024–2027 Llywodraeth Cymru yn cyfeirio byrddau iechyd at y Cyngor ar Wyddoniaeth a Thystiolaeth, gan egluro ei fod yn disgwyl gweld tystiolaeth o atal yng nghynlluniau y byrddau iechyd. Fodd bynnag, nid yw Llywodraeth Cymru yn mynd ymhellach i annog ac arwain byrddau iechyd i ddatblygu mentrau atal lleol.

2.27 Byddai atal canser hefyd yn lleihau'r galw ar gapasiti y GIG. Mae **Arddangosyn 21** yn nodi mewn termau crai pa effaith y gallai gostyngiad o 10%, 20% a 38% mewn achosion o ganser ei chael, yn seiliedig ar lefelau gweithgarwch 2022–2023. Byddai'r arbedion ariannol blynyddol posibl o oddeutu £8.2 miliwn i £31.4 miliwn o ganlyniad i'r gostyngiad yn nifer y diwrnodau gwelyau[56]. Mae'n bosibl hefyd y byddai arbedion sylweddol yn sgil lleihau apwyntiadau cleifion allanol a chostau cyffuriau. Fodd bynnag, byddai costau yn gysylltiedig â gweithgarwch i atal canser hefyd.

54 Sefydliad Iechyd y Byd, Health Topics – Cancer Prevention.

55 Llywodraeth Cymru, Cyngor ar Wyddoniaeth a Thystiolaeth – Y GIG mewn 10 Mlynedd a Mwy – Archwiliad o Effaith Amcanestynedig Cyflyrau Hirdymor a Ffactorau Risg yng Nghymru, Medi 2023.

56 Cyfrifo arbedion yn seiliedig ar gost gwely o £500 fesul diwrnod yn y GIG yng Nghymru.

Arddangosyn 21: enillion capasiti posibl sy'n gysylltiedig ag atal canser rhag digwydd yn y lle cyntaf ar sail gweithgarwch 2022–2023

				
2022-23	Gorffennwyd **90,532** o episodau ymgynghori	**84,583** o episodau derbyn	**164,971** o ddiwrnodau gwelyau	**10,864** o fynychwyr rheolaidd*
-10% 	Gorffennwyd **81,479** o episodau ymgynghori (gostyngiad o 9,053)	**76,125** o episodau derbyn (gostyngiad o 8,458)	**148,474** o ddiwrnodau gwelyau (gostyngiad o 16,497)	**9,778** o fynychwyr rheolaidd (gostyngiad o 1,086)
-20% 	Gorffennwyd **72,426** o episodau ymgynghori (gostyngiad o 18,106)	**67,666** o episodau derbyn (gostyngiad o 16,917)	**131,977** o ddiwrnodau gwelyau (gostyngiad o 32,994)	**8,691** o fynychwyr rheolaidd (gostyngiad o 2,173)
-38% 	Gorffennwyd **56,130** o episodau ymgynghori (gostyngiad o 34,402)	**52,441** o episodau derbyn (gostyngiad o 32,142)	**102,282** o ddiwrnodau gwelyau (gostyngiad o 62,689)	**6,736** o fynychwyr rheolaidd (gostyngiad o 4,128)

Ffynhonnell: Dadansoddiad Archwilio Cymru o ddata Iechyd a Gofal Digidol Cymru o Gronfa Ddata Cyfnodau Gofal Cleifion Cymru, Ffigurau Pennawd a Setiau Data Diagnosis Sylfaenol, Darparwyr Cymru.

Noder:

*Mae ein dadansoddiad yn arwydd o'r enillion capasiti posibl ar sail cyfartaledd. Gwnaethom gyfrifo enillion posibl mewn cysylltiad â lleihad o 38% mewn gweithgarwch ar sail yr honiad yn y Cynllun Gwella Canser bod modd atal 38% o'r canserau bob blwyddyn.

*Cleifion sy'n cael eu derbyn i'r ysbyty yn rheolaidd i gael triniaeth yw mynychwyr rheolaidd.

2.28 Er gwaethaf tystiolaeth gref a'i bod yn uchelgais hirsefydlog, nid yw Llywodraeth Cymru wedi trosi'r nodau ehangach o atal yn ddulliau polisi mwy pendant a chydlynol eto gyda'r nod o symud cydbwysedd y gofal tuag at atal (**argymhelliad 4**). Yn benodol:

- nid yw erioed wedi nodi dull strategol clir a throsfwaol o gyflawni'r newid hwn ar draws y nifer o gyrff sector cyhoeddus y byddai angen newid eu blaenoriaethau, eu dewisiadau a'u hymddygiad;
- mae ganddi ddull tameidiog gyda strategaethau unigol ar bwysau iach a rheoli tybaco,[57] ond nid oes cynllun yn ymwneud ag effeithiau defnyddio alcohol ar iechyd; ac
- ymhlith eraill, beirniadodd Comisiynydd Cenedlaethau'r Dyfodol Lywodraeth Cymru am dorri ei chyllidebau gwella iechyd ataliol yn 2024–2025[58].

Mae bylchau yn ansawdd y data a'r graddau y maent ar gael, er mwyn deall pa mor dda y darperir gofal canser.

2.29 Mae'n hanfodol cael data o ansawdd da er mwyn cynllunio, darparu a gwella gofal canser. Mae Gweithrediaeth y GIG wedi gwella amseroldeb a hygyrchedd data perfformiad mewn dangosfwrdd rhyngweithiol heb ei gyhoeddi a ddefnyddir gan fyrddau iechyd, y Weithrediaeth a Llywodraeth Cymru. Mae Iechyd a Gofal Digidol Cymru yn cyhoeddi Dangosfwrdd Llwybr Amheuaeth o Ganser gwahanol gyda gwybodaeth lai manwl[59].

2.30 Fodd bynnag, mae bylchau yn y data cyhoeddedig ar draws llwybr y claf (**Arddangosyn 22**). Mae Llywodraeth Cymru yn cyhoeddi data am lwybrau 'caeëdig' sy'n dangos faint o gleifion a gafodd eu trin o fewn 62 o ddiwrnodau, ond nid yw'n cyhoeddi llwybrau aros 'agored' sy'n dangos faint o gleifion cyfredol sy'n aros am driniaeth.

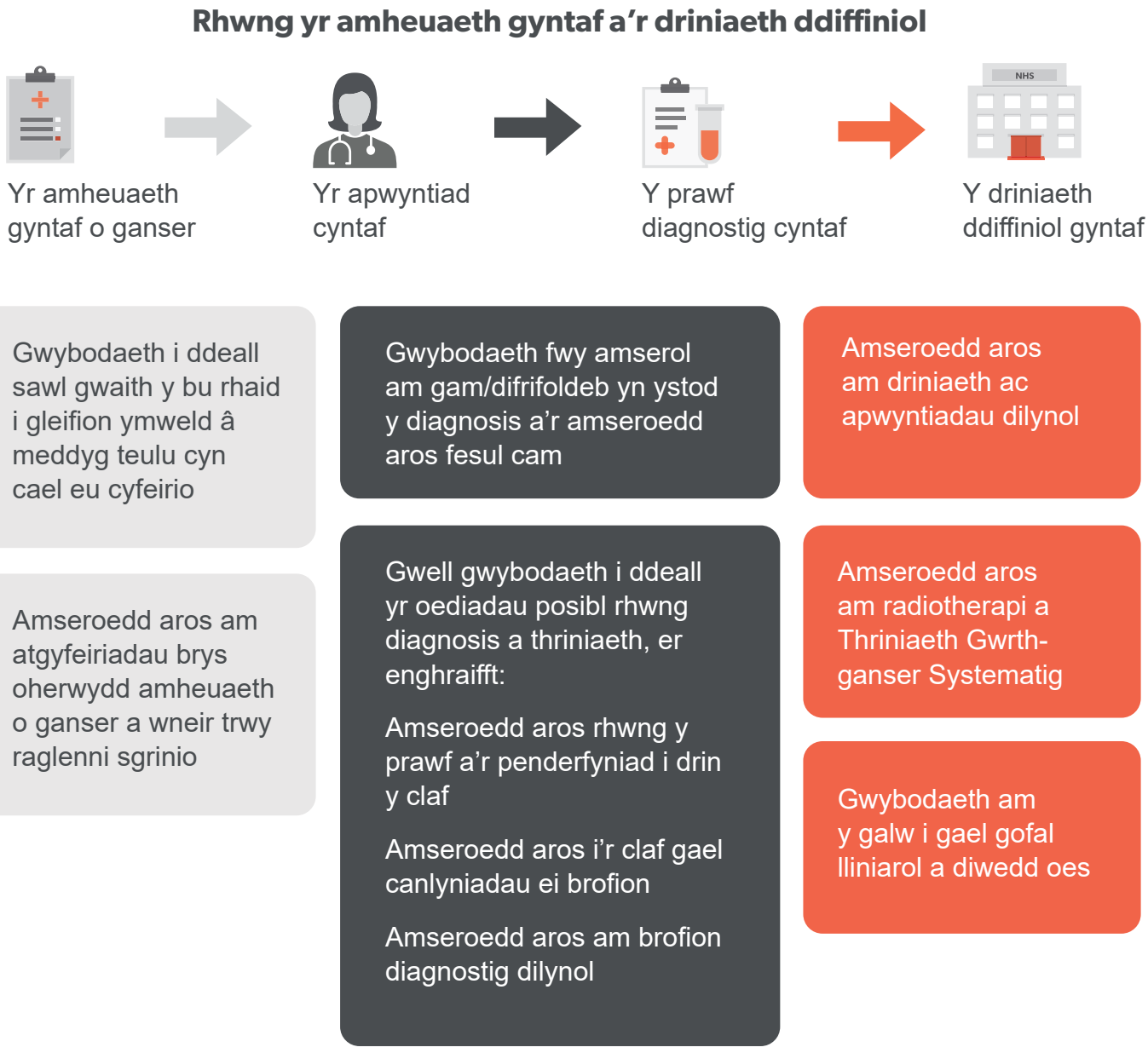
2.31 Mae llawer o'r data sydd ar gael yn canolbwyntio'n rhy gyfyng ar y cyfnod rhwng atgyfeirio a diagnosis neu'r driniaeth gyntaf. Nid oes data cenedlaethol am y gweithgaredd a'r amseroldeb sy'n arwain at atgyfeiriad. Hefyd, nid oes data ar gael am weithgaredd ar ôl i'r driniaeth gyntaf ddechrau (gweler **paragraff 1.6)**, gan gynnwys profion dilynol, triniaeth barhaus a'r gallu i gael gafael ar ofal lliniarol a gofal diwedd oes (**argymhelliad 9**).

57 Llywodraeth Cymru, Pwysau Iach Cymru Iach, 2019 a Llywodraeth Cymru, Cymru Ddi-fwg: Strategaeth hirdymor Cymru ar gyfer rheoli tybaco, 2022.

58 Bu lleihad o £3.8 miliwn yn y gyllideb ar gyfer gwella iechyd a byw'n iach, gan ddod â chyfanswm y gyllideb i £10.8 miliwn; bu lleihad o £2.5 miliwn yng nghronfa y cynllun gweithredu ar gamddefnyddio sylweddau, gan ddod â chyfanswm y gyllideb i £47.5 miliwn); a bu lleihad o £710,000 yn y gyllideb hybu iechyd, i £12.2 miliwn.

59 Mae dangosfwrdd Iechyd a Gofal Digidol Cymru yn defnyddio data sydd wedi eu dilysu er mwyn nodi camgymeriadau, ond data perfformiad heb eu dilysu yw dangosfwrdd mewnol Gweithrediaeth y GIG.

Arddangosyn 22: bylchau mewn data ar wahanol gamau o'r llwybr canser



Ffynhonnell: Archwilio Cymru

2.32 Mae data cyfyngedig iawn i olrhain y cynnydd o'i gymharu â'r uchelgeisiau yn y Datganiad Ansawdd. O'i chymharu â'r uchelgais cyffredinol o atal a chanfod yn gynnar, daethom o hyd i wybodaeth gyfyngedig am achosion galw cynyddol y gellir ei defnyddio i atal neu ganfod canser yn gynnar ymhlith y rhai sydd â'r risg fwyaf. Er enghraifft, ychydig a wyddom ynghylch pam mae rhai pobl yn ymgyflwyno ar gam mwy datblygedig, neu fel argyfwng. Cyfyngedig yw'r wybodaeth hefyd am broffil demograffig a lleoliad pobl sydd â ffyrdd o fyw nad ydynt yn iach. Mae gan brosiect newydd dan arweiniad Uned Gwybodaeth ac Arolygaeth Canser Cymru y potensial i wella gwybodaeth genedlaethol am ffactorau risg canser. Bydd yn cysylltu data y Gofrestrfa Ganser â gwybodaeth Cyfrifiad 2021 drwy Banc Data SAIL, er mwyn archwilio dylanwad ffactorau megis ethnigrwydd, incwm a statws addysgol ar ganlyniadau canser[60].

2.33 Cyfyngedig iawn hefyd yw'r wybodaeth er mwyn deall pa mor deg yw gwasanaethau cymorth canser. Er enghraifft:

- mae Llywodraeth Cymru yn ei gwneud yn ofynnol i fyrddau iechyd gofnodi ethnigrwydd cleifion canser,[61] ond isel iawn yw'r gydymffurfiaeth. Nid oeddem yn gallu dadansoddi tueddiadau rhestrau aros ac amseroldeb yn ôl ethnigrwydd oherwydd nad oedd gan dros ddwy ran o dair o'r llwybrau unrhyw wybodaeth am ethnigrwydd cleifion.
- mae Iechyd a Gofal Digidol Cymru yn adrodd y perfformiad o'i gymharu â'r targed 62 o ddiwrnodau yn ôl rhyw, ond nid oes llawer o wybodaeth i ddeall profiadau a chanlyniadau cleifion yn ôl rhyw. Canfu ymchwiliad y Senedd i ganser gynaecolegol fod menywod yn gallu profi llawer o rwystrau rhag cael triniaeth ganser, ond nid oes llawer o wybodaeth ar gyfer deall faint o fenywod yr effeithir arnynt[62].
- mae data cyhoeddus annigonol i ddeall gwahaniaethau posibl mewn amseroldeb diagnosis a thriniaeth canser ledled Cymru, yn enwedig i bobl sy'n byw ym Mhowys. Cynhwysir data amseroldeb ar gyfer trigolion Powys sy'n cael eu trin gan fyrddau iechyd eraill yng Nghymru yn y data ar gyfer y byrddau iechyd hynny. Nid yw'r data'n cael eu gwahanu i ddangos amseroldeb o ran trigolion Powys neu drigolion y bwrdd iechyd sy'n darparu triniaeth[63]. Mae diffyg data hefyd am gleifion o Gymru o unrhyw fwrdd iechyd sy'n cael eu trin gan GIG Lloegr (**argymhelliad 10**).

60 Mae'r prosiect yn bwriadu adrodd ei ganfyddiadau ddiwedd 2024.

61 O dan Hysbysiadau Newid Safonau Data o 2020 ymlaen (DCSN 2020/21 a DSCN 23/45). Mae'r Hysbysiadau yn mandadu cydymffurfiaeth â safonau data.

62 Pwyllgor Iechyd a Gofal Cymdeithasol Senedd Cymru, Heb lais: Taith menywod drwy ganser gynaecolegol, Rhagfyr 2023.

63 Mae data eraill a gyhoeddwyd gan GIG Cymru yn cynnwys data perfformiad 'preswyl' a 'darparwr' sy'n benodol i fyrddau iechyd. Er enghraifft, y data Atgyfeirio ar gyfer Triniaeth ar StatsCymru.

- prin yw'r wybodaeth hefyd ar gyfer deall tegwch y ddarpariaeth i blant a phobl ifanc. Mae Iechyd a Gofal Digidol Cymru yn grwpio'r holl ddata ar gyfer pobl o dan 30 oed gyda'i gilydd yn nata y Dangosfwrdd Amheuaeth o Ganser ac mae cleifion eraill yn cael eu grwpio mewn bandiau oedran 10 mlynedd. Eithrir pobl ifanc dan 16 oed o arolwg profiad cleifion canser Macmillan.

2.34 Mae problemau gydag ansawdd rhai o'r data sydd ar gael. Dywedodd swyddogion Uned Gwybodaeth ac Arolygaeth Canser Cymru wrthym fod Cymru flwyddyn y tu ôl i Loegr o ran cyhoeddi data y Gofrestrfa Ganser oherwydd bod nifer uchel y gwallau yn y data ffynhonnell yn creu gwaith ychwanegol i'w staff. Dywedodd cyrff y GIG wrthym fod cydymffurfiaeth wael â safonau data ymhlith staff y GIG sy'n mewnbynnu gwybodaeth am gleifion yn creu gwallau data. Canfuom fod dryswch ynghylch pwy sy'n gyfrifol am wella cydymffurfiaeth (**argymhelliad 8**). Nid ydym wedi adolygu ansawdd data yn benodol yn rhan o'r adolygiad hwn ond rydym wedi datgelu sawl anghywirdeb yn y data a gyhoeddwyd a dadansoddiad pwrpasol a ddarparwyd gan Iechyd a Gofal Digidol Cymru.

Tameidiog yw'r systemau digidol ac mae cynnydd o ran gweithredu'r system newydd gwybodaeth am ganser wedi bod yn araf

2.35 Araf iawn y bu'r cynnydd wrth ddiweddaru'r system digidol craidd ar gyfer cleifion canser. Adeiladwyd y system flaenorol (Canisc) gan ddefnyddio iaith raglennu ym 1997 y rhoddodd Microsoft y gorau i'w chefnogi yn 2014. Yn dilyn ein hadroddiad yn 2018 ar systemau gwybodeg GIG Cymru[64], cododd ymchwiliad Pwyllgor Cyfrifon Cyhoeddus y Senedd bryderon difrifol am gynnydd araf wrth ddisodli Canisc[65]. Cymerodd bum mlynedd arall i weithredu cam cyntaf y system newydd gwybodaeth am ganser. Dywedodd Iechyd a Gofal Digidol Cymru wrthym fod y pandemig wedi ychwanegu at oediadau. Yn ddiweddar, mae Llywodraeth Cymru wedi cadarnhau cyllid ar gyfer ail gam y rhaglen, gyda'r nod o wella integreiddiad a phrosesau digidol ac o ymdrin â cheisiadau am newidiadau penodol gan gyrff unigol y GIG.

64 Swyddfa Archwilio Cymru, Systemau Gwybodeg yn GIG Cymru, 2018.

65 Pwyllgor Cyfrifon Cyhoeddus Cynulliad Cenedlaethol Cymru, Systemau Gwybodeg yn GIG Cymru, 2018.

2.36 Yn ehangach, dywedodd cyrff y GIG wrthym fod diffyg systemau digidol integredig yn cymryd amser staff gwerthfawr oherwydd eu bod yn defnyddio gweithredoedd â llaw i drosglwyddo cleifion ar draws y gwahanol systemau gweinyddu cleifion. Mae'r broses yn rhwystredig i'r staff ac yn cymryd o'u hamser ar gyfer gweld cleifion. Mae hefyd yn peri risgiau i ddiogelwch cleifion oherwydd y gellid trosglwyddo'r manylion yn anghywir neu ddim o gwbl. Mae Iechyd a Gofal Digidol Cymru yn gyfrifol am gyflawni systemau digidol cenedlaethol ar gyfer GIG Cymru, ond nid eu cyfluniad lleol. Disgrifiodd Iechyd a Gofal Digidol Cymru rwystrau sylweddol i integreiddio'r systemau hynny. Yn benodol, mae nifer o enghreifftiau o gyrff y GIG naill ai'n caffael eu systemau digidol eu hunain yn hytrach na defnyddio'r cynhyrchion cenedlaethol, neu addasu'r cynhyrchion cenedlaethol sy'n cyfyngu ar y gallu i ryngweithredu.

2.37 Mae'r Cynllun Gwella Canser yn ymrwymo Iechyd Cyhoeddus Cymru, y Rhwydwaith Canser ac Iechyd a Gofal Digidol Cymru i ddatblygu fersiwn canser o'r Strategaeth Digidol a Data cenedlaethol i Gymru erbyn diwedd Mehefin 2023. Nid oedd cynllun o'r fath wedi ei greu ar adeg ein hadolygiad a chanfuom ddryswch ynghylch yr ymrwymiad i greu un yn y lle cyntaf. Dywedodd Iechyd a Gofal Digidol Cymru wrthym nad oes angen creu cynllun canser digidol ar wahân oherwydd bod y Strategaeth Digidol a Data cyffredinol yn nodi'r dull system gyfan o wella'r ddarpariaeth ddigidol.

Atodiad

1 Cyd-destun strategol

2 Dadansoddi data ychwanegol

3 Ynglŷn â'n gwaith

1 Cyd-destun strategol

Arddangosyn 23: rolau a chyfrifoldebau eang ar gyfer gwasanaethau canser yng Nghymrua

Llywodraeth Cymru

Gosod blaenoriaethau ar gyfer cyrff iechyd a Gweithrediaeth y GIG

Gweithrediaeth y GIG

Rhwydwaith Clinigol Strategol Cenedlaethol ar gyfer Canser. (Rhwydwaith Canser Cymru gynt)

Arwain at wella gwasanaethau canser

Cyrff y GIG sy'n gyfrifol am ddarparu gwasanaethau canser

Byrddau Iechyd

Yn gyfrifol am iechyd eu poblogaeth breswyl, gan gynnwys gwella iechyd, darparu gwasanaethau canser* a gofal diwedd oes a lliniarol

Ymddiriedolaeth GIG Felindre

Yn gyfrifol am ddarparu gwasanaethau canser** yn Ne-ddwyrain Cymru a gwasanaethau gwaed arbenigol ledled Cymru

Ymddiriedolaeth GIG Iechyd Cyhoeddus Cymru

Yn gyfrifol am wella iechyd a llesiant, lleihau anghydraddoldeb iechyd, darparu gwasanaethau sgrinio canser, a'r gofrestrfa ganser (Uned Gwybodaeth ac Arolygaeth Canser Cymru)

Cyrff y GIG yn cefnogi GIG Cymru ***

Iechyd a Gofal Digidol Cymru

Yn gyfrifol am gefnogi datblygiad y gweithlu iechyd a gofal

Partneriaeth Cydwasanaethau GIG Cymru

Darparu swyddogaethau a gwasanaethau cymorth i GIG Cymru

Addysg a Gwella Iechyd Cymru

Yn gyfrifol am gefnogi datblygiad y gweithlu iechyd a gofal

Cyrff sy'n cefnogi cleifion canser a'u teuluoedd, gan gynnwys:
Y sector gofal cymdeithasol, y trydydd sector, awdurdodau lleol, a grwpiau cleifion

Ffynhonnell: Archwilio Cymru

Noder:

*Gan gynnwys profion diagnostig; triniaeth; a chymorth a chyngor i gleifion. Oherwydd bod darparwyr gofal iechyd eraill yn darparu rhai gwasanaethau, mae lefel a math y gwasanaethau a ddarperir yn wahanol rhwng byrddau iechyd. Er enghraifft, mae Bwrdd Iechyd Addysgu Powys yn darparu rhai gwasanaethau diagnostig, ond mae'n comisiynu gwasanaethau canser eraill gan ddarparwyr GIG eraill yng Nghymru a Lloegr.

**Gan gynnwys cemotherapi; Radiotherapi; a chymorth a chyngor i gleifion.

***Mae sefydliadau a grwpiau hefyd sy'n gyfrifol am ymchwilio, datblygu ac arloesi, gan gynnwys: Partneriaeth Genomeg Cymru; Ymchwil Iechyd a Gofal Cymru; Hwb Gwyddorau Bywyd Cymru; a Chanolfan Ymchwil Canser Cymru.

Arddangosyn 24: elfennau allweddol o'r dull strategol o ymdrin â gwasanaethau canser yng Nghymru

Rhaglen Lywodraethu

Blaenoriaethau gweinidogol

Deddf Iechyd a Gofal Cymdeithasol (Ansawdd ac Ymgysylltu) (Cymru) 2020

Cymru Iachach: Ein Cynllun Iechyd a Gofal Cymdeithasol

Gosod gweledigaeth Llywodraeth Cymru ar gyfer iechyd a gofal cymdeithasol

Fframwaith Cynllunio y GIG

Canllawiau ac egwyddorion cynllunio ar gyfer cyrff y GIG

Fframwaith Perfformiad y GIG

Gosod mesurau perfformiad i gyrff y GIG

Fframwaith Clinigol Cenedlaethol

Egwyddorion ar gyfer cynllunio i ddarparu gwasanaethau clinigol

Datganiad Ansawdd ar gyfer Canser 2022

Y weledigaeth genedlaethol ar gyfer gwasanaethau canser

Llwybrau Delfrydol Cenedlaethol

Canllawiau ar gyfer pob cam o lwybrau y claf, gan ddibynnu ar safle y tiwmor

Cynlluniau Tymor Canolig Integredig

Rhwydwaith Canser Cymru: Cynllun Gwella Canser 2023

Cynllun casglu ar gyfer GIG Cymru er mwyn gwella gwasanaethau i gleifion canser

Gweithrediaeth y GIG: Rhaglen Adfer Canser Genedlaethol 2024

Rhaglen genedlaethol i wella gwasanaethau canser

Hwb Gwyddorau Bywyd Cymru: Canser: Menter Gwella Canlyniadau

Rhaglen a gomisiynwyd gan Lywodraeth Cymru, gyda'r nod o gyflawni arloesedd yn sydyn

Strategaeth ehangach Llywodraeth Cymru, gan gynnwys:

Strategaeth Adfer a Thrawsnewid Diagnosteg yng Nghymru 2023–2025

Strategaeth Digidol a Data ar gyfer Iechyd a Gofal Cymdeithasol yng Nghymru 2023

Cynllun Gweithredu Cenedlaethol ar gyfer y Gweithlu: Mynd i'r Afael â Heriau Gweithlu GIG Cymru 2023 a Cymru Iachach: Ein Strategaeth Gweithlu ar gyfer Iechyd a Gofal Cymdeithasol, 2020 (comisiynwyd gan Lywodraeth Cymru gan Addysg a Gwella Iechyd Cymru)

Pwysau Iach, Cymru Iach, 2019 gan gynnwys cynllun cyflawni 2022 i 2024

Cymru Ddi-fwg: Strategaeth hirdymor Cymru ar gyfer rheoli tybaco, 2022, gan gynnwys cynllun cyflawni 2022 i 2024

Ffynhonnell: Archwilio Cymru

2 Dadansoddi data ychwanegol

Data am y galw am wasanaethau canser

Arddangosyn 25: cleifion a gafodd eu trin fesul ffynhonnell yr amheuaeth, cyfartaledd misol drwy gydol 2023–24

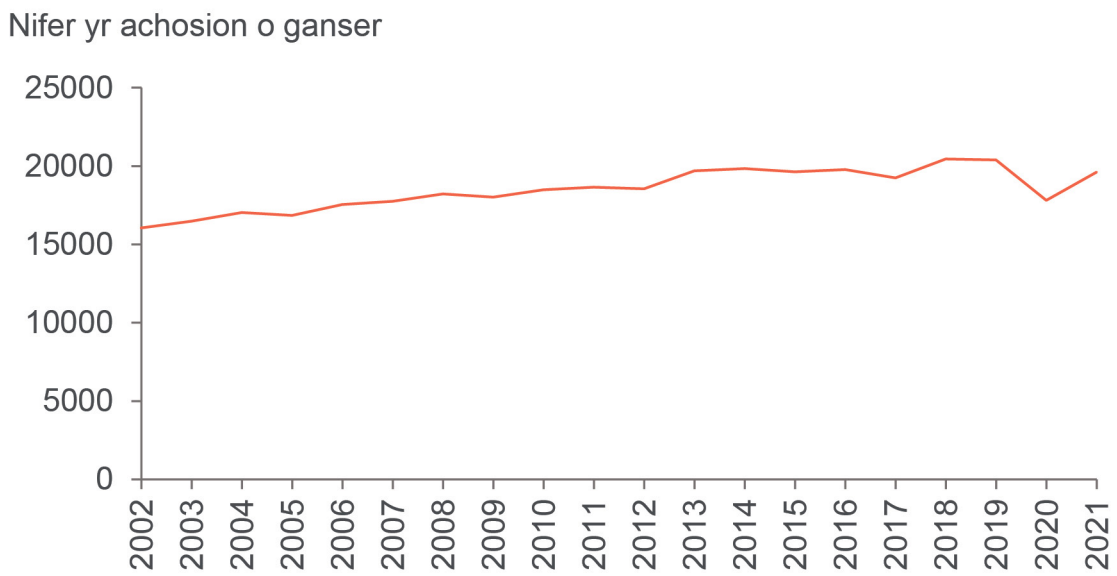
Ffynhonnell amheuaeth / atgyfeiriad	% gyffredinol yr atgyfeiriadau canser a amheuid	% y cleifion yn dechrau triniaeth fel cyfran o'r atgyfeiriadau, fesul ffynhonnell amheuaeth
Meddyg teulu	**80%** (12,635 o bobl)	**8% o'r atgyfeiriadau gan feddygon teulu** (975 o bobl)
Gofal eilaidd mewnol	**10%** (1,570 o bobl)	**17% o'r atgyfeiriadau gofal eilaidd mewnol** (266 o bobl)
Yn dilyn prawf diagnostig	**6%** (911 o bobl)	**37% o'r atgyfeiriadau yn dilyn prawf diagnostig** (341 o bobl)
Sgrinio'r coluddyn	**1%** (120 o bobl)	**28% o'r atgyfeiriadau i sgrinio'r coluddyn** (33 o bobl)
Sgrinio'r fron	**1%** (106 o bobl)	**92% o'r atgyfeiriadau sgrinio'r fron (98 o bobl)**
Sgrinio serfigol	**<1%***	**50% o'r atgyfeiriadau sgrinio serfigol***
Adran frys	**1%** (214 o bobl)	**38% o'r atgyfeiriadau at adrannau brys** (81 o bobl)
Gweithiwr gofal sylfaenol proffesiynol arall	**1%** (120 o bobl)	**5% o'r atgyfeiriadau gan weithwyr gofal sylfaenol proffesiynol eraill***
Gweithwyr iechyd proffesiynol eraill	**<1%** (66 o bobl)	**15% o'r atgyfeiriadau gan weithwyr iechyd proffesiynol eraill***
Ymgynghorydd o fwrdd iechyd arall	**<1%** (38 o bobl)	**21% o'r atgyfeiriadau gan ymgynghorwyr allanol***

Ffynhonnell: Dadansoddiad Archwilio Cymru o Ddata Llwybr Amheuaeth o Ganser gan Iechyd a Gofal Digidol Cymru—llwybrau caeëdig fesul ffynhonnell yr amheuaeth.

Noder: Roedd nifer bach o lwybrau cleifion nad oedd ganddynt ddata am ffynhonnell yr amheuaeth/atgyfeiriad.

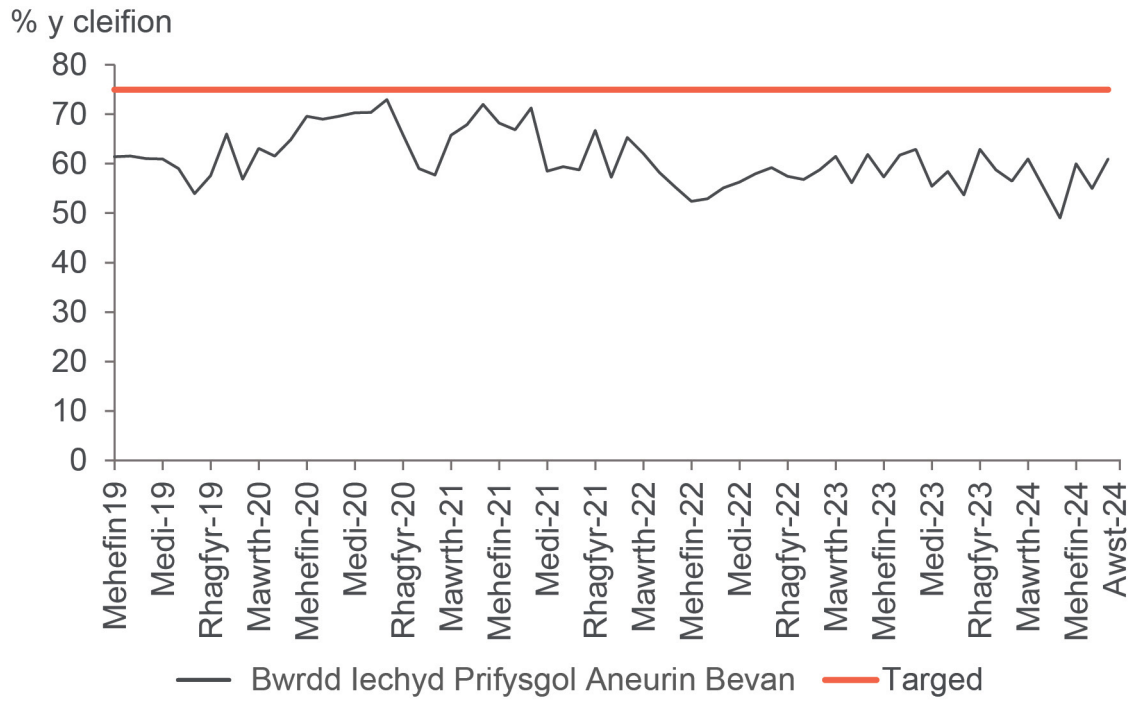
*Pan fo 10 neu lai o bobl.

Arddangosyn 26: nifer y diagnosisau newydd o ganser yng Nghymru (ac eithrio canser croen nad yw'n felanoma), 2002–2021



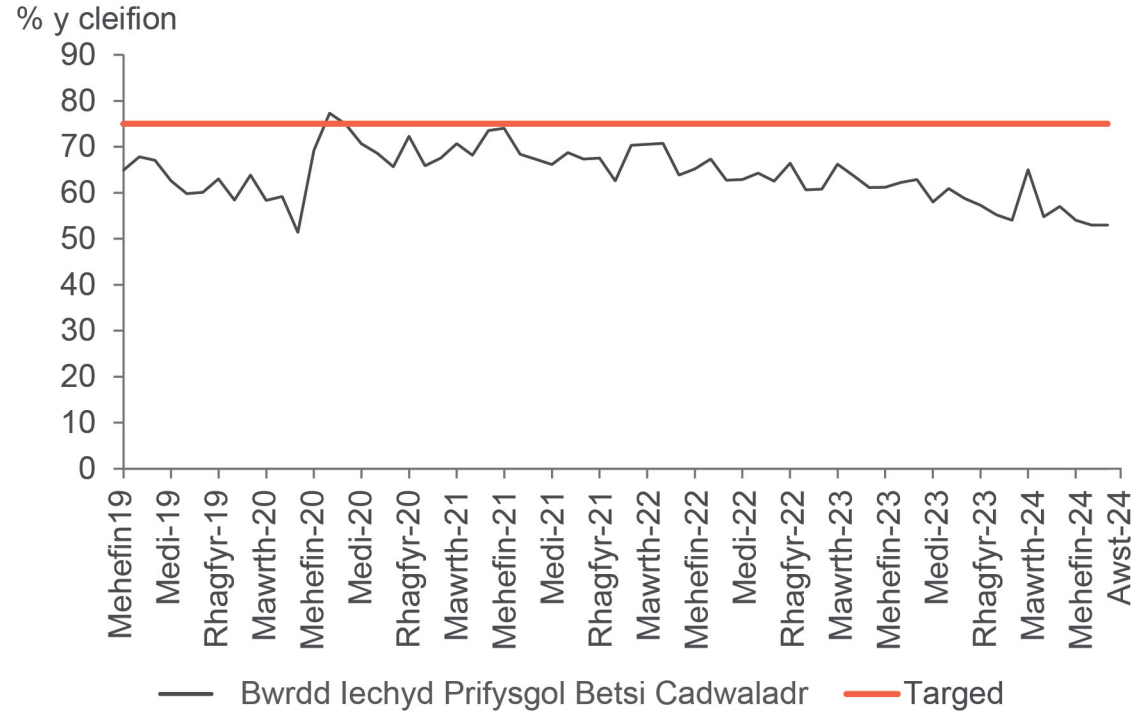
Ffynhonnell: Data achosion canser Uned Gwybodaeth ac Arolygaeth Canser Cymru

Arddangosyn 27a: perfformiad Bwrdd Iechyd Prifysgol Aneurin Bevan o'i gymharu â'r targed 62 o ddiwrnodau, mis Mehefin 2019 i fis Awst 2024



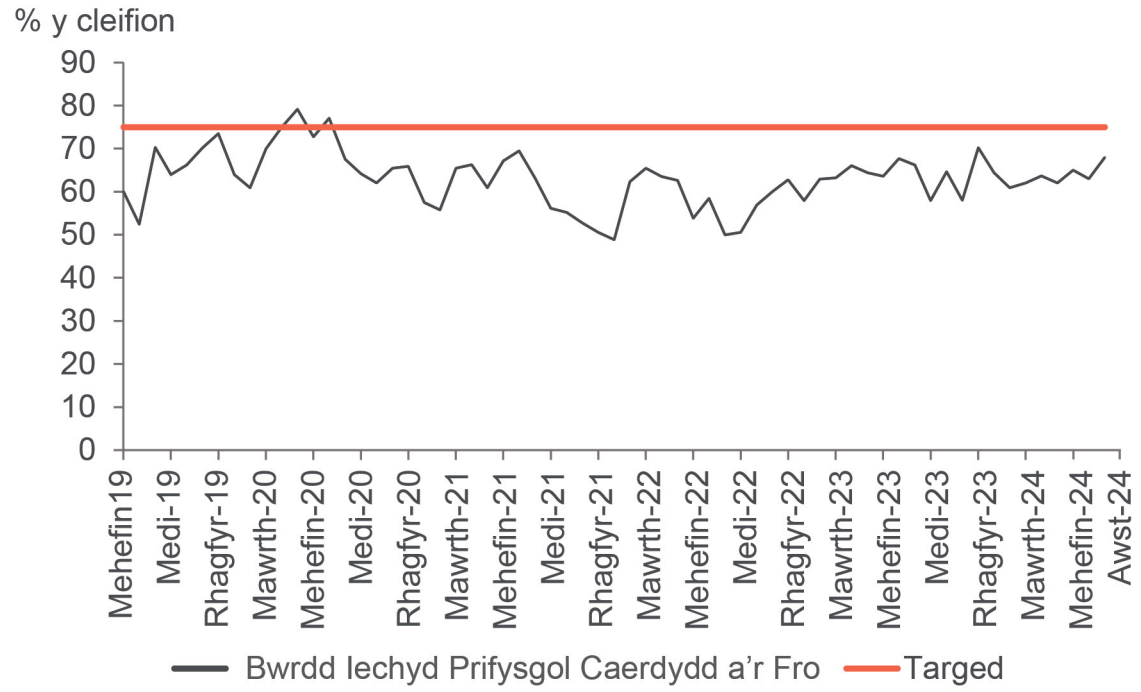
Ffynhonnell: Iechyd a Gofal Digidol Cymru, Llwybr Lle'r Amheuir Canser—set ddata Llwybrau Caeëdig, ar StatsCymru.

Arddangosyn 27b: perfformiad Bwrdd Iechyd Prifysgol Betsi Cadwaladr o'i gymharu â'r targed 62 o ddiwrnodau, mis Mehefin 2019 i fis Awst 2024



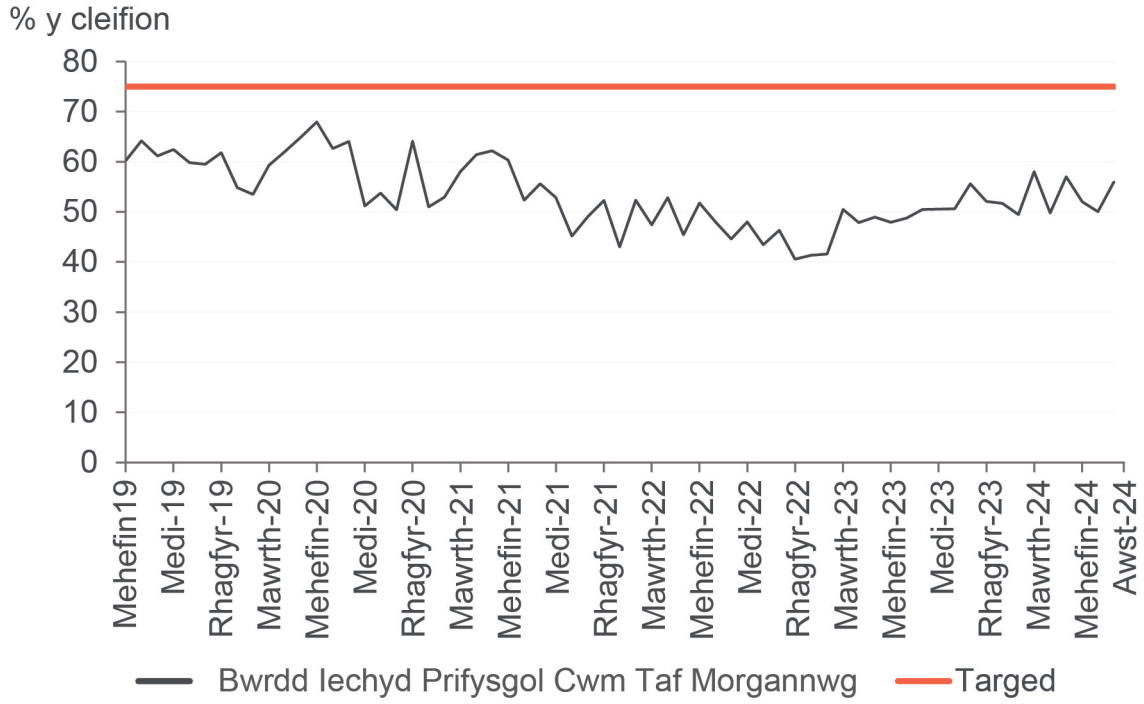
Ffynhonnell: Iechyd a Gofal Digidol Cymru, Llwybr Lle'r Amheuir Canser—Llwybrau Caeëdig, ar StatsCymru.

Arddangosyn 27c: perfformiad Bwrdd Iechyd Prifysgol Caerdydd a'r Fro o'i gymharu â'r targed 62 o ddiwrnodau, mis Mehefin 2019 i fis Awst 2024



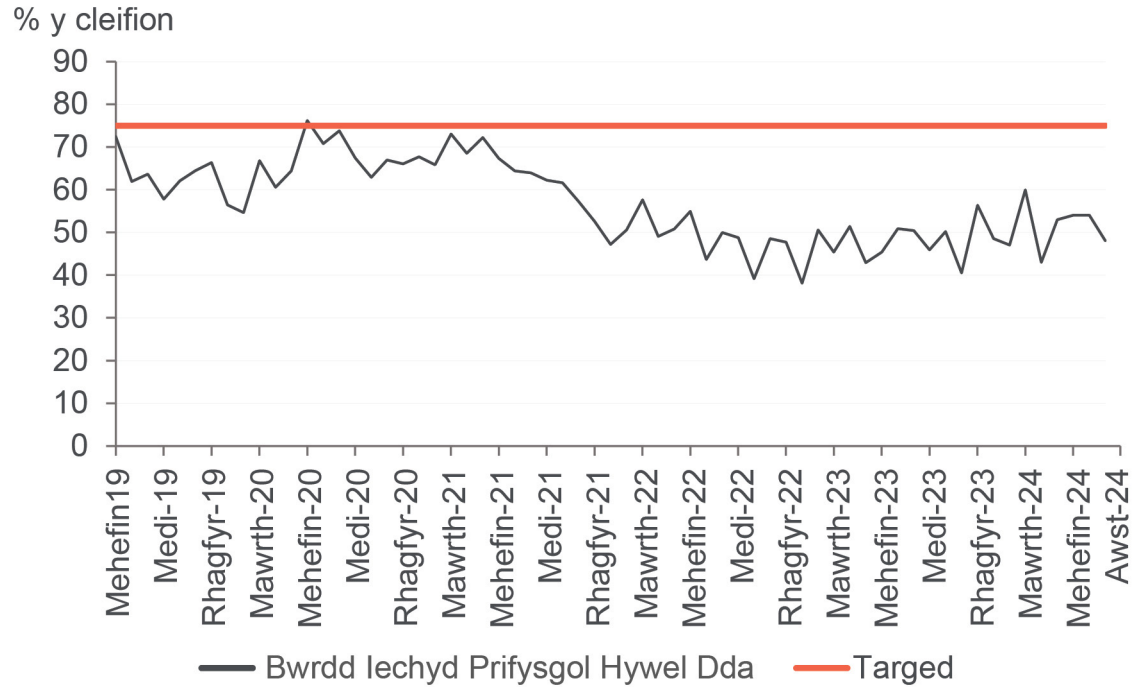
Ffynhonnell: Iechyd a Gofal Digidol Cymru, Llwybr Lle'r Amheuir Canser—set ddata Llwybrau Caeëdig, ar StatsCymru.

Arddangosyn 27d: perfformiad Bwrdd Iechyd Prifysgol Cwm Taf Bro Morgannwg o'i gymharu â'r targed 62 o ddiwrnodau, mis Mehefin 2019 i fis Awst 2024



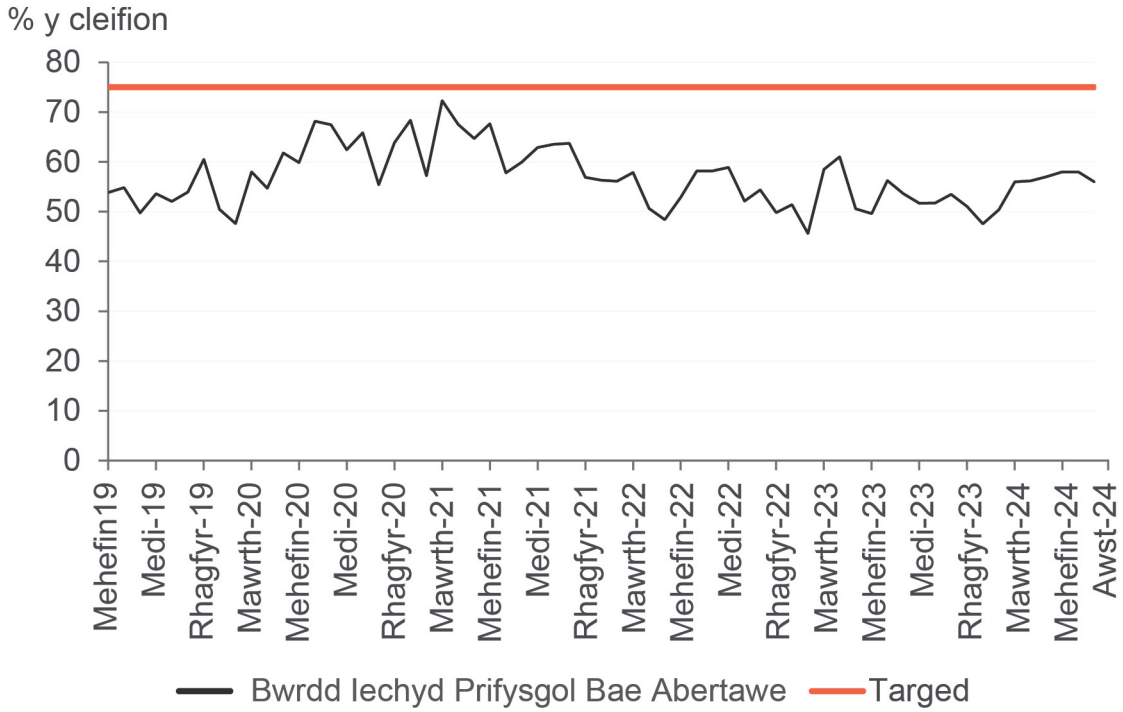
Ffynhonnell: Iechyd a Gofal Digidol Cymru, Llwybr Lle'r Amheuir Canser—set ddata Llwybrau Caeëdig, ar StatsCymru.

Arddangosyn 27e: perfformiad Bwrdd Iechyd Prifysgol Hywel Dda o'i gymharu â'r targed 62 o ddiwrnodau, mis Mehefin 2019 i fis Awst 2024



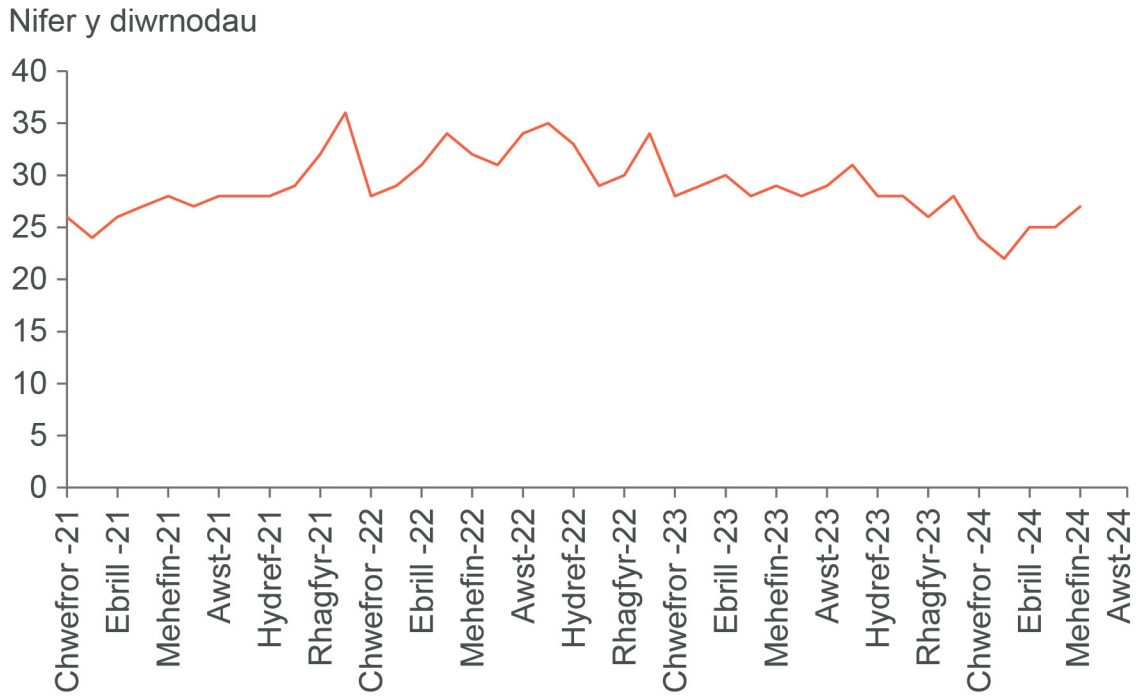
Ffynhonnell: Iechyd a Gofal Digidol Cymru, Llwybr Lle'r Amheuir Canser—set ddata Llwybrau Caeëdig, ar StatsCymru.

Arddangosyn 27f: perfformiad Bwrdd Iechyd Prifysgol Bae Abertawe o'i gymharu â'r targed 62 o ddiwrnodau, mis Mehefin 2019 i fis Awst 2024



Ffynhonnell: Iechyd a Gofal Digidol Cymru, Llwybr Lle'r Amheuir Canser—set ddata Llwybrau Caeëdig, ar StatsCymru.

Arddangosyn 28: arosiadau canolrifol o'r amheuaeth gyntaf hyd at ddiagnosis, rhwng mis Chwefror 2021 a mis Awst 2024



Ffynhonnell: Data Iechyd a Gofal Digidol Cymru o Ddangosfwrdd y Llwybr Amheuaeth o Ganser

3 Ynglŷn â'n gwaith

Cwestiwn, cwmpas a meini prawf archwilio

Gwnaethom ddewis canolbwyntio ar y dull strategol cenedlaethol o wella amseroldeb diagnosis a thriniaeth canser oherwydd ein bod wedi nodi heriau systemig sylweddol sy'n wynebu gwasanaethau canser yn ystod ein gwaith cwmpasu. Mae'r adolygiad hwn yn canolbwyntio ar Lywodraeth Cymru a Gweithrediaeth y GIG (a'i Rhwydwaith Clinigol Strategol Cenedlaethol ar gyfer Canser) fel arweinwyr y system, gan gydnabod bod gan fyrddau iechyd ac ymddiriedolaethau y GIG gyfrifoldeb dros y ddarpariaeth weithredol ar gyfer gwahanol agweddau ar wasanaethau canser. Byddwn yn ystyried rhinweddau gwaith pellach sy'n canolbwyntio ar ddull cyrff y GIG o ddarparu gwasanaethau canser yn ein rhaglen waith 2025–2026.

Gwnaethom ddatblygu ein meini prawf archwilio ar sail dysg o'n harchwiliadau gofal a gynlluniwyd blaenorol[66] a gwaith archwilio iechyd lleol, dadansoddiad dogfennau strategol allweddol[67], ac ymchwil gan sefydliadau perthnasol ar yr heriau sy'n gysylltiedig â gwasanaethau canser yng Nghymru.

66 Archwilio Cymru, Amseroedd Aros y GIG ar Gyfer Gofal Dewisol yng Nghymru, 2015; Archwilio Cymru, 10 Cyfle i Ailosod ac Ailgychwyn System Gofal wedi'i Gynllunio y GIG, 2020; ac Archwilio Cymru, Mynd i'r Afael â'r Ôl-groniad mewn Gofal wedi'i Gynllunio yng Nghymru, 2022.

67 Gan gynnwys Llywodraeth Cymru, Cymru iachach: cynllun hirdymor ar gyfer iechyd a gofal cymdeithasol, 2021; Llywodraeth Cymru, Ein rhaglen i drawsnewid a moderneiddio gofal a gynlluniwyd a lleihau rhestrau aros yng Nghymru, 2022, Llywodraeth Cymru, Y Datganiad Ansawdd ar gyfer Canser, 2022, Llywodraeth Cymru, Strategaeth adfer a thrawsnewid diagnosteg yng Nghymru 2023 i 2025; a'r Rhwydwaith Clinigol Strategol Cenedlaethol ar gyfer Canser, Cynllun Gwella Canser ar gyfer GIG Cymru 2023–26, 2023.

Dulliau archwilio

Adolygu dogfennau

Gwnaethom adolygu dogfennau perthnasol gan gynnwys:

- dogfennau sy'n nodi'r dull strategol cenedlaethol. Mae dogfennau allweddol yn cynnwys y Datganiad Ansawdd ar gyfer Canser, Cynllun Gwella Canser, y Strategaeth Adfer a Thrawsnewid Diagnosteg, Fframwaith Clinigol Cenedlaethol, Llwybrau Delfrydol Cenedlaethol a fframweithiau cynllunio a pherfformiad y GIG;
- dogfennau sy'n ymwneud â rhaglen adfer canser genedlaethol Gweithrediaeth y GIG;
- cynlluniau cyrff unigol y GIG sy'n nodi eu dull o ddarparu gwasanaethau canser, a phapurau bwrdd a phwyllgorau perthnasol ar berfformiad canser;
- papurau o gyfarfodydd rheoli perfformiad Llywodraeth Cymru;
- Gwybodaeth gan Ymddiriedolaeth GIG Iechyd Cyhoeddus Cymru am ddarparu gwasanaethau sgrinio'r boblogaeth;
- gwybodaeth am ddata canser ac iechyd y boblogaeth, gan gynnwys adroddiadau gan Uned Gwybodaeth ac Arolygaeth Canser Cymru a Cyngor ar Wyddoniaeth a Thystiolaeth Llywodraeth Cymru[68]; ac
- adroddiad Pwyllgor Iechyd a Gofal Cymdeithasol y Senedd ar ei ymchwiliad i ganserau gynaecolegol[69] a thystiolaeth ategol

68 Llywodraeth Cymru, Cyngor ar Wyddoniaeth a Thystiolaeth—Y GIG mewn 10 Mlynedd a Mwy—Archwiliad o Effaith Amcanestynedig Cyflyrau Hirdymor a Ffactorau Risg yng Nghymru, Medi 2023.

69 Pwyllgor Iechyd a Gofal Cymdeithasol Senedd Cymru, Heb lais: Taith menywod drwy ganser gynaecolegol, Rhagfyr 2023.

Cyfweliadau lledstrwythuredig

Gwnaethom gyfweld swyddogion o'r sefydliadau a ganlyn:

- Llywodraeth Cymru;
- Gweithrediaeth y GIG, gan gynnwys ei Rhwydwaith Clinigol Strategol Cenedlaethol ar gyfer Canser;
- sampl o fyrddau iechyd, gan gynnwys swyddogion o Fyrddau Iechyd Prifysgol Betsi Cadwaladr, Hywel Dda a Bae Abertawe, a Bwrdd Iechyd Addysgu Powys;
- swyddogion o gyrff eraill y GIG, gan gynnwys Iechyd a Gofal Digidol Cymru, Addysg a Gwella Iechyd Cymru, Ymddiriedolaethau GIG Iechyd Cyhoeddus Cymru a Felindre; a
- Gwnaethom gwrdd hefyd â swyddogion o Weithrediaeth y GIG, Byrddau Iechyd Prifysgol Caerdydd a'r Fro, Hywel Dda a Bae Abertawe er mwyn llywio ein gwaith cwmpasu.

Gweithdy gyda chynrychilwyr y trydydd sector

Gwnaethom gynnal gweithdy gyda chynrychiolwyr o'r trydydd sector ar 1 Mai 2024 a drefnwyd gan Gynghrair Canser Cymru[70]. Gwnaethom ofyn i'r cyfranogwyr am eu safbwyntiau am gryfderau a gwendidau y dull strategol cenedlaethol a gwahoddwyd ymatebion ysgrifenedig ychwanegol gyda rhagor o fanylion am yr un pwnc. Gwnaethom gynnal cyfweliadau dilynol gyda rhai sefydliadau er mwyn cael eglurhad yn ôl yr angen. Cymerodd cynrychiolwyr o'r sefydliadau isod ran yn y gweithdy:

- ALK Positive UK
- Cymdeithas Diwydiant Fferyllol Prydain
- Blood Cancer UK
- Bowel Cancer UK
- Breast Cancer Now
- Cancer Research UK
- Triniaeth Deg i Fenywod Cymru
- Leukaemia Care
- Macmillan Cancer Support
- Marie Curie
- Prostate Cancer UK
- Coleg Brenhinol y Patholegwyr
- Coleg Brenhinol Pediatreg ac Iechyd Plant
- Coleg Brenhinol y Meddygon
- Gofal Canser Tenovus
- Young Lives vs Cancer

Gwnaethom sefydlu panel arbenigol i lywio ein dealltwriaeth o'r rhwystrau systemig i amseroldeb diagnosis a thriniaeth canser ac i ddarparu her hanfodol ar ein canfyddiadau. Roedd y panel yn cynnwys cynrychiolwyr o Marie Curie, Cymdeithas Diwydiant Fferyllol Prydain, Coleg Brenhinol y Meddygon, a Chynghrair Canser Cymru.

70 Cynghrair o elusennau sy'n gweithio i atal canser, gwella gofal, ariannu ymchwil a dylanwadu ar bolisïau yng Nghymru.

Dadansoddi data

Rydym wedi adolygu data o wahanol ffynonellau, gan gynnwys:

- Cyhoeddodd Iechyd a Gofal Digidol Cymru ddata am lwybrau canser agored a chaeëdig, ar StatsCymru;
- Cyhoeddodd Iechyd a Gofal Digidol Cymru ddata am nifer y derbyniadau i'r ysbyty. Gwnaethom ofyn hefyd am ddata am gyrchfannau rhyddhau cleifion canser sy'n cael eu derbyn i'r ysbyty;
- gwnaethom ofyn am ddata o set ddata Llwybr Ameuaeth o Ganser a reolir gan Iechyd a Gofal Digidol Cymru na chyhoeddir mewn mannau eraill. Gwnaethom ddadansoddi data am y perfformiad o'i gymharu â tharged y Llwybr Ameuaeth o Ganser yn ôl ethnigrwydd; ffynhonnell amheuaeth; a llwybrau caeëdig yr oedd cleifion yn dechrau triniaeth ar gyfer canser â nhw, yn cael eu hisraddio am beidio â chanser, neu a fu farw cyn cael eu hisraddio neu ddechrau triniaeth; a
- data Uned Gwybodaeth ac Arolygaeth Canser Cymru am achosion, marwolaethau a'r nifer a oroesodd canser.

Archwilio Cymru
1 Cwr y Ddinas
Stryd Tyndall
Caerdydd CF10 4BZ

Ffôn: 029 2032 0500

Ffôn Testun: 029 2032 0660

E-bost: gwybodaeth@archwilio.cymru

Gwefan: www.archwilio.cymru

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

We welcome correspondence and telephone calls in Welsh and English.

Management response form

Archwilio Cymru
Audit Wales

Report title: Cancer Services in Wales: A review of the strategic approach to improving the timeliness of diagnosis and treatment

Completion date: 14/01/25

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R1	The Welsh Government should publicly clarify the status of the Cancer Improvement Plan and its links to the National Cancer Recovery Programme and the Cancer: Improving Outcomes initiative. As part of this the Welsh Government should clarify how it intends to hold NHS bodies to account for delivery of the Cancer Improvement Plan.	Accept. The Welsh Government will update the Quality Statement for Cancer to clarify the respective roles of the Cancer Recovery Programme, Cancer improvement Plan, and other important national work streams such as the Making it Happen initiative. This will include a description of accountability arrangements.	End quarter 1 2025-26	Sue Tranka Chief Nursing Officer
R2	The Welsh Government should set out a coherent model for system leadership in respect of cancer services that clarifies its own role and that of the NHS Executive and sets out how it will bring on board clinicians and other key stakeholders to build a common view of	Accept. The Welsh Government is in the process of finalising a revised governance and leadership model for cancer service development. This will include the introduction of a National Cancer Leadership Board	End quarter 4 2024-25	Nick Wood Deputy Chief Executive, NHS Wales

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	cancer service performance, quality and opportunities for improvement.	that will coordinate or lead on national actions. The NHS Executive will provide the clinical, third sector, and private sector input to its work. This model will continue to develop in response to the feedback of those directly involved and those involved through related leadership groups. These arrangements will be described in the updated Quality Statement for Cancer.		
R3	The Welsh Government should review its oversight and performance framework in respect of cancer services to focus on a broader range of issues, including a more explicit alignment to the ambitions and quality attributes set out in the Quality Statement for Cancer.	Accept. The NHS Performance Framework only includes the top-level strategic metrics for the NHS; it does not include all the metrics that are routinely applied in accountability processes. There are a broader set of metrics which sit outside the Framework. This includes component waits in the cancer pathway, access to treatment measures, data on care quality and outcome, screening and immunisation uptake, and patient outcomes. The broader set of metrics	End quarter 1 2025-26	Jeremy Griffith Director of Operations

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		are used as part of routine accountability process as required. The updated Quality Statement for Cancer will include additional detail to explain how cancer service delivery will be measured.		
R4	The Welsh Government should develop a more coherent approach to population health improvement by setting out how it intends to use its Science Evidence Advice: NHS in 10+ Years to harness the opportunities associated with prevention to reduce the incidence of cancer and other major conditions.	The Welsh Government pursues an evidence-led approach to prevention and to reducing population-level risk for cancer and major conditions. There are established programmes for smoking prevention through the Smoke Free Wales Strategy and Tobacco Control Delivery Plan (with additional supportive legislation imminent) and on tackling overweight and obesity, through the Healthy Weight Healthy Wales strategy and delivery plan, including through the facilitation of physical activity. These programmes are under constant review and development as new evidence and technologies emerge. The NHS Planning Framework for 2025-28 has population health and prevention as one of the five	Establishment of preventing ill-health advisory group by end quarter 1 2025-26	Sioned Rees Director for Public Health Protection

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		priority areas and this will support a further drive and focus on primary, secondary and tertiary prevention interventions in the plans of NHS organisations. We are also in the process of establishing a preventing ill-health advisory group under the Chief Medical Officer to support and harness opportunities to implement sustainable, evidence informed policies that focus on preventing ill-health and related inequalities. The initial focus will be on securing and measuring funding of ill-health prevention, strengthening the current architecture, progressing work on data, and supporting the cross-government role in prevention of ill-health. The establishment of this group will assist in providing sustained engagement and a coherent, coordinated approach to the development of appropriate policy and system responses.		

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
R5	The Welsh Government should work with Public Health Wales to accelerate decision making for a national lung screening programme. It should clarify as soon as possible whether it will fund national lung screening for Wales and the timescale for implementing such a programme.	Accept. The Welsh Government has asked Public Health Wales to accelerate its work on scoping lung screening to permit a decision by Welsh Ministers on its introduction and funding. Public Health Wales is due to provide an interim report by end of March and a final report by end of September to permit Welsh Ministers to make a decision on introducing a national lung screening programme.	End quarter 2 2025-26	Sioned Rees Director for Public Health Protection
R6	As part of a wider approach to encourage greater regional working between health boards, the Welsh Government and the NHS Executive should work with the service to understand and help address any key barriers to delivering regional services. This should include working with DHCW to identify digital solutions to support shared waiting lists for	Accept. The Welsh Government will work with NHS organisations to support regional working for services, where appropriate, to address service fragility. This will include working with Digital Health and Care Wales on the development of digital solutions to permit shared waiting lists.	Ongoing	Mike Emery Chief Digital Officer

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	cancer diagnosis and treatment, where it is appropriate to do so.			
R7	The Welsh Government should work with the NHS Executive, HEIW and other NHS bodies to ensure there are employment opportunities for radiologists who have been trained in the National Imaging Academy.	Accept. The Welsh Government will work with health boards in Wales, which are responsible for planning their workforce, to enable employment of Imaging Academy graduates in line with local or regional workforce needs.	Quarter 2 2025-26	Helen Arthur Director of Workforce and Government Business
R8	The Welsh Government should clarify national roles and responsibilities for monitoring and ensuring compliance with its data standards including how it will hold NHS bodies to account for poor compliance.	Accept. Digital Health and Care Wales develop and design data standards, including minimum data sets for NHS Wales. DHCW advises the Welsh Government on what should be included and how they should be collected. Only the Welsh Government can mandate	Quarter 3 2025-26	Mike Emery Chief Digital Officer

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
		requirements through national policy, planning guidance or Welsh Health Circulars. To ensure compliance, the Welsh Government expects organisations to audit themselves against the standards and DHCW to deliver a quality assurance and review process. Regulatory bodies such as Audit Wales and Healthcare Inspectorate Wales also have a role in auditing organisations against national standards. DHCW and regulatory bodies should report to the Welsh Government any significant failure to comply with national data requirements, so that these can be addressed with NHS organisations through accountability processes and meetings.		
R9	The Welsh Government should work with the NHS Executive (particularly the Cancer Network), DHCW and Public Health Wales NHS Trust to develop a more comprehensive set of publicly available data on cancer services, which as a minimum should include:	Accept in principle. The Welsh Government will develop a cancer data road map to improve the available data on cancer service delivery for use by the NHS, the Welsh Government, and the public. However, it may not be	Quarter 3 2025-26	Mike Emery Chief Digital Officer

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	• the number of people currently waiting for cancer diagnosis or treatment (open pathway data); • Performance against the 62-day target for the health board providing diagnosis and treatment and health board of residence, including people living Powys Teaching Health Board area; • Performance across the patient pathways including timeliness of diagnostic reporting across different tumour sites; timeliness from the decision to treat a patient to the start of that treatment (including surgery, radiotherapy and Systemic Anti-Cancer Therapy); and diagnosis and treatment of recurrent disease. Performance information should be provided at cancer sub-tumour level where possible; • Timeliness of diagnosis and treatment for patients referred from the breast and cervical screening programmes; and	possible to provide all of this data to the public for reasons of data accuracy, reporting burden on NHS services, and patient confidentiality. In addition, the barriers to providing data on treatment in England must first be understood before commitments can be made to publishing this data, but we support the principle of doing so, subject to their further analysis.		

Ref	Recommendation	Management response Please set out here relevant commentary on the planned actions in response to the recommendations	Completion date Please set out by when the planned actions will be complete	Responsible officer (title)
	• accurate information on equity of access, including ethnicity of cancer patients as well as the experiences of different patient groups (this should include children and young people).			
R10	The Welsh Government should work with DHCW and NHS England to share regular and consistent data on the timeliness of diagnosis and treatment for Welsh cancer patients treated by NHS England.	Accept. The Welsh Government will work with health boards, NHS England, and Digital Health and Care Wales to ensure relevant data on the diagnosis and treatment of Welsh residents seen in England is appropriately shared.	Quarter 4 2025-26	Mike Emery Chief Digital Officer

4

10:45, 0 Mins

4 - Clinical Audit

4.1

10:45, 15 Mins

4.1 - Clinical Audit Update

Sharon Daniel (Hywel Dda UHB - Interim Executive Director of Nursing, Quality & Patient Experience), Ian Bebb (Hywel Dda UHB - Clinical Audit Manager), Mandy Davies (Hywel Dda UHB - Assistant Director of Nursing & Quality Improvement)

For assurance

Attachments

4.1 Clinical Audit Update ARAC April 2025.pdf

4.1 National Clinical Audit and Outcome Review Programme 2024-25.pdf

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	15 April 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Clinical Audit Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Sharon Daniel, Interim Director of Nursing, Quality and Patient Experience
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.

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 issue 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.

A large number of new audits were added to the programme in 2024-25 and the Clinical Audit Department was determining whether or not they were applicable to the Health Board. This has now been completed.

Local Clinical Audit Programmes
The Clinical Audit Department (CAD) liaise with a number of services to establish a local programme each financial year. A total of 32 local projects were submitted to the 2024/25 programme. NCAORP projects are automatically included, bringing the total to 77. The 2024/25 programme is currently being finalised, in line with development of next year's programme.

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 training of various staff, and ad hoc training is also provided.

Asesiad / Assessment

Audit Management and Tracking (AMAT) Software
The CAD are now implementing an additional module within the AMAT software. The Ward & Area module will support audits to be carried out across multiple areas of the Health Board on a regular basis. The software will act as a data collection platform and audit results and actions can be tracked through dashboard displays.

The new module will primarily be used for nurse-led audits, which will be carried out on all applicable wards throughout the hospital sites and include community areas. A total of 7 audits will have been launched by the time of this meeting, with additional audits expected to be added within the next 3 months. This represents a significant change in the way nurse-led audits are carried out, and will offer increases to transparency, tracking, improvements and ease of access. This software is now available to use within the Health Board.

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. In the previous ARAC report on 10 December 2024, a number of these areas were classed as "TBC" and these are all now resolved. A small number of audits have been identified as having low participation levels but there is an element of participation for all audits.

Any exceptions to expected participation have been:

- Escalated to senior management within the respective services
- Reported to the relevant senior quality and governance forums
- Reviewed at the Clinical Audit Scrutiny Panel (CASP)
- Expected to complete a Quality Impact Assessment (Pilot stage)
- Continually monitored

Discussions with audit and service leads are underway for all areas where low participation has been identified. Where participation shortfalls are identified and not mitigated, services are asked to complete a risk assessment, include details within the relevant risk register and provide an improvement plan.

In January 2025, the CAD has included an additional element to the audit process. Any audits with insufficient participation will now require a Quality Impact Assessment. This is currently being piloted with a number of audits/services, with both positive and negative impacts/ outcomes being identified.

Previously, two areas were flagged as outliers by the audit providers: Epilepsy 12 and National Joint Registry. Both of these issues were resolved, although both projects will continue to be monitored. It is worth noting that Withybush General Hospital was flagged as a “Gold standard” data quality reporter in recent correspondence for the National Joint Registry and the Health Board has received a number of letters like this for various audits in the past.

Three audits were flagged in the previous report to ARAC: National Hip Fracture, Major Trauma Audit and National Joint Registry. The services involved are providing Quality Impact Assessments and the National Hip Fracture Audit is currently being piloted through the system. All audits are being contributed to, but as participation remains at low levels, they have been escalated through the system.

Decisions will be made by Senior Health Board staff, as all QIA Panels are chaired by a Clinical Executive who will consult with the Service/Audit Leads. Decisions at panel are escalated as appropriate to the Board. The outcomes of this will be monitored carefully and reported to Quality, Safety and Experience Committee and the Clinical Audit Scrutiny Panel.

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

Clinical Audit Programme 2024/25

Letters were sent to owning groups regarding the 2025/26 CAP and the deadline for submission is 30 April 2025. The new programme is expected to contain a number of re-audits, which is excellent for continuous improvement. There will also be a large number of nurse-led whole Health Board audits featuring on the programme. A total of 45 National audits will be included. The programme is being split into a bi-annual programme to encourage timely participation and provide more opportunities for the planning of these projects.

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. Four more have been planned for 2025/26.

The CAD continues 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 11 February 2025, at which a talk on the links between Quality Improvement and Clinical Audit was given.

The CAD regularly meets with the Clinical Effectiveness team, Quality Assurance and Assurance and Risk teams to discuss work on the AMAT system and other activity.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to:

- **NOTE** the expansion of the use of AMAT software within the Health Board
- **TAKE ASSURANCE** from the continuation of the majority of mandatory national audits and the processes followed for escalation
- **TAKE ASSURANCE** from the resolution of all of the projects that were awaiting confirmation of participation
- **NOTE** the increased monitoring of some projects and the new assessment process that is being piloted
- **NOTE** the development of the 2025/26 programme and new approach
- **TAKE ASSURANCE** from the continued shared learning through the Whole Hospital Audit Meetings (WHAM)

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:	3. Data to knowledge 4. Learning, improvement and research

Quality and Engagement Act (sharepoint.com)	
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 2023/24 Hywel Dda UHB Forward Clinical Audit Programme 2023/24, 2024/25 (draft)
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 Interim Director of Nursing, Quality and Patient Experience

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 2024-25

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
Renal Registry	n/a
National Early Inflammatory Arthritis Audit (NEIAA)	Yes
National Diabetes Paediatric Audit	Yes
National Adult Diabetes Audit (NDA) National Diabetes Core Audit (PC)	Yes
NDA: Diabetes Prevention Programme Audit (DPP)	n/a
NDA: National Diabetes Footcare	Yes
NDA: National Diabetes Inpatient Safety Audit (NDISA)	Yes
NDA: Gestational Diabetes Audit	n/a
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 Vascular Registry	n/a
National Cardiac Audit Programme (NCAP)	Yes

Myocardial Ischaemia National Audit Project (MINAP)	
NCAP: National Adult Cardiac Surgery Audit	n/a
NCAP: National Audit of Cardiac Rhythm Management (CRM)	Yes
NCAP: National Audit of Percutaneous Coronary Interventions (PCI)	n/a
NCAP: National Congenital Heart Disease Audit (NCHDA)	n/a
National Heart Failure Audit	Yes
National Audit of Mitral Valve Leaflet Repairs (MVLR)	n/a
The UK Transcatheter Aortic Valve Implantation Registry (TAVI)	n/a
National Clinical Audit of Psychosis	Yes
National Audit of Metastatic Breast Cancer	Yes
National Audit of Primary Breast Cancer	Yes
National Bowel Cancer Audit (NBOCA)	Yes
National Oesophago-Gastric Cancer Audit (NOGCA)	Yes
National Lung Cancer Audit	Yes
National Prostate Cancer Audit	Yes
National Ovarian Cancer Audit	Yes
National Pancreatic Cancer Audit	Yes
National Non-Hodgkin Lymphoma Audit	Yes
National Kidney Cancer Audit	Yes
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy 12)	Yes
National Maternity and Perinatal Audit	Yes
National Neonatal Audit Programme	Yes
Paediatric Intensive Care Network (PICANet)	n/a
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

n/a – not relevant to this Health Board or Wales

5

11:00, 10 Mins

5 - BREAK

6

11:10, 0 Mins

6 - NWSSP – Audit and Assurance Services - Internal Audit

6.1

11:10, 5 Mins

6.1 - Internal Audit Plan Progress Report

James Johns (NWSSP - Internal Audit)

For assurance

Attachments

6.1 SBAR IA Plan Progress Report April 2025.pdf

6.1 IA Plan Progress Report April 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:	15 April 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 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 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

April 2025

Audit & Assurance Services
Internal Audit Progress Report

CONTENTS

1. Introduction
2. Outcomes from Finalised Audits
3. Internal Audit plan 2024-25 - Delivery and Planning Update
4. Internal Audit Plan 25/26

Appendix A - Assignment Status Schedule

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Please note

This report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit & Risk Assurance Committee.

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

1. Introduction and Background

1.1 This progress report provides the Audit & Risk Assurance Committee (ARAC) with the current position in relation to the delivery of the 2024/25 Internal Audit Plan. The report also includes details of the progress with the delivery of individual audits, outcomes from finalised audits and any updates required to the plan.

2. Outcomes from Finalised Audits

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

ASSIGNMENT	ASSURANCE RATING	
Financial Management	Reasonable	
Job Planning	Reasonable	
Lessons Learned	Reasonable	
Performance Management	Substantial	
Elective Waiting List Management	Substantial	

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

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

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

Audit	Current status	Current Position/ comments	ARAC
Cleanliness Standards	WIP	Slight delay in be able to start as queries raised by management and impacted by other audit work. Fieldwork taking additional time to be concluded.	

3.3 Following discussion with management additional follow up recommendation tracking will be taking place, prior to the conclusion of the 24/25 audit work, in relation to limited assurance audits and high priority actions. This will replace the managed practices audit which will now be Q1/2 in 2025/26. It was also requested by management to defer the medical locums work until mid-25/26 as this will be line with progress with the medical workforce stabilisation programme. The Committee is asked to note the changes outlines.

3.4 Regular meetings with the Director of Corporate Governance have continued, along with meetings taking place with Executive Directors and senior managers in relation to individual audits currently being planned and delivered.

4. Internal Audit Plan 2025/26

4.1 Audit & Assurance Services has, following the annual planning process and in accordance with the requirements of the new Global Internal Audit Standards, prepared the Internal Audit Plan for the year 2025/26. This sets out our risk-based programme of work and the plan contains the Internal Audit Mandate and Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service. The document is presented as a separate agenda item for the Committee's consideration and approval.

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

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

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

Digital Strategic Partner	Q3/4	May	Director of Finance	Initial draft				
IT/Digital - benefits realisation	Q2/3	Oct	Director of Finance	FINAL	Substantial	-	-	-
IT/Digital – Data Quality/Use of Data	Q2/3	Feb	Director of Finance	FINAL	Limited	3	1	
Withybush General Hospital - RAAC.	Q3/4	May	Chief Operating Officer	Initial draft				
Estates Assurance – Energy Management	Q3	Feb	Chief Operating Officer	FINAL	Reasonable	-	8	-
Capital Systems	Q2/3	Dec	Chief Operating Officer	FINAL	Reasonable	-	4	-
Continuing Health Care		May/June		WIP				
Follow Up Discharge Management		June	Chief Operating Officer	Planning				
Additional follow up and recommendation tracking.		June		Planning				



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6.2

11:15, 10 Mins

6.2 - Internal Audit Plan 2025

James Johns (NWSSP - Internal Audit)

For approval

Attachments

6.2 SBAR Annual Internal Audit Plan and Charter 25-26 ARAC April 2025.pdf

6.2 HDUHB Internal Audit Plan and Charter 2025-26.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:**	15 April 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Audit & Assurance Services - Internal Audit Plan & Charter 2025-26
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

Audit & Assurance Services has, following the annual planning process and in accordance with the requirements of the new Global Internal Audit Standards, prepared the Internal Audit Plan for the year 2025/26. The plan sets out our risk-based programme of work and also contains the Internal Audit Mandate and Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The new Standards require that a risk based internal audit plan is created that supports the achievement of the organisation's objectives. The Plan will be delivered in accordance with the Internal Audit Mandate and Charter and the agreed KPIs, which are monitored and reported to the Health Board and Audit & Risk Assurance Committee. All Internal Audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

The plan covers the whole of the 2025/26 audit year, however, will be subject to regular on-going review and adjustment as required to ensure that the audits reflect the Health Board's evolving risks and changing priorities and therefore providing effective assurance.

Cefndir / Background

The NHS Wales Shared Services Partnership (NWSSP) Audit and Assurance Service provides an Internal Audit service to the Hywel Dda University Health Board (UHB). It is a requirement of the Global Internal Audit Standards to establish risk-based plans. The plan is presented to the Audit & Risk Assurance Committee for approval.

The plan sets out the programme of work for the year ahead, covering a broad range of organisational risks. The full document also describes how we deliver that work in accordance with professional standards. The plan has been prepared following discussions with Chair of the Audit & Risk Assurance Committee, a number of Executive Directors and Senior Managers and the Director of Corporate Governance.

Asesiad / Assessment

The report provides the Committee with a level of assurance that an appropriate Internal Audit Plan and Charter have been prepared for the 2025/26 year, in the with the requirements of the Global Internal Audit Standards, which covers a broad range of organisational risks and will allow for an appropriate annual opinion to be delivered.

Argymhelliad / Recommendation

The Audit & Risk Assurance Committee is asked to Approve the Internal Audit Plan and Charter for 2025/26.

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

Quality and Engagement Act (sharepoint.com)	
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Internal Audit Plan & Charter and Internal Audit Standards. Outcomes from individual Internal Audit reports. Information gathered as part of the delivery of audit annual Internal Audit planning process, including meetings with Executive Directors, Health Board Chair, Chair of ARAC and Director of Corporate Governance. Health Board documents, risk registers and Board Assurance Framework.
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:	Audit & Risk Assurance Committee Chair Director of Corporate Governance Executive Directors

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

Gweithlu: **Workforce:**	n/a
Risg: **Risk:**	n/a
Cyfreithiol: **Legal:**	n/a
Enw Da: **Reputational:**	n/a
Gyfrinachedd: **Privacy:**	n/a
Cydraddoldeb: **Equality:**	n/a

Internal Audit Plan & Charter 2025/26

Hywel Dda University Health Board

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1. Introduction

This document sets out the Internal Audit Plan for 2025/26 (the 'Plan') detailing the audits to be undertaken and information of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit and Risk Assurance Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the key findings and agreed actions from internal audit reviews may be used by Hywel Dda University Health Board's (UHB) management to improve governance, risk management, and control within their operational areas.

In January 2025 new Global Internal Audit Standards (the 'Standards') became effective and apply to UK public sector audits from 1 April 2025 to align with the financial year. These new standards replace the previous guidance: the Public Sector Internal Audit Standards. The new Standards are accompanied by a UK public sector application note (the 'Application Note'), which provides public sector interpretations and additional requirements for the Standards The new Standards require that a risk based internal audit plan is created that supports the achievement of the organisation's objectives.

Accordingly, this document sets out the risk-based approach and the Plan for 2025/26. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs, which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by other organisations on behalf of NHS Wales. These are: Digital Health and Care Wales (DHCW); NHS Wales Shared Services Partnership (NWSSP); and the NHS Wales Joint Commissioning Committee (JCC), which replaced EASC and WHSSC from April 2024. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for the JCC), but the results, as in previous years, are reported to the relevant health organisations and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Global Internal Audit Standards

The Plan has been developed in accordance with Principle 9: Plan Strategically, which includes Standard 9.4 – Internal Audit Plan, of the Standards, and the accompanying Application Note, which provides public sector interpretations and additional requirements for the Standards, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals.
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks.
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work.
- confirmation of the audit resources required to deliver the Internal Audit Plan.
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning considers the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place. In addition, the Plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit and Risk Assurance Committee (ARAC) in line with the Internal Audit Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the 'audit universe'). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Director of Corporate Governance (Board Secretary) and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our Plan is made up of several key components:

1) Consideration of key governance and risk areas: We have identified several areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover the Governance, the Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management, and an overall assessment of Digital and Information Technology. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.

2) Organisation based audit work – this covers key risks and priorities from the Board Assurance Framework and the corporate risk register, together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

3) Follow up - this is follow-up work on previous 'limited' and 'unsatisfactory' assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.

4) Work agreed with the Directors of Corporate Governance, Directors of Finance, other executive peer groups, or Audit & Risk Assurance Committee Chairs in response to common risks faced by several organisations. This may be advisory work to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that may impact on HEIW, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), and the Joint Commissioning Committee (JCC).

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the final business case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to Hywel Dda UHB's systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; therefore, we have considered the following:

- A review of Hywel Dda UHB's vision, values and forward priorities as outlined in the Integrated Medium Term Plan (IMTP).
- An assessment of The UHB's governance and assurance arrangements and the contents of the corporate risk register.
- Risks identified in papers to the Board and its Committees in particular the Audit and Risk Assurance Committee and the Quality, Safety & Experience Committee.
- Key strategic risks identified within the corporate risk register and assurance processes.
- Discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility, including compliance and ethics programmes.
- Cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions).
- New developments and service changes.
- Legislative requirements to which the organisation is required to comply.
- Planned audit coverage of systems and processes provided through NWSSP, DHCW, and the JCC.
- Work undertaken by other supporting functions of the Audit and Risk Assurance Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV), where appropriate.
- Work undertaken by other review bodies, including Audit Wales.
- Coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with the executive team and independent members (UHB Chair and ARA Chair) to discuss current areas of risk and related assurance needs.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and corporate risk register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also considers corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2025/26

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan refers to key strategic risks identified within the corporate risk register and related systems of assurance, together with the proposed audit response within the outline scope.

When developing the audit scope, in discussion with the responsible executive director(s) and operational management, the scope, objectives and audit resource requirements, and timing will be refined in each area.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit and Risk Assurance Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit and Risk Assurance Committee meeting.

Most of the audit work will be undertaken by our regionally based teams with support from our national capital and estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of information governance, IT security and digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the executive team

and endorsed by the Audit and Risk Assurance Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit and Assurance Committee for approval.

Regular liaison with Audit Wales, as your External Auditor, will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The Plan has been put together based on the planning process described in this document. The Plan includes sufficient audit work to be able to give an annual Head of Internal Audit opinion in line with the requirements of Standard 11.3 – Communicating Results, and Application Note 10B – Overall conclusions and annual reporting.

Audit & Assurance Services confirms that it has the necessary human, financial and technological resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit and Risk Assurance Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by Hywel Dda, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

Included with the plan are audit assignments delivery by our Specialist Services Unit team in relation to Estates and Capital. The current recharge for the Estates & Capital audit work is £38,978.81. In addition, any capital audit work in relation to specific projects will be charged for separately on the basis of a separately agreed Integrated Audit & Assurance Plan. Where this is the case, a provision for this work would have been included by Hywel Dda in its business case submission.

6. Action required

The Audit and Assurance Committee is invited to consider the Internal Audit Plan for 2025/26 and:

- approve the Internal Audit Plan for 2025/26.
- approve the Internal Audit Charter. and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

James Johns
Head of Internal Audit
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2025/26

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Corporate Risk Register (CRR)] / Rationale	Executive Lead/Responsible Director	Planned start
1. Joint Committee (with SBUHB) – (Advisory) - To undertake a joint review of the governance arrangements in place to support effective partnership working between the Swansea Bay and Hywel Dda UHBs through the Regional Joint Committee.		Corporate Governance	Q3/4
2.Operational Governance Arrangements – (Assurance) Review implementation of governance arrangement to support new operational structures.	UHB Priority	Chief Operating Officer	Q2/3
3.Level Three / Four Directorates (Assurance) Assess actions taken by directorates to improve internal escalation level.	UHB Priority	Chief Operating Officer	Q2/3
4.Nursing Management - (Assurance) To review the systems in place for rostering and staff management, including agreed actions from previous audit and expansion of testing across the UHB areas.	Re audit & 1978	Nursing, Quality Safety & Experience	Q1/2
5.Estates/Facilities Directorate – (Assurance) - Review governance arrangements and a sample of controls in key risk areas.	UHB Priority	Allied Health Professionals & Health Science	Q3/4
6.Medical Workforce Stabilisation - (Assurance) – Review key controls implemented for the management and control of medical variable pay including for Medical Locums.	1978	Medical	Q3/4
7.Validation of Emergency Departments (Eds) performance and waiting time data - (Assurance) – Review implementation across UHB of revised Standard Operating Procedure and to provide assurance that this has been consistently implemented.	1027	Chief Operating Officer	Q1/2
8.Staff sickness Management –(Assurance) - Review sample of controls in key risk areas of sickness management, including reasons for sickness.	1821	Workforce & OD	Q1/2

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Corporate Risk Register (CRR)] / Rationale	Executive Lead/Responsible Director	Planned start
9.Commissioning– Long Term Agreement – (Assurance) - Review a sample of controls in key risk areas, including monitoring, performance and quality.	UHB Priority	Strategy & Planning	Q1/2
10.Commissioning – Third Sector – (Assurance) - Review a sample of controls in key risk areas including contracting, monitoring, performance and quality.	UHB Priority	Chief Operating Officer	Q3/4
11.Decision making high cost drugs – (Assurance) - Review governance arrangements and a sample of controls in key risk areas.	UHB Priority	Finance	Q2/3
12.Risk of increasing fragility in primary care contractor services due to external factors - (Assurance) - Assess controls in place key risk areas as ser out in the Corporate Risk register.	1708	Chief Operating Officer	Q2/3
13.GP Out of Hours – (Assurance) – Assess controls in place for the management of key systems and risk areas.	1708	Chief Operating Officer	Q3/4
14.Corporate Risk Ophthalmology - (Assurance) – Assess controls in place key risk areas as set out in the Corporate Risk register.	1664	Chief Operating Officer	Q1/2
15.Vaccination & Immunisation - (Assurance) Assess controls in place over key risk areas including to monitor and promote the uptake of vaccinations and immunisations amongst the public.	Exec priority	Public Health	Q1/2
16.Patient Experience - (Assurance) Assess controls in place over key risk areas, including arrangements and processes in place within the Health Board for capturing and utilising learning form patient experience.	Exec priority	Nursing, Quality Safety & Experience	Q3/4
17.Complaints - Assess controls in place over key risk areas, including arrangements and processes in place	TI	Nursing, Quality Safety & Experience	Q3

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Corporate Risk Register (CRR)] / Rationale	Executive Lead/Responsible Director	Planned start
within the Health Board manging complaints including information from Welsh Risk Pool.			
18.Infection Prevention & Control - (Assurance) – Assess controls in place for the management of key systems and risk areas.	TI	Nursing, Quality Safety & Experience	Q3/4
19.Health & Safety – (Assurance) - Assess controls in place over key risk areas, including arrangements and processes in place within the Health Board managing Health & Safety including agreed actions form previous audit.	Re-audit &1860/1	Allied Health Professionals & Health Science	Q3/4
20.Theatre Stock System Implementation – Review robustness of system controls and operation.	New System	Chief Operating Officer	Q3
21.Human Tissue Authority (Assurance) – Assess controls in place for the management and monitor compliance.	Exec priority	Allied Health Professionals & Health Science	Q3/4
22.IRMER – (Assurance) Assess controls in place for the management and monitor compliance	Exec priority	Allied Health Professionals & Health Science	Q2/3
23.Medical Devices Regulations (Assurance) Assess controls in place for the implementation, management and to monitor compliance.	Exec priority	Chief Operating Officer	Q2/3
24.Targeted Intervention (TI) (Assurance) Assess controls in place for the management of key risk areas and actions.		Corporate Governance /CEO	Q3/4
25.Managed Practices (Assurance) Assess controls in place for the management of key systems and risk areas.	Carried forward	Chief Operating Officer	Q1/2
26.Follow up and agreed Action Implementation Tracking - Review status of agreed action implementation and supporting evidence.		Corporate Governance	

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Corporate Risk Register (CRR)] / Rationale	Executive Lead/Responsible Director	Planned start
27.Digital /IT – Cyber Security – (Assurance) Assess controls in place over key risk areas including the risk statement, governance process and improvement plan.	1352	Finance	Q2/3
28.Digital /IT - Departmental / Local IT systems management (Assurance) – Assessing controls in place for how this is identified and how professional oversight is maintained for digital systems across the organisation.		Finance	Q3
29.Estates Assurance - Space Utilisation (Assurance) - To assess the systems and controls in place within the UHB to measure the efficiency and effectiveness of space utilisation across the UHB's facilities ensuring the optimal use of available space and identifying opportunities for improvement.	1745	Strategy & Planning	Q2/3
30.Major Infrastructure Investment Plan (MIIP) (Assurance) - The MIIP seeks to address the major infrastructure risks identified across the UHB. Recognising the annual allocation of capital monies, the audit will evaluate the processes and procedures put in place by the UHB to target the highest risk areas and support the management and control arrangements applied to deliver the programme.	1745	Strategy & Planning	Q3/4
31.Control of Contractors [Advisory & Assurance] To assess the compliance with the UHB's current Estates Control of Contractors Policy No 541 version 2.0 dated March 2025. ensuring Right to Work in the UK issue is adequately covered, along with other issues identified as part of an audit of the UHB's Control of Contractor's processes and procedures.	Compliance with UK Legislation, incl. Employment Law and Health and Safety Legislation	Chief Operating Officer	Q1/2

Planned output, Outline scope, Review reference	Strategic Priority (SP)/BAF Risk / [Corporate Risk Register (CRR)] / Rationale	Executive Lead/Responsible Director	Planned start
Integrated Audit & Assurance Plans (SSU)– Withybush General Hospital Fire – Phase 2; and Glangwili General Hospital Fire – Phase 2	1745	Strategy & Planning	IAAP

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2025/26
Audit plan 2025/26 agreed/in draft by 30 April	✓	To deliver plan
Audit opinion 2024/25 delivered by 31 May	✓	To deliver opinion
Audits reported versus total planned audits, and in line with Audit & Risk Assurance Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	✓	85%
Report turnaround management response to draft report [15 working days maximum]	✓	85%
Report turnaround draft response to final reporting [10 working days]	✓	95%

Appendix C: Internal Audit Mandate and Charter

1 Introduction

1.1 This Mandate and Charter is produced and updated annually to comply with the Global Internal Audit Standards (introduced from 1 April 2025 for the UK Public Sector). The Standards (with specific reference to Standard 6.1 Internal Audit Mandate and 6.2 Internal Audit Charter) require the production and maintaining of an Internal Audit Charter that, at a minimum, sets out:

- The purpose of Internal Auditing;
- a commitment to adhere to the Global Internal Audit Standards;
- the Mandate, including the scope and types of services to be provided, and the Board's responsibilities and expectations regarding management's support of the internal audit function; and
- the organisational position and reporting relationships, including Independence.

The Mandate and Charter are complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:

- Board means the Board of Hywel Dda University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit & Risk Assurance Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Hywel Dda University Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Director of Corporate Governance (Board Secretary).

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Hywel Dda University Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit & Risk Assurance Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives.
- the appropriate assessment and management of risk, and the related system of assurance.
- the arrangements to monitor performance and secure value for money in the use of resources.
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets.
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence is described in the Global Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit & Risk Assurance Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit & Risk Assurance Committee on behalf of the Board. Such functional reporting includes the Audit & Risk Assurance Committee:

- approving the internal audit charter.
- approving the risk based internal audit plan.
- approving the internal audit resource plan.
- receiving outcomes of all internal audit work together with the assurance rating. and

- reporting on internal audit activity's performance relative to its plan.

3.3 While maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit & Risk Assurance Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Global Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit & Risk Assurance Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit & Risk Assurance Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit & Risk Assurance Committee approves all Internal Audit plans and may review any aspect of its work. The Audit & Risk Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any

committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Director of Corporate Governance will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Director of Corporate Governance in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, the Joint Commissioning Committee.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The Audit & Risk Assurance Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit & Risk Assurance Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Global Internal Audit Standards and the UK Public Sector Application Note in discharging its responsibilities.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2024) and associated performance standards agreed with the Audit & Risk Assurance Committee and the Shared Services Partnership Committee. The Service Level Agreement includes several Key Performance Indicators, and we will agree with each Audit Risk Assurance

Committee which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information.
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance.
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets.
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice.
- reviewing operations or programmes to ascertain whether results are consistent with the organisation’s objectives and goals and whether the operations or programmes are being carried out as planned.
- reviewing specific operations at the request of the Audit & Risk Assurance Committee or management, this may include areas of concern identified in the corporate risk register.
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance.
- ensuring effective co-ordination, as appropriate, with external auditors and other regulators. and
- reviewing the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation’s risk environment.

7.3 If the Head of Internal Audit or the Audit & Risk Assurance Committee consider that the level of audit resources or the Mandate and Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales equirements of the Charter
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives priorities and risk assessment
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit Risk Assurance Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement.
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks.
- improvement of the organisation's risk management, control and governance by providing management with

constructive recommendations arising from audit work.

- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan'.
- effective co-operation with external auditors and other review bodies functioning in the organisation. and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit & Risk Assurance Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead and will also be copied to the Director of Corporate Governance.

9 Reporting

9.1 Internal Audit will report formally to the Audit & Risk Assurance Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes.
  b) Disclose any qualification to that opinion, together with the reasons for the qualification.
  c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies.

d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement.

e) Compare work undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria. and

f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.

- For each Audit & Risk Assurance Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit & Risk Assurance Committee requirements; and
- The Audit & Risk Assurance Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage.
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director.
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The draft report will also indicate priority ratings for individual report findings and recommendations.
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken.
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate, or disagreement remains then the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit & Risk Assurance Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit & Risk Assurance Committee Chair to ensure that the issues raised in the report are addressed appropriately.
- Reminder correspondence will be issued after the set response date where no management response has been

received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit & Risk Assurance Committee where no management response is forthcoming.

- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary, return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable
  - Achievable
  - Relevant / Realistic
  - Timely.
- The relevant Executive Director, Director of Corporate Governance and the Chair of the Audit & Risk Assurance Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Director of Corporate Governance and placed on the agenda for the next available Audit & Risk Assurance Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access is granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Global Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit Risk Assurance Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit & Risk Assurance Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Mandate and Charter

14.1 This Internal Audit Mandate and Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit & Risk Assurance Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
[March/April] 2025

Disclaimer & Public Sector Internal Audit Standards

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

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

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

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

Public Sector Internal Audit Standards

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

6.3

11:25, 10 Mins

6.3 - Learning Lessons (Reasonable Assurance)

James Johns (NWSSP - Internal Audit), Sharon Daniel (Hywel Dda UHB - Interim Executive Director of Nursing, Quality & Patient Experience), Louise O'Connor (Hywel Dda Health Board - Assistant Director), Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding)

For assurance

Attachments

6.3 Learning Lessons Final IA Report.pdf

Learning Lessons

Final Internal Audit Report

2024/25

Hywel Dda University Health Board



Reasonable Assurance

Contents

Executive Summary 1
Findings & Agreed Action Plan 2
Appendix A 6

Review Reference	HDU-2425-09
Fieldwork	January - February 2025
Executive Sign Off	1 April 2025
Audit Committee	April 2025
Executive Lead	Sharon Daniel, Interim Executive Director of Nursing, Quality & Patient Experience
Audit Team	James Johns, Head of Internal Audit
	Sophie Corbett, Deputy Head of Internal Audit

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

Executive Summary

Purpose

This review sought to provide the Health Board with assurance that following incidents and complaints, lessons are identified and learned to avoid similar instances, where possible, in the future. Learning from incidents and complaints is important to help improve services for patients.

Overview

We have concluded **Reasonable** assurance on this area. Matters requiring management attention include:

- The Listening & Learning Framework is yet to be finalised and launched. This will reinforce responsibilities and mechanisms for sharing learning.
- Learning is not always captured clearly and consistently in Datix
- Greater clarity is required over the circumstances where an action plan should be completed following investigation of a concern (incident or complaint).
- Our sample testing identified some instances where there was a lack of evidence to demonstrate sharing of learning

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

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	Processes are in place to capture and share learning from incidents and complaints	1, 2, 3	**Reasonable**
2	Implementation of associated actions is monitored and effectiveness assessed, with assurance reported through the appropriate governance structures	4	**Reasonable**

Management Actions

-	4
High Priority	Medium Priority

Themes



Risk Types

Quality or Safety Issues

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: Processes are in place to capture and share learning from incidents and complaints	Reasonable

Overview / Summary of Observations

A Listening & Learning Framework is being developed to reinforce the Health Board's commitment to learning, clarify roles and responsibilities and set out the sources and routes for learning. **[Finding 1]**

The Health Board utilises a single point of entry for raising and recording incidents and complaints ('concerns') via the Datix system. Responsibility for recording lessons learned within Datix lies with the designated directorate or service area (for incidents) or the Complaints Team (for complaints).

Cursory review of Datix reports of closed incidents and complaints noted that the quality of the narrative in the "Lessons Learned" field varied, often not concisely documenting the learning from the event where appropriate. **[Finding 2]** Detailed sample testing of 29 concerns identified that even where this field had not been adequately completed, learning identified was recorded elsewhere within the Datix file.

Directorates are responsible for the dissemination and escalation of lessons learned from concerns. For the 15 incidents sampled, it was stated on the Datix record that learning had been discussed with the staff members involved, and there was evidence of wider sharing of learning via Directorate quality governance structures where appropriate. For the 14 complaints sampled, in some cases there was no evidence of learning shared at Directorate level. **[Finding 3]**

Governance arrangements are in place for sharing learning more widely within the Health Board (covered in Objective 2). We noted that there is opportunity to improve the timeliness of sharing learning outside of formal governance structures. A Learning Library is being established, for staff to submit learning to the Quality, Assurance & Safety Team (QAST) for sharing via appropriate mechanisms such as the *7-minute briefings*. The Learning Library is in its infancy and dependent on Directorates and services proactively sharing learning. The Listening & Learning Framework will reinforce responsibilities and mechanisms for doing so. **[Finding 1]**

	Key Findings	Risk & Impact	Agreed Management Action
1	**Learning & Learning Framework** Whilst development of the Listening & Learning Framework is ongoing, it has been discussed at Listening & Learning Sub Committee and Quality Safety & Experience Committee in November / December 2024. The framework will be key to raising awareness of sources of learning, and the responsibilities and mechanisms for sharing and escalating learning.	Staff are not aware of their responsibilities or processes in place for sharing learning.	**Agreed Action:** The Learning Framework will be finalised and made available to all staff through the Health Board's SharePoint site. The Framework will include responsibilities and routes / mechanisms for sharing learning. The SharePoint page will be presented at the Listening and Learning Sub-Committee for support in May 2025.
			Expected Evidence of Implementation: Finalised Learning Framework available on SharePoint
		Medium Priority	**Officer:** Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding
	Theme: Lessons Learnt	Control Design	**Date:** 31/05/2025

2	**Capturing Learning in Datix** The 'Lessons Learned' field in Datix is not consistently used as intended, to concisely record the learning from the event. Common examples identified include: • "new processes implemented" • "appropriate actions taken / in place" • "will discuss with staff	Learning is not identified or captured	**Agreed Action:** Guidance on what is meant by "lessons learned" is being written by the Quality Assurance and Safety Team. The guidance will be sent to all investigation managers and made available on the Concerns Investigation and Management SharePoint page.
			Expected Evidence of Implementation: Evidence of guidance being shared via email Availability of guidance on SharePoint
		Medium Priority	**Officer:** Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding
	Theme: Lessons Learnt	Control Operation	**Date:** 31/05/2025
3	**Learning is Shared** There was no evidence of shared learning, either within or outside of the Directorate, for six complaints.	Learning is not shared	**Agreed Action:** The new template for Clinical Care Groups (CCG) to report to the Quality, Safety and Experience Sub-Committee (QSESC) includes lessons learned. A workshop will be held to discuss the governance and reporting expectations from Service Groups to the CCG and from the CCG to the Integrated Quality Performance and Finance Delivery Group and QSESC.
			Expected Evidence of Implementation: Workshop held Reporting template circulated
		Medium Priority	**Officer:** Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding
	Theme: Lessons Learnt	Control Operation	**Date:** 31/05/2025

Objective 2: Implementation of associated actions is monitored and effectiveness assessed, with assurance reported through the appropriate governance structures	Reasonable

Overview / Summary of Observations

The Concerns Investigation & Management SharePoint page states that an improvement action plan should be developed and implemented in a timely manner following completion of the investigation. Only six of the 29 concerns reviewed had action plans in Datix, and there was evidence of monitoring arrangements in each case. For those that didn't have an action plan, in some cases details of action taken was identified elsewhere within the Datix record (e.g. within a Learning From Events report, for Redress cases). The Quality Assurance and Safety Team (QAST) advised that the necessity for an action plan depends on the nature and extent of learning identified, although it is encouraged for all concerns. **[Finding 4]**

A review of the Quality Governance meetings for three directorates (Scheduled Care, Unscheduled Care and Women and Children's) confirmed that improvement and learning for concerns and serious incidents are a standing agenda item. Reports/snapshots of incidents (via the Patient and Safety dashboards), complaints, Public Services Ombudsman Wales and claims are submitted with the detail being scrutinised for the identification of themes, trends, and learning. Review of the meeting notes confirmed that concerns data, including scrutiny meeting notes are presented.

Directorate Quality Governance meetings feed into the Quality, Safety & Experience Sub-Committee (QSESC), with Directorates responsible for escalating learning from events as appropriate via the update reports. Learning from serious incidents and concerns progressing to redress are also reported to the Listening & Learning Sub Committee (LLSC). QSESC and the LLSC report to the Health Board's Quality, Safety & Experience Committee (QSEC). The Quality, Assurance & Safety Team (QAST) also report learning via the Quality Assurance report.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Action Plans** Greater clarity is required over the circumstances where an action plan should be completed following investigation of a concern (incident or complaint).	Action plans are not developed or implemented	**Agreed Action:** The Learning Framework will be finalised and made available to all staff through the Health Board's SharePoint site. The Framework will include responsibilities for development of an improvement action plan and the arrangements for monitoring of the plan. The SharePoint page will be presented at the Listening and Learning Sub-Committee for support in May 2025. The new template for Clinical Care Groups (CCG) to report to the Quality, Safety and Experience Sub-Committee (QSESC) includes monitoring of improvement action plans for nationally reportable incidents and serious concerns. A workshop will be held to discuss the governance and reporting expectations from Service Groups to the CCG and from the CCG to the Integrated Quality Performance and Finance Delivery Group and QSESC.

			Expected Evidence of Implementation: Finalised Learning Framework made available on SharePoint Workshop held Reporting template circulated
		Medium Priority	**Officer:** Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding
	Theme: Lessons Learnt	Control Design	**Date:** 31/05/2025

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

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

6.4

11:35, 10 Mins

6.4 - Elective Waiting List Management (Substantial Assurance)

James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Keith Jones (Hywel Dda UHB - Director of Operational Planning & Performance)

For assurance

Attachments

6.4 Elective Waiting List Mgmt Final IA Report.pdf

Elective Waiting List Management

Final Internal Audit Report

2024/25

Hywel Dda University Health Board



Substantial Assurance

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Findings & Agreed Action Plan 2
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Review Reference	HDU-2425-20
Fieldwork	January – March 2025
Executive Sign Off	2nd April 2025
Audit Committee	April 2025
Executive Lead	Andrew Carruthers, Director of Operations
Audit Team	James Johns, Head of Internal Audit
	Sophie Corbett, Deputy Head of Internal Audit

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Executive Summary

Purpose

The overall objective of this audit was to provide assurance of the key controls in place to manage and mitigate the risks facing Orthopaedic Services to achieve ministerial waiting list targets.

Overview

There are clear established arrangements in place for the monitoring and management of patient waiting lists from daily and weekly Orthopaedic meetings through to Health Board Watchtower meetings. Progress on waiting lists actions and risks are regularly submitted through to the Health Board whilst also being scrutinised at Directorate Improving Together Session/ Escalation Meetings.

The Health Board also has an established Validation Team that undertake reviews of patient waiting lists to validate the accuracy of booking activities and the removal of patients from waiting lists in line with the local policy, including open inpatient and day case referrals that appear to have closed RTT pathways.

A review of RTT figures submitted to the Health Board and Welsh Government, and the internal reporting of arrangements with the NHS Delivery Unit for additional activity above core activity following funding accurately reconciled to source data.

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

Scope & Assurance Summary

	Objectives[1]	Related Findings	Assurance
1	Arrangements are in place to monitor performance, action implementation and ensure any barriers to achievement of targets are escalated where appropriate	-	**Substantial**
2	Arrangements are in place that allow for valid and accurate waiting list numbers	-	**Substantial**
3	Robust governance arrangements are in place to monitor and report waiting list performance through to the Health Board and Welsh Government	-	**Substantial**

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

Findings & Agreed Action Plan

Objective 1: Arrangements are in place to monitor performance, action implementation and ensure any barriers to achievement of targets are escalated where appropriate	**Substantial**

Overview / Summary of Observations

Trauma & Orthopaedic (T&O) specialty have established a daily meeting focused on addressing the actions laid out in their delivery plan. Internal Audit attended these daily meetings in January 2025 and noted discussions centred around the current patient appointment schedules, additional solutions through the use of internal resources, outsourcing, and insourcing capacities. Additionally, emerging issues, outlined next steps, progress in slot allocation for patients and cleansing of the waiting list were also discussed.

Weekly meetings take place between the T&O specialty and the appointment booking centre serve to address issues risks raised at the daily meetings to facilitate collaboration and optimise the scheduling of patients, especially those with the longest waiting times.

T&O waiting lists are scrutinised at weekly Watchtower meetings. A review of Watchtower meetings during December 2024 to January 2025 evidenced discussions centred on the actions being taken to reduce patient numbers in each cohort, with particular emphasis in the reduction of the 52-week and 104-week cohorts. In addition to the performance and position review of waiting lists, the forecasted landing position for the end of March 2025 is also maintained.

In November 2024, the Health Board received additional financial allocation from the Welsh Government (WG) to support clearance of outstanding forecast 104-week breaches by March 2025. This additional funding was also used to support the outsourcing of work to external providers. Whilst noting this additional resource, the projected landing position (reported to the Watchtower meeting in January 2025) for T&O at the end of March 2025 for the 104-week cohort (Stage 4) was 134 patients. The 'Performance Update' report presented to the Board in January 2025 reported a delivery risk of approximately 100 Orthopaedic inpatients, for which further mitigating solutions were actively being explored.

The entry (Risk 1842) on the corporate risk register recognises the risk of non-delivery of planned care ministerial targets by March 2025 due to a mismatch between demand and capacity in key specialities, workforce limitations and the impact of the Health Board financial forecasts for 2024/25. We can confirm that two Orthopaedic-specific gaps in controls listed on the risk register, as at December 2024, have been implemented.

Objective 2: Arrangements are in place that allow for valid and accurate waiting list numbers	**Substantial**

Overview / Summary of Observations

The Health Board has in place a Validation Team that undertake regular reviews of patients on waiting lists to validate the accuracy of appointment and treatment booking activities, including the removal of patients from waiting lists, in line with the *Patient Access Elective Care Policy*. The aim of this service is to maximise outpatient, diagnostic and theatre capacity.

A paper was presented to the Strategic Development and Operational Delivery Committee (SDODC) in April 2024 outlining validation processes, including the removal of patients from waiting list are undertaken correctly and in accordance with the national and Health Board policies. Following the presentation, additional governance and assurance measures to further mitigate the risk of patients being incorrectly removed from the waiting list was implemented.

The Validation Team have an annual plan in place that ensures full coverage of all specialties. Development of the validation plan for 2025/26 will commence shortly and be presented to Watchtower meetings for consideration and approval. During 2024, two validation audits were undertaken on the T&O waiting lists.

The Validation Team also receives regularly monthly patient lists from the Information Services Department highlighting open inpatient and day case referrals that appear to have closed RTT pathways. The Validation Team will include these case referrals within their validation reviews to ensure all patients are active

on the patient tracking list where appropriate. A sample analysis of 40 outcomes reported in the two Orthopaedic audits, periodic snapshot audits for reset pathways and the cleansing processes of the T&O patient tracker list was tested and accurately reconciled to source documentation within WPAS[2] and Welsh Clinical Portal.

A review of the RTT[3] Dashboard for T&O reported the total number of patients on the waiting list has seen a gradual reduction from 10,932 to 10,569 between June 2024 and January 2025 with significant progress in reducing the 104+ week cohort (all stages) from 1,019 patients to 734 patients between the end of December 2024 and the end of January 2025. We can confirm the accuracy of these patient waiting list figures to source data.

Objective 3: Robust governance arrangements are in place to monitor and report waiting list performance through to the Health Board and Welsh Government	**Substantial**

Overview / Summary of Observations

A review of the Directorate Improving Together Session (DITS) and the Escalation Meetings for Planned Care during 2024 confirmed the monitoring and reporting of waiting list information, whilst the Integrated Quality Planning and Delivery (IPQD) received a Planned Care Recovery presentation that provided a comprehensive overview of RTT performance and waiting list metrics, including volume, performance & trajectory, and delivery plan variances.

The SDODC received regular papers and reports during 2024-25 on the performance and waiting list figures for T&O. Integrated Performance Assurance Reports (IPARs) are also regularly presented to both the SDODC and the Health Board that provides progress updates on RTT position, challenges and issues together with identified key actions and initiatives.

The South West Wales (SWW) Regional Orthopaedics Programme has been established with the aim to effectively manage orthopaedic demand, capacity, and productivity across Swansea Bay and Hywel Dda University Health Boards resulting in a reduction to waiting list numbers. A review of meeting minutes highlighted discussions centred on target alignment, addressing challenges, evaluating performance and exploring potential improvements.

The Health Board was allocated approximately £6m in funding for additional activity above core activity in order to address the 104+ week cohort figures by the end of March 2024. The NHS Delivery Unit (DU) was tasked with monitoring progress of additional activity on a weekly basis. However, to compensate for the information required by the DU (which is not recorded in WPAS) the T&O Team developed a 'live' demand & capacity tracker to capture this data. A review of the weekly figures for January 2024 submitted to the DU reconciled to source data (noting minor variances due to timing differences).

[2] Welsh Patient Administration System
[3] Referral to Treatment

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

6.5

11:45, 10 Mins

6.5 - Consultant Job Planning Follow-up (Reasonable Assurance)

James Johns (NWSSP - Internal Audit), Mark Henwood (Hywel Dda UHB - Interim Medical Director)

For assurance

Attachments

6.6 Consultant Job Planning Final IA Report.pdf

Consultant Job Planning

Final Internal Audit Report

2024/25

Hywel Dda University Health Board



Reasonable Assurance

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Review Reference	HDU-2425-19
Fieldwork	February 2025
Executive Sign Off	11th March 2025
Audit Committee	April 2025
Executive Lead	Mark Henwood, Interim Medical Director
Audit Team	James Johns, Head of Internal Audit
	Sophie Corbett, Deputy Head of Internal Audit

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Executive Summary

Purpose

The overall objective of this follow-up review was to assess progress in implementing the actions agreed with management to address the issues identified in the previous audit, including additional testing.

Overview

Positive actions have been taken to implement new internal controls and processes to ensure job plans are completed in a timely manner with the Health Board reporting a compliance percentage of 87% (against the target 90%) as at January 2025. The Medical Workforce Department are also undertaking reviews of consultant job plans to ensure contractual details align with ESR as part of their stabilisation project. We can also confirm the inclusion of Board outcomes in all job plans sampled.

However, the matters requiring management attention include:

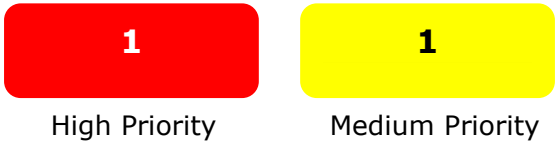
- Instances of personal or service outcomes not documented in agreed job plans *[High Priority]*
- Instances where sessions recorded on agreed job plans did not align to ESR, whilst the baseline assessment of consultant session payments has not yet been finalised *[Medium Priority]*

We have concluded **reasonable** assurance against progress on the implementation of agreed management actions supported by additional testing. Full details of matters arising are detailed within the Findings & Agreed Action Plan.

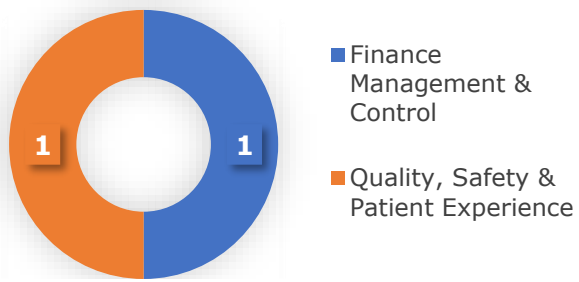
Scope & Assurance Summary

	Objectives[1]	Related Findings	Assurance
1	Job plans have been prepared with engagement of all parties with annual review completed in a timely manner	-	**Substantial**
2	Job plans include personal outcomes that are linked to the Health Board's organisational objectives	1	**Limited**
3	Agreed job plans reconcile to ESR records	2	**Reasonable**

Management Actions



Themes



Risk Types

Quality or Safety Issues

Financial Loss

Legal & Regulatory Non-Compliance

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

Findings & Agreed Action Plan

Objective 1: Job plans have been prepared with engagement of all parties with annual review completed in a timely manner	**Substantial**

Overview / Summary of Observations

The previous internal audit report (HDU-2324-35) identified the need to implement mechanisms to ensure completed job plans attain the 90% compliance target.

A letter was issued by the Interim Medical Director in June 2024 to consultants, SAS doctors, service delivery managers (SDMs) and clinical leads highlighting the need to undertake appropriate job plan reviews in a timely manner, whilst Medical Directorate Team issue monthly reminders to SDMs on job planning compliance levels with focus on upcoming and outstanding plans.

Discussions with SDMs confirmed that many had implemented a system that informed them of upcoming consultant job plans either through utilising the Allocate system and/or maintain their own register, whilst the Medical Directorate Team provide monthly compliance breakdowns highlighting key specialties that require addressing.

These internal controls and processes have contributed to a significant increase in job planning compliance from 56% in February 2023 (noted in the original Internal Audit report) to 87% as at January 2025. Of the 13% of non-compliant job plans, 9% were in progress/ being reviewed whilst 4% had expired.

Objective 2: Job plans include personal outcomes that are linked to the Health Board's organisational objectives	**Limited**

Overview / Summary of Observations

A finding in the previous report noted the lack of completion of personal and service outcomes, whilst Supporting Professional Activities (SPA) was not always detailed within consultant job plans.

Supporting Professional Activities (SPA) forms a key element of a consultant's job plan. Clarity of core SPA was discussed at a local negotiating committee (LNC) meeting in June 2024 and is to be reflected in the *Consultant Job Planning Toolkit* document. The revised toolkit document was agreed by the LNC and published in October 2024.

We can confirm that the Allocate system has updated the SPA activity drop down list to allow more detailed information to be recorded and is confirmed on agreement of each job planning. This change to the Allocate system was communicated to clinical staff and SDMs via an email from the Interim Medical Director.

A review of 25 consultant job plans was undertaken and identified that Board outcomes had been outlined for all individuals with all plans approved by the consultant and Service Delivery Managers. However, personal outcomes were not evident in nine job plans whilst 10 did not have completed service outcomes.

In addition, 16 Service Delivery Managers (SDMs) listed in the *Consultant Job Planning Toolkit* document were contacted to confirm whether their allocated specialties had dedicated service outcomes. Of the eight SDMs that replied to the email, only four SDMs confirmed dedicated services outcomes.

Key Findings		Risk & Impact	Agreed Management Action
1	**Personal and Service Outcomes** A review of 25 consultant job plans identified nine instances where personal outcomes and 10 instances where service outcomes had not been recorded. In addition, out of eight SDMs only four confirmed that they had dedicated services outcomes.	Patients' quality of care is impacted due to the consultant job plans not aligning with the service being provided.	**Agreed Action:** Service outcomes to be identified by each Clinical Service Group Director with support from the Medical Directorate in line with those already developed in MHLD. **Expected Evidence of Implementation:** Review of job plans will evidence both personal and service outcomes.
		High Priority	**Officer:** Gareth Cottrell (Deputy Chief Operating Officer) **Date:** 31st July 2025
	Theme: Quality, Safety & Patient Experience	Control Operation	

Objective 3: Agreed job plans reconcile to ESR records — **Reasonable**

Overview / Summary of Observations

The previous internal audit report identified instances where the contractual details outlined in agreed job plans did not accurately align to the information held within the ESR system.

The agreed management response included a baseline assessment of consultant payments against agreed job plan sessions and additional duties that was due to be completed by October 2024 as part of the stabilisation work undertaken by Medical Workforce Department. However, this assessment has yet to be finalised.

A review was undertaken on a sample of 25 consultants to ensure their agreed sessions recorded on their job plans (including additional sessions) accurately reconciled to ESR. Testing identified three instances where agreed sessions did not match individual's payslip in January 2025. Two consultants had also been identified in the stabilisation work, whilst one consultant had partially retired and the service have not uploaded a new job plan onto Allocate. This represents improvement against the position reported in the last Internal Audit report where seven out of 15 instances were identified where sessions recorded in job plans did not reconcile to ESR.

Key Findings		Risk & Impact	Agreed Management Action
2	**Baseline Assessment of Session Payments** A baseline assessment of consultant session payments was due to be completed by October 2024. This assessment has yet to be finalised.	Financial risk as a result of job plan data not being accurately input into ESR.	**Agreed Action:** Medical workforce to develop and agree a process from 1st April 2025 on ensuring Operational Teams are responsible for ensuring session payment is in line with ESR through the Medical Variable Pay Stabilisation workstream. Completion of assessment to be

	A review of 25 consultants identified three instances where agreed sessions did not match individual's payslip in January 2025.		finalised and actions identified to ensure this is remedied going forward to avoid having to repeat assessments.
			Expected Evidence of Implementation: Agreement of actions to be devolved to operational teams Completion of assessment
		Medium Priority	**Officer:** Bethan Griffiths (Senior Medical Workforce Manager) **Date:** 31st July 2025
	Theme: Finance Management & Control	Control Operation	

Appendix A

Assurance Opinion

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	**Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
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Prioritisation of Findings

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

6.6

11:55, 10 Mins

6.6 - Financial Management (Reasonable Assurance)

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

For assurance

Attachments

6.7 Financial Management Final IA Report.pdf

Financial Management

Final Internal Audit Report

2024/25

Hywel Dda University Health Board



Reasonable Assurance

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Executive Summary 1
Findings & Agreed Action Plan 2
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Review Reference	HDU-2425-05
Fieldwork	December 2024 - January 2025
Executive Sign Off	6 March 2025
Audit Committee	April 2025
Executive Lead	Huw Thomas, Director of Finance
Audit Team	James Johns, Head of Internal Audit
	Sophie Corbett, Deputy Head of Internal Audit

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Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To review the control systems in place for financial management, budgetary control and delivery of savings. The Health Board has been operating under Targeted Intervention (TI) status since September 2022 for Finance and Planning and continues to face significant financial and operational challenges resulting in the inability to submit a balanced 3-year IMTP for 2024-27. The forecast end of year deficit as at month 10 is £24m.

Overview

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

- Budgets have not been formally delegated beneath Executive Director level.
- Budget holders have limited access to suitable training to enable them to perform their role effectively.
- Not all budget holders have access to QlikSense for live budget monitoring and interrogation, and those that do have access do not use the system regularly.
- There is scope for greater monitoring of the extent to which opportunities in the Compendium of Variation are explored, transacted into savings or efficiencies, or rejected.
- There is limited evidence to demonstrate formal monitoring and management of savings schemes at directorate level.

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

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	Sufficient, relevant and reliable information is available to budget holders to enable effective monitoring and review of their delegated budgets	1, 2, 3	**Reasonable**
2	Directorates work collaboratively with their Finance Business Partners to manage their budgets, ensuring early identification, management and escalation of cost pressures	-	**Reasonable**
3	Directorates have identified recurrent savings opportunities and developed and agreed achievable savings plans for 2024/25 in line with savings expectations set out within each executive portfolio accountability letters. Implementation and risks to achievement are monitored and managed within directorate governance structures and escalated corporately where appropriate.	4, 5	**Limited**

Management Actions

1 High Priority

4 Medium Priority

Themes



Risk Types

Financial Loss

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: Sufficient, relevant and reliable information is available to budget holders to enable effective monitoring and review of their delegated budgets	**Reasonable**

Overview / Summary of Observations

Budget delegation and accountability arrangements are set out within the Budgetary Control FCP. Budgets for 2024/25 have been formally delegated to Executive Directors with signed acceptance from all. Budgets have not been formally delegated beneath Executive Director level, as required by FCP. **[Finding 1]**

There is limited training available to budget holders to enable them to perform their role effectively. **[Finding 2]**

In 2024 the Health Board implemented QlikSense, a data analytics and business intelligence tool linked to the Oracle finance system. Access was prioritised based on regular users of the preceding QlikView system and consequently not all budget holders have access to QlikSense, although Phase II implementation will see increased access and is being actively progressed. Review of system usage data also revealed that the system is not being regularly accessed by all those that do have access. **[Finding 3]**

Whilst QlikSense is intended to be the primary source of information for budget holders, Finance Business Partner teams provide bespoke reports for weekly/monthly directorate governance meetings and respond to ad hoc requests for information as necessary.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Budget Delegation** FCP states: *following agreement of the Board to the Budget, the Chief Executive will issue a formal budget letter to each Director, who will in turn issue similar letters to their line managers. This process will be repeated through each tier of management, setting out the expectations and responsibilities in terms of budgetary control and financial management*. However, budgets have not been formally delegated beneath Executive Director level – we were advised that Directors were given the option but it was not mandatory. The budget delegation letter template (appended to the FCP) gives Executive Directors the option to notify Finance of the senior managers they will be delegating part of their budget to so that they can be issued with an accountable officer letter. In some cases this had been completed by the Executive Director, but accountable officer letters have not been issued.	Budget holders are not aware of and not accountable for the budgets delegated to them.	**Agreed Action:** As part of the 2025/26 financial planning process, Finance will issue Accountability Letters to both the Executive Directors and Clinical Care Group Directors / Executive Function (for all other executive portfolios) leads to ensure a more granular formal cascade, recognising that ultimate accountability sits with the Executive Directors receiving the delegation from the Chief Executive Officer. The Accountability Letters will mandate the requirement for Clinical Care Group Directors / Executive Function leads to formally cascade their budget to each appropriate tier of management they have in their structure. **Expected Evidence of Implementation:** 2025/26 Accountability Letters issued to Executive Directors and Clinical Care Group Directors, and signed copies returned. Formal record of outstanding responses shared to the Executive Team and Finance and Performance Committee. Evidence of a communicated cascade and response received for each appropriate tier of management within their structure.

		Medium Priority	**Officer:** Jennifer Thomas, Senior Finance Business Partner **Date:** 31 March 2025
	Theme: Finance Management & Control	Control Operation	
2	**Budget Holder Training** With the exception of QlikSense system training and LEAP leadership programme, budget holders do not have access to suitable training to enable them to perform their role effectively.	Budgets are not managed effectively resulting in overspend, increasing the deficit position.	**Agreed Action:** Budget holder training is being developed in conjunction with Swansea Bay University Health Board and will be rolled out later in 2025/26. We have set out an intention to develop a series of products, starting with a broad introductory piece for budget holders and later more specific subject areas.
			Expected Evidence of Implementation: Delivery of introductory training package.
		Medium Priority	**Officer:** Sian Jenkins, Deputy Director of Finance **Date:** 31 January 2026
	Theme: Training & Development	Control Design	
3	**QlikSense** Only 58% of the 45 budget holders within the three sampled directorates (GGH, Planned Care and W&C) have been granted access to QlikSense, and only 42% of those with access have accessed the system at least once.	Budgets are not managed effectively resulting in overspend, increasing the deficit position.	**Agreed Action:** Phase 2 exercise to review budget holders and access arrangements is complete, and communications are being coordinated to send out to an additional 100 users. This will include links to training materials and training recordings already available via the Finance SharePoint site. To supplement this, the team are establishing a regular remote session whereby users can access a 'drop in clinic' to get support on specific issues. We will actively monitor usage stats and periodically share this data with Service Group leads for awareness to consider in their line management discussions.
			Expected Evidence of Implementation: All budget holders have access to QlikSense. Access and usage monitoring.
		Medium Priority	**Officer:** Sian Jenkins, Deputy Director of Finance **Date:** 31 December 2025
	Theme: Finance Management & Control	Control Operation	

Objective 2: Directorates work collaboratively with their Finance Business Partners to manage their budgets, ensuring early identification, management and escalation of cost pressures	**Reasonable**

Overview / Summary of Observations *This section focuses on the three sampled directorates: GGH, Planned Care and W&C.*

There is good engagement between directorate senior management and their respective Finance Business Partner (FBP) teams, with touchpoint meetings held at least weekly, often more frequently. Formal governance arrangements varied, with GGH and W&C directorates having a formal monthly performance meeting with a Terms of Reference, agenda and minutes, where the financial position, cost pressures and savings progress are scrutinised. Planned Care hold weekly operational meetings focusing solely on financial performance, plus more formal bi-monthly meetings with Service Delivery Managers on their specific portfolios. The General Managers and Finance teams spoken to during the review all stated that the arrangements in place were appropriate and effective for their respective directorates.

Analysis of the month 8 budget reports identified key drivers of the financial position within each sampled directorate and we confirmed that these are included in the monthly reporting packs for directorate finance meetings, and also the Directorate Improving Together Session (DITS) / Escalation meeting packs. General Managers demonstrated a thorough understanding of the cost pressures within their respective directorates and cited numerous examples of the collaborative work ongoing with their FBP teams to try and mitigate these.

Notwithstanding this, all three directorates have failed to deliver against savings targets to mitigate the impact of cost pressures, ultimately impacting on the end of year forecast. For this reason we have concluded reasonable assurance for this objective. Savings is covered in more detail under objective 3 below.

Objective 3: Directorates have identified recurrent savings opportunities and developed and agreed achievable savings plans for 2024/25 in line with savings expectations set out within each executive portfolio accountability letters. Implementation and risks to achievement are monitored and managed within directorate governance structures and escalated corporately where appropriate.	**Limited**

Overview / Summary of Observations

The Business Intelligence & Value Team maintains a 'Compendium of Variation' which serves as a central resource outlining relative financial performance in both operational and clinical contexts through triangulation of data with activity and quality metrics, highlighting areas of variation and system waste. Potential opportunities are identified through the analysis and comparison of available benchmarking data from sources such as the Bevan Commission, CHKS healthcare intelligence, NHS Benchmarking Network, NHS Executive and the NHS Wales Value & Sustainability Board. The onus is on directorates to consult the compendium to identify suitable opportunities for exploration with the aim of translating these into formal savings schemes. There is scope for greater monitoring of the extent to which opportunities are explored, transacted into savings or efficiencies, or rejected. **[Finding 4]**

For 2024/25 savings aspirations were set as the higher of i) 50% of deficit opportunities or ii) 5% of non-ringfenced budget, communicated to Executive Directors via the budget delegation letters. Unidentified savings targets are to be rolled forward to 2025/26, plus 1.5%. The January 2025 finance report to the Board highlights a recurrent savings delivery shortfall of £13.8m, significantly impacting on the end of year forecast.

All three directorates sampled have failed to identify sufficient recurrent savings schemes to meet 2024/25 targets. Whilst savings are discussed at formal and informal directorate governance meetings, there is limited evidence to demonstrate formal monitoring and management of individual savings schemes. **[Finding 5]**

Corporate monitoring and scrutiny of directorate savings delivery is via the monthly DITS/Escalation meetings. At the time of reporting 17 of the 26 directorates were in escalation level 3 for the Finance, Strategy & Planning domain.

Key Findings		Risk & Impact	Agreed Management Action
4	**Identification of Savings** There is a shortfall in identified savings for 2024/25. There is scope for greater monitoring of the extent to which opportunities in the compendium are explored, transacted into savings or rejected. Opportunities remain on the compendium indefinitely even where a variation has been explored and either taken forward or written off. There is limited evidence for how the sampled directorates manage and review the identification of savings ideas within their business management teams, with no formal agenda or actions captured to demonstrate all cost areas are routinely reviewed and tested for value for money.	Missed savings opportunities	**Agreed Action:** Whilst items of variation will not be removed from the compendium, we will establish a record of what items have been explored and capture the outcome, to be coordinated within Finance by the BI & Value team with input from Business Partners and operational teams. Maintain monitoring of operational teams reviewing opportunities and ensure this is on the radar of new Care Group leadership teams so that they can track progress.
			Expected Evidence of Implementation: Record of items investigated and the resulting outcome.
		Medium Priority	**Officer:** Sian Jenkins, Deputy Director of Finance
	Theme: Finance Management & Control	Control Operation	**Date:** 31 July 2025
5	**Delivery of Savings Schemes** Financial overspend and/or savings delivery is reflected on the risk registers for all three sampled directorates and actions identified to address this. However, there is limited evidence to demonstrate a structured approach to savings delivery via monitoring and management of individual savings schemes within Directorates, such as the identification of formal actions to progress schemes and risks to delivery. Only the Planned Care directorate demonstrated documented actions to support delivery of green schemes.	Non-delivery of identified savings schemes impacting on the financial position.	**Agreed Action:** Recognising we have a central approach to tracking savings delivery from a corporate perspective, we will incorporate a common and consistent monthly business management output to identify and monitor financial overspends and their mitigating actions, and to track savings schemes across all Clinical Care Group and Executive Functions We will also include savings delivery as a strand within our budget training offer to highlight how this should be approached.
			Expected Evidence of Implementation: Savings schemes supported by formal delivery plans/actions. Areas of overspend supported by mitigating actions. Savings included within budget holder training package.
		High Priority	**Officer:** Sian Jenkins, Deputy Director of Finance
	Theme: Finance Management & Control	Control Operation	**Date**: 30 June 2025

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

Disclaimer

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

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

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

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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]

6.7

12:05, 10 Mins

6.7 - Performance Management (Substantial Assurance)

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

For assurance

Attachments

6.8 Performance Management Final IA Report.pdf

Performance Management

Final Internal Audit Report

2024/25

Hywel Dda University Health Board



Substantial Assurance

Contents

Executive Summary 1
Findings & Agreed Action Plan 2
Appendix A 5

Review Reference	HDU-2425-07
Fieldwork	December 2024 - January 2025
Executive Sign Off	11 February 2025
Audit Committee	April 2025
Executive Lead	Huw Thomas, Director of Finance
Audit Team	James Johns, Head of Internal Audit
	Sophie Corbett, Deputy Head of Internal Audit

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

Executive Summary

Purpose

The NHS Wales Performance Framework 2024-25, issued by the Welsh Government in February 2024, sets out the performance measures for NHS Wales organisations, aligned to the 'A Healthier Wales's quadruple aims. Organisations are also required to complete Policy Assurance Assessments, to provide assurance on key areas of focus, strategies and pathways that cannot be monitored via traditional quantitative measurement. The Health Board's Improving Together Framework sets out the approach to embedding performance improvement within the organisation's governance structure, and is supported by four key dashboards, Board Assurance Framework, Integrated Performance Assurance Report, Our Performance and Our Safety.

This audit has reviewed the Health Board's performance management arrangements including the Directorate Improving Together Process, alignment with the NHS Wales Performance Framework and mechanisms for data collation.

Overview

We have concluded **Substantial** assurance on this area. The audit highlighted that Hywel Dda has in place a good strong Performance Management team who not only curate and collate the performance reporting but also chase, advise and support departments where necessary. Data is reported at Board, Committee and Executive level through the Board Assurance Framework and Integrated Performance Assurance Reports. Directorate Improving Together Sessions are held at a service directorate level, to review priorities and goals, current challenges.

Two medium priority findings have been identified requiring management action:

- No formal system exists within the performance management team or Information Quality Assurance Team (IQA) to ensure that data received from the directorates has been quality assured.
- Whilst performance management processed are working well, a number of Directorates have not made the required progress over a period of months and remain on level three escalation for a number of domains.

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

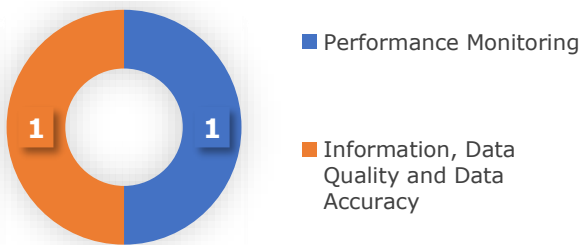
Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	Performance measures are aligned to the NHS Wales Performance Framework 2024-25 and the requirements of the Health Board	-	**Substantial**
2	Mechanisms for data collation and validation are robust to ensure complete, timely and accurate performance reporting	1	**Reasonable**
3	Directorate Improving Together and internal escalation processes are operating in line with the respective frameworks, with actions identified and implemented to address any areas of concern.	2	**Reasonable**

Management Actions

High Priority	Medium Priority
-	2

Themes



Risk Types

Quality or Safety Issues

Financial Loss

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: Performance measures are aligned to the NHS Wales Performance Framework 2024-25 and the requirements of the Health Board.	**Substantial**

Overview / Summary of Observations

Hywel Dda has in place a good strong Performance Management team who not only curate and collate the performance reporting but also chase, advise and support departments where necessary. The structure and roles and responsibilities of the team are documented so external departments know who their main point of contact is.

The HB uses the WG framework itself rather than publishing its own and therefore HB reporting complies by default with WG stipulations.

Information is supplied bimonthly to the Board (Board assurance framework and Integrated performance assurance report) and to the Strategic Development and Operational Delivery Committee (Integrated performance assurance report and details for deep dives) alternately thus performance is critically examined every month.

Audit work showed evidence of strong systems that are good and resilient and delivers the reporting structure required by the WG framework.

Objective 2: Mechanisms for data collation and validation are robust to ensure complete, timely and accurate performance reporting.	**Reasonable**

Overview / Summary of Observations

Significant amounts of qualitative and quantitative, both strategic and operational data is made available monthly to Board, appointed Committee and managers and staff.

Data is quality assured by the providers with enquiries from the Performance Team should data look as if it is not following trend. No formal system exists within the performance management team or Information Quality Assurance Team (IQA) to ensure that data received from the directorates for performance reporting has been quality assured. The recent Data Quality audit (report HDU-2425-28 refers) includes an agreed action which will address data quality for clinical systems, separate assurance arrangements will be required for other data sources feeding into performance reporting. **[Finding 1]**

Data is scrutinised and queried by those responsible at Board level (strategic) and Committee (operational) with assurance constantly being sought over goal achievement.

Within the number of reports produced RAG (Red (NO assurance) Amber (Limited assurance) and Green (sufficient assurance)) tables are used to good effect as well as graphs to show trends.

Audit testing and review revealed the mechanisms of Performance Management to be good and fit for purpose with the need to strengthen quality assurance.

Key Findings		Risk & Impact	Agreed Management Action
1	**Data Quality Assurance** No formal system exists within the performance management team or Information Quality Assurance Team (IQA) to ensure that data received from the directorates for performance reporting has been quality assured. The Data Quality audit (HDU-2425-28) includes the following agreed action: *The Information Quality Assurance (IQA) Team along with the Performance Team will design specific metrics for data quality and these will be used in directorate escalation meetings to provide a greater focus on data quality. The IQA will continue to conduct regular audits and reviews of data quality practices at both the centralised and service levels.* Whilst this will address data quality for clinical systems, assurance will need to be sought separately for other data sources that do not fall within the remit of the IQA Team.	Decisions made on incomplete or inaccurate data	**Agreed Action:** A procedure will be developed detailing how the performance team will assess the quality of the data that has not been derived from clinical / core operational systems. **Expected Evidence of Implementation:** Procedure developed and operationalised
		Medium Priority	**Officer:** Head of Performance **Date:** 30 April 2025
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Objective 3: Directorate Improving Together and internal escalation processes are operating in line with the respective frameworks, with actions identified and implemented to address any areas of concern	**Reasonable**

Overview / Summary of Observations

Data is reported at Board, Committee and Executive level through the Board Assurance Framework and Integrated Performance Assurance Reports. Data is compiled by the relevant department and verified by them internally, then sent at agreed intervals to the performance team who compile the reports for the Board and Committee meetings.

Directorate Improving Together Sessions are held at a service directorate level, to review priorities and goals, current challenges. Directorates are allocated an escalation level status of one to three, based on their current situation, against the six escalation domains.

The audit noted that whilst it can be seen that the current process is working well, there are a number of Directorates that have not made the required progress over a period of months and are still on Level three escalation for a number of domains.

Key Findings		Risk & Impact	Agreed Management Action
2	**Service Improvement** The audit noted that whilst it can be seen that the current process is working well, there are a number of Directorates that have not made the required progress over a period of months and are still on Level three escalation for a number of domains.	Lack of progress on actual improvements will lead to further financial loss and loss of reputation with WG	**Agreed Action:** The already established escalation process for directorates will be used and an exception report will be developed to provide the additional context of the rationale to the Executive Team to determine whether further intervention is required and what form this would take.
			Expected Evidence of Implementation: A reporting template is developed providing the necessary escalation to the Executive Team for consideration
		Medium Priority	**Officer:** Head of Performance **Date:** 28 February 2025
	Theme: Performance Monitoring	Control Design	

Appendix A

Assurance Opinion

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 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
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Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

6.8

12:15, 0 Mins

6.8 - Executive Team Working

James Johns (NWSSP - Internal Audit), Philip Kloer (Hywel Dda UHB - Chief Executive), Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

DEFERRED to 8 May 2025 meeting

For assurance

6.9 **12:15, 0 Mins**

6.9 - Cleanliness/Cleaning Standards Follow-up

James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

DEFERRED to 8 May 2025 meeting

For assurance

6.10

12:15, 0 Mins

6.10 - Withybush Hospital (WGH) RAAC

James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

DEFERRED to 8 May 2025 meeting

For assurance

6.11

12:15, 0 Mins

6.11 - Continuing Healthcare – Database Maintenance and Finance Processes

James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Jill Paterson (Hywel Dda Health Board - Director of Primary Care, Community and Long Term Care), Huw Thomas (Hywel Dda UHB - Director of Finance)

DEFERRED to 8 May 2025 meeting

For assurance

6.12

12:15, 0 Mins

6.12 - Annual Planning

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

DEFERRED to 8 May 2025 meeting

For assurance

6.13

12:15, 0 Mins

6.13 - Discharge Management Follow-up

James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

DEFERRED to 24 June 2025 meeting

For assurance

6.14

12:15, 0 Mins

6.14 - Contract Management

James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Huw Thomas (Hywel Dda UHB - Director of Finance), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning)

DEFERRED to 24 June 2025 meeting

For assurance

6.15

12:15, 0 Mins

6.15 - Medical Workforce (Medical Locums Planned Care)

James Johns (NWSSP - Internal Audit), Mark Henwood (Hywel Dda UHB - Interim Medical Director)

DEFERRED to 2025/26 IA Plan

For assurance

7

12:15, 0 Mins

7 - Financial Focus

7.1

12:15, 5 Mins

7.1 - Financial Assurance Report

Huw Thomas (Hywel Dda UHB - Director of Finance)

For assurance

Attachments

7.1 SBAR Financial Assurance Report ARAC April 2025.pdf

7.1 Financial Assurance Report ARAC April 2025 (incl Appendix 1 - 3).pdf

7.1 Appendix 4 - S28 Money transfer Statement of Expenditure 23-24 (Signed).pdf

7.1 Appendix 4 - Ceredigion CC CF1 HLG03.pdf

7.1 Appendix 4 - CF2 HLG03 23-24 Ceredigion.pdf

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	15 April 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Financial Assurance Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Tim John, Senior Finance Business Partner (Accounting & Statutory Reporting)

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
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, which the Committee can take assurance from the actions being undertaken (Assure).

Alert:

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

Advise:

a) The level of staff overpayments is increasing, though the average recovery period continues to be at a reduced level when compared to the last financial year.

Assure:

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

Argymhelliad / Recommendation

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

- **DISCUSS** the breaches of Standing Financial Instructions (SFIs) as detailed in Appendix 1.
- **TAKE ASSURANCE** from the actions taken to reduce the instances of non-compliance with the No PO No Pay policy.
- **TAKE ASSURANCE** from the controls in place to manage Single Tender Actions (STAs).
- **DISCUSS** the staff overpayments and seek assurance that actions to control them are sufficiently embedded.
- **SCRUTINISE** the award of contracts listed in Appendix 1.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.4 The Committee's principal duties encompass the following: 2.4.2 Seek assurance that the systems for financial reporting to Board, including those of budgetary control, are effective, and that financial systems processes and controls are operating. 3.10 The Committee will be responsible for reviewing the UHB's Standing Orders and Standing Financial Instructions and Scheme of Delegation annually, (including associated framework documents as appropriate), monitoring compliance, and reporting any proposed changes to the Board for consideration and approval. 3.13 Approve the writing-off of losses or the making of special payments within delegated limits. 3.15 Receive a report on all Single Tender Actions and extensions of contracts.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	BAF SO9-PR20 BAF SO10-PR33
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	6. Sustainable use of resources

Amcanion Cynllunio Planning Objectives	2c Workforce and OD strategy 6a Clinical services plan 8c Financial Roadmap
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Monitoring returns to Welsh Government based on the Health Board's financial reporting system. Activity recorded in the AR and AP modules of the Oracle business system and activity recorded in the procurement Bravo system.
Rhestr Termau: Glossary of Terms:	AP - Accounts Payable AR – Accounts Receivable BGH – Bronglais General Hospital CF – Counter Fraud COS – Contracted Out Service VAT EOY – End of Year ERs NI – Employers National Insurance GGH – Glangwili General Hospital HMRC – His Majesty's Revenue and Customs IFRS – International Financial Reporting Standards NWSSP – NHS Wales Shared Services Partnership PID – Patient Identifiable Data PO – Purchase Order POL – Probability of Loss PPH – Prince Philip Hospital PSPP – Public Sector Payment Policy SFI – Standing Financial Instructions SLA – Service Level Agreement STA – Single Tender Action VAT – Value Added Tax WGH – Withybush General Hospital WRP – Welsh Risk Pool
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	UHB's Finance Team UHB's Management Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Financial implications are inherent within the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	Risk to our financial position affects our ability to discharge timely and effective care to patients.

Gweithlu: **Workforce:**	Overpayments are reported within this report.
Risg: **Risk:**	Financial risks are detailed in the report.
Cyfreithiol: **Legal:**	The UHB has a legal duty to deliver a breakeven financial position over a rolling three-year basis and an administrative requirement to operate within its budget within any given financial year.
Enw Da: **Reputational:**	Adverse variance against the UHB's financial plan will affect our reputation with Welsh Government, Audit Wales and with external stakeholders.
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

1.1 Purpose

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

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

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

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

2.1 Scheme of delegation changes

No changes.

2.2 Compliance with Purchase to Pay Requirements

2.2.1 No PO, No Pay Policy Adherence

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

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

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

Invoices on Hold (IOH)

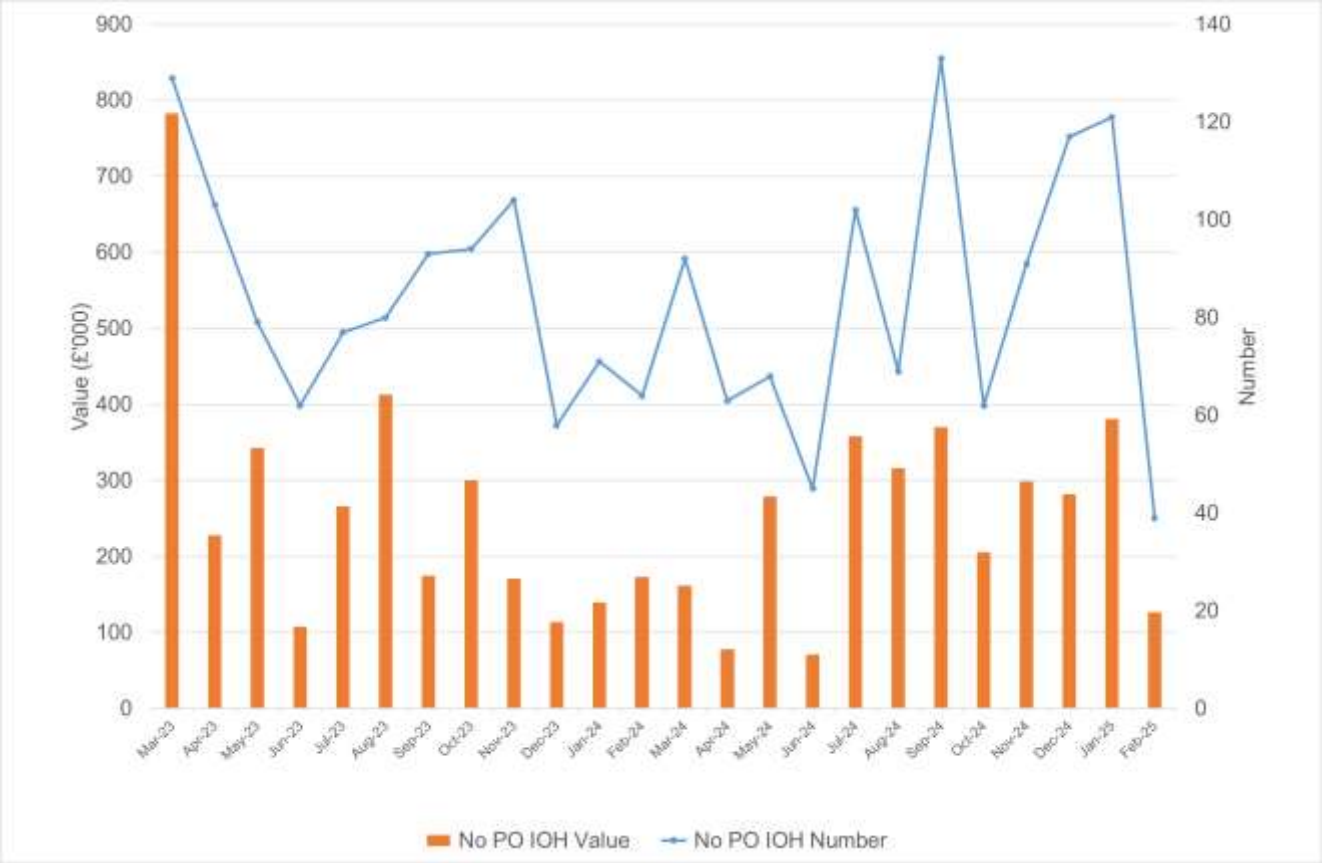
Whilst there have been zero invoices paid without a purchase order, preventative control checks are in place to ensure proactive management minimises the potential for non-compliance in the future and any delays for vendor payment. This preventative control is called invoices on hold (IOH).

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

Figure 2 below illustrates the numbers and value of IOH as a result of no purchase order being quoted on the presented invoice. For the months of January and February 2025 there were a total of 160 IOH with a combined value of £508k. This compares to a total of 208 IOH on hold with a combined value of £581k for November and December 2024.

The cumulative position as at end of February 2025 has decreased compared to at the end of December 2024 in terms of frequency, but slightly increased in value; a total of 108 IOH with a combined value of £385k compared to 187 IOH with a combined value of £355k respectively.

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



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

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

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

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

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

Supplier	No. Inv	£	Actions to improve:
INSULET	23	22,732	Procurement to improve contract management
JUST WALES	32	31,434	No further action required. Meeting held with supplier to explain that Health Board will stop using them if they do not comply with the No PO NO Pay policy. The numbers reported here are from items received prior to that meeting. Since that meeting there have been no further issues.

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

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

Below are the three directorates with non-compliance in excess of £20,000 during the period ending February 2025:

Directorate	No. Inv	£
RADIOLOGY	1	171,546*
MEDICAL	1	109,368**
MENTAL HEALTH & LEARNING DISABILITIES	5	64,070

*Everlight Radiology Ltd / **Aberystwyth University

2.2.2 Public Sector Payment Policy (PSPP) Compliance

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

The Health Board successfully achieved its monthly PSPP target of paying 95% of non-NHS invoices for the months of January and February 2025 achieving 97.70% and 97.30% respectively. In addition, at the end of February 2025 the Health Board had met the target on a cumulative basis (96.60%).
Regarding the payment of NHS invoices, the Health Board paid 93.00% and 87.50% of these within 30 days for the months of January and February respectively.

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.

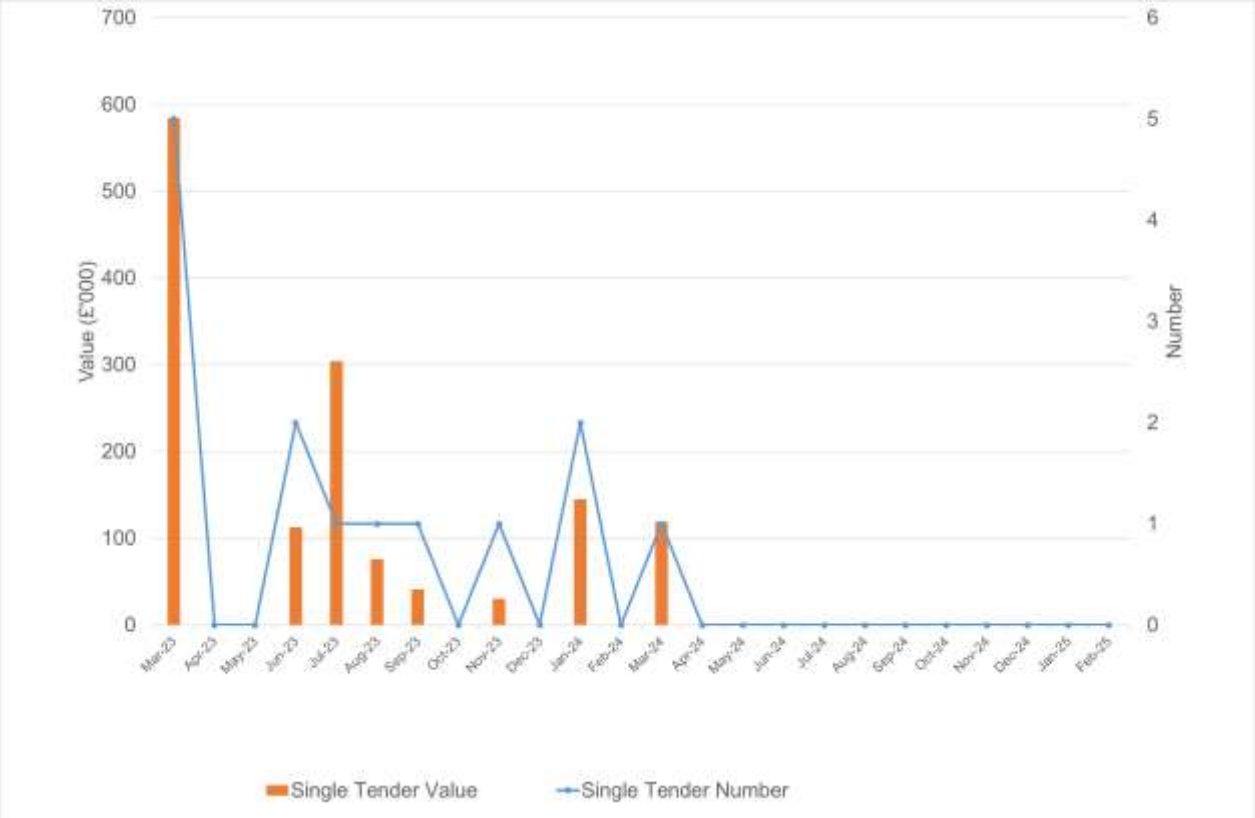
2.2.3 Single Tender Actions

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

There were no Single Tender Actions (in excess of £25,000) during January and February 2025.

The graph (Figure 3) shows the trend of all Single Tender Actions (STA) approved from 1 March 2023 to 28 February 2025.

Figure 3: Numbers and value of Single Tender Actions



2.2.4 Tenders Awarded and Breaches of Standing Financial Instructions

There were 13 contracts awarded, including direct awards through framework and VEAT process during the period 1 January 2025 to 28 February 2025, totalling £4,322,263.

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

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

There were 2 breaches of SFIs totalling £24,600 during the period 1 January 2025 to 28 February 2025. Full details are provided in Appendix 1.

2.2.5 Consultancy contracts

There were no consultancy contracts awarded during January and February 2025.

2.3 Compliance with Income to Cash

2.3.1 Overpayment of Salaries

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

Appendix 2 shows the volume and value of invoices raised in respect of overpayments for the period 1 January to 28 February 2025; 34 cases totalling £66,075, which represents 0.17% of the average monthly net pay costs.

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

The second of these panel meetings was held in March 2025; 3 meetings took place compared to 10 in December 2024. The key points from the panel meetings were that:

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

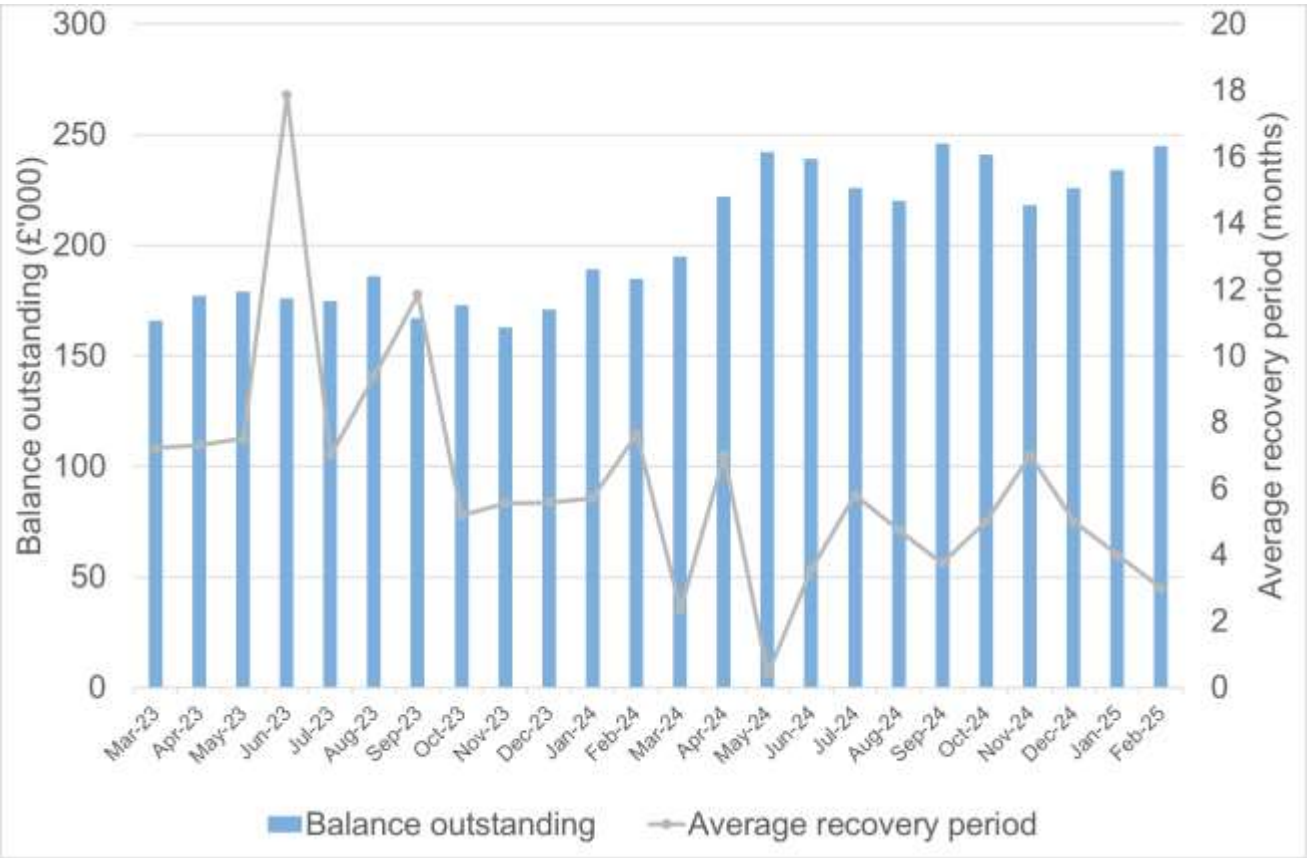
All attendees recognised the need to improve the timeliness of completing termination forms and all assured the panel that there would not be any further instances. All attendees gave assurance that they would ensure better processes are put in place within their teams.

The graph below (Figure 4) demonstrates the total balance outstanding against the average recovery period. The average recovery period reflects the number of debts settled in the current period only. The total value raised in the period 1

January to 28 February 2025 was £66k compared to £54k in the period ended 31 December 2024.

The overall debt balance has increased to £246k at the end of February 2025 compared to £226k at the end of December 2024, with the average recovery period decreasing from five months at the end of December to three months at the end of February 2025.

Figure 4: Trend of aged overpayments and recoveries

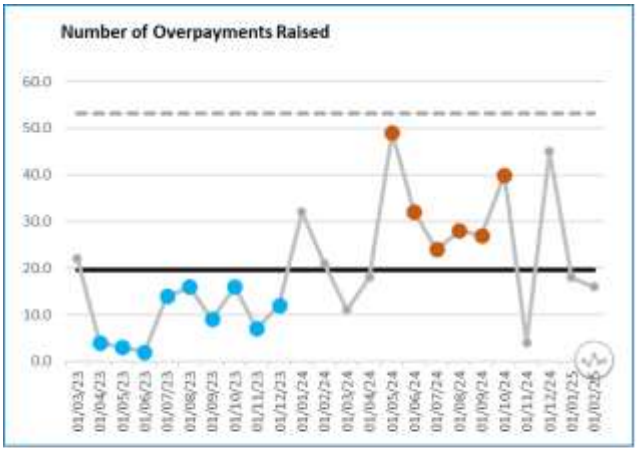


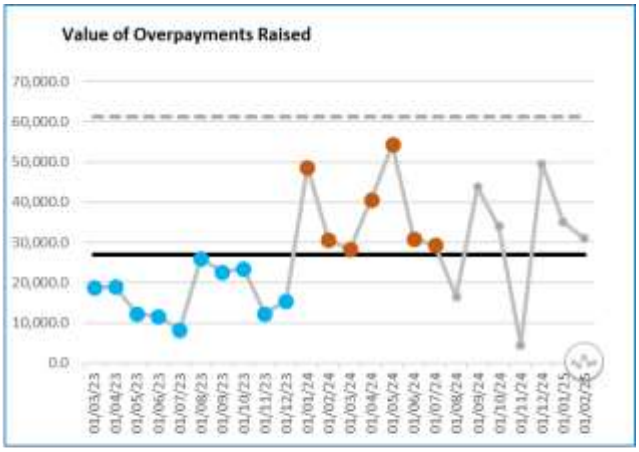
Further statistical analysis in respect of the overpayment of salaries is provided below:

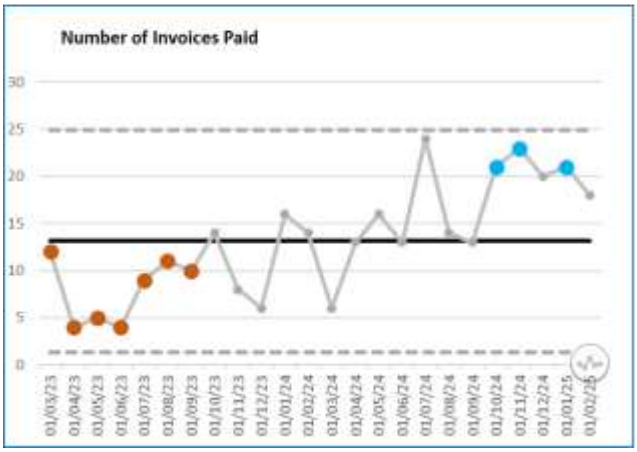
The four charts show the number and volume of invoices raised by the Health Board in respect of the overpayment of salaries during the period March 2023 to February 2025.

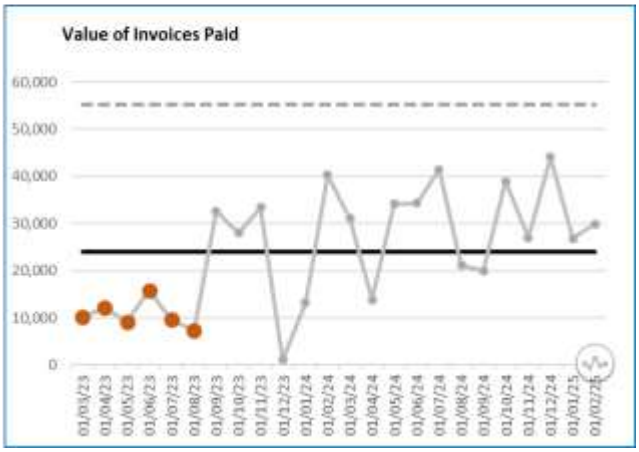
The rate at which the invoices have been raised varies based on the information gathered by the Payroll Department. The average number of invoices raised has increased to 24 invoices at the end of February 2025, compared to 19 invoices raised at the end of December 2024 and the average value per month has also increased to £27k at the end of February 2025, compared to £26k at the end of December 2024.

The rate at which the Health Board receives payment for these invoices has increased to an average of 13 invoices per month at the end of February 2025 compared to an average of 12 at the end of the previous period of December 2024. The average amount recovered per month has remained at £24k when comparing these periods.









2.3.2 Underpayment of salaries

NWSSP have provided details of emergency payments requested and paid in January and February 2025 for underpaid salaries, the total of which was £34,012.

Reasons for salary underpayments include:

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

2.4 Losses and Special Payments for Approval

2.4.1 General Losses and Special Payments

Losses and special payments require the Audit and Risk Assurance Committee's approval given their contentious nature. There are no losses over £5k arising in the period January to February 2025 requiring the Committee's approval (Appendix 3).

Losses and write offs under £5k, as per requirement under FP02 – Income and Cash Collection, have been presented and approved by the Director of Finance and Chief Executive. In total these amounted to £54,931.

2.5 Compliance with Capital Requirements

No issues to report.

2.6 Compliance with Tax Requirements

2.6.1 Compliance with VAT Requirements

Significant updates regarding existing matters are set out in the following table:

Key VAT issue	Update
Capital Front of House Scheme (Bronglais Hospital)	In February 2025, HMRC informed the Health Board of its decision to approve the Health Board's determination of the total VAT recoverable in respect of this scheme. Consequently, a potential liability to HMRC of £621k will not be payable and this matter is concluded.

2.6.2 Compliance with Employment Tax Requirements

The Health Board, along with other organisations across NHS Wales, has accepted an invitation from HMRC to participate in a National Minimum Wage (NMW) Employer Support Programme. The programme offers an opportunity for NHS Wales organisations to utilise HMRC's expert advice and support to check that they are paying all workers in accordance with NMW regulations. This opportunity comes following a rapid increase in the NMW over recent years, which has brought more staff groups within its range.

The programme commenced in January 2025 with an interactive face-to-face workshop hosted by HMRC, in which HMRC explained key risk areas. The Health Board is currently considering the robustness of its processes around the recording of staff working time, the potential impact of employee benefit schemes and other initiatives offered to staff and the quality of controls within the payroll system with a view of obtaining assurance over its compliance. The Health Board will be working with HMRC over the coming months as the programme proceeds.

2.7 Compliance with reporting requirements

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

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

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

2.8 Financial Compliance

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

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

There are no further updates to report.

3.1 Recommendations

The Audit and Risk Assurance Committee is asked to:

a) Discuss the breaches of SFIs as detailed in Appendix 1.
b) Take assurance from the actions taken to reduce the instances of non-compliance with the No PO No Pay policy.
c) Take assurance from the controls in place to manage Single Tender Actions
d) Discuss the staff overpayments and seek assurance that actions to control them are sufficiently embedded.
e) Scrutinise the award of contracts listed in Appendix 1.

Appendix 1: Contracts awarded

Direct awards via Framework Agreement											
Period Covered by this report				01/01/2025	28/02/2025						
Reference	Framework Used & Reference	Supplier	Description	One off or Period		Value, exc VAT	Department	Professional Services	Date of Board Approval (if applicable)	Compliant	Comment
				Start	End						
HDD-DCO-23-30	Crown Commercial Services (CCS) Postal Goods, Services and Solutions (RM6017)	Whistl UK Ltd	Collection and Delivery of Letters	01/01/2025	31/03/2025	£75,000	Digital	No	N/A	Y	An extension to a direct award via the Crown Commercial Services (CCS) Postal Goods, Services and Solutions Framework (RM6017) has been awarded to Whistl UK Limited for the Collection and Delivery of Letters for 3 months. This contract award does not allow for an extension.
Not Available	Crown Commercial Services (CCS) Postal Goods, Services and Solutions (RM6017)	Quadient Ltd	Franking Machine Lease and Postage Credit	22/01/2025	31/03/2028	£40,498	Digital	No	N/A	Y	Following the award of the initial contract, an additional £40,498.08 has been awarded for the Franking Machine Lease and Postage Credit across the remaining 36 months of the contract.

Direct awards via VEAT process										
Period Covered by this report			01/01/2025	28/02/2025						
Reference	Supplier	Description	One off or Period		Value, exc Vat	Department	Professional Services	Date of Board Approval (if applicable)	Compliant	Comment
			Start	End						
HDD-VEAT-24-02	Healios Ltd	Autism Diagnostic Assessments - Children	21/01/2025	31/03/2025	£312,000	Mental Health & Learning Disabilities	No	N/A	Y	A VEAT Notice was issued to confirm that Healios Ltd were awarded a three (3) month contract for Autism Diagnostic Assessments specifically relating to Children. This contract award does not allow for an extension.

Contracts awarded post competitive tender										
Period Covered by this report			**01/01/2025**	**28/02/2025**						
Reference	**Supplier**	**Description**	**One off or Period**		**Value, exc Vat**	**Department**	**Professional Services**	**Date of Board Approval (if applicable)**	**Compliant**	**Comment**
			Start	**End**						
HDD-MIN-57268	WSP Ltd	Building Services Engineer for Major Infrastructure Scheme	01/01/2025	31/03/2029	£475,000	Estates	Yes	N/A	Y	Following a competitive tender, WSP Ltd were awarded a 50-month contract for a Building Services Engineer for the Major Infrastructure Scheme. This contract award does not allow for an extension.
HDD-MIN-57220	WSP Ltd	Civil & Structural Engineering Services for Major Infrastructure Investment Programme for Business Continuity Scheme	01/01/2025	31/03/2029	£475,000	Estates	Yes	N/A	Y	Following a competitive tender, WSP Ltd were awarded a 50-month contract for Civil & Structural Engineering Services for the Major Infrastructure Scheme. This contract award does not allow for an extension.
HDD-ITT-51433	Healios Ltd	Autism Diagnostic Assessments	17/01/2025	31/03/2025	£171,860	MH & LD	No	N/A	Y	Following the award of the initial contract to Healios Ltd, under a Contract Change Notice (CCN) an additional £171,860.00 has been awarded for Autism Diagnostic Assessments across the remaining 3 months of the contract.

HDD-MIN-58053	Softcat Plc	Care Partner Enterprise Licence Renewal	01/02/2025	31/01/2027	£343,945	Digital	No	N/A	Y	Following a competitive tender, Softcat Plc were awarded a 24-month contract for a Care Partner Enterprise Licence Renewal. An option to extend the contract for a further 12 months is included in the award.
HDD-MIN-57727	Mace Consulting Ltd	Project Management Services for Glangwili Fire Scheme	01/02/2025	31/03/2029	£475,000	Estates	Yes	N/A	Y	Following a competitive tender, Mace Consulting Ltd were awarded a 50-month contract for Project Management Services for the Glangwili Fire Scheme. This contract award does not allow for an extension.
HDD-MIN-57728	Lee Wakemans Ltd	Cost Advisor Services for Glangwili Fire Scheme	01/02/2025	31/03/2029	£475,000	Estates	Yes	N/A	Y	Following a competitive tender, Lee Wakemans Ltd were awarded a 50-month contract for Cost Advisor Services for the Glangwili Fire Scheme. This contract award does not allow for an extension.
HDD-MIN-57677	Phoenix Software Ltd	Beyond Trust Remote Support Platform Renewal	01/02/2025	31/01/2028	£30,040	Digital	No	N/A	Y	Following a competitive tender, Phoenix Software Ltd were awarded a 36-month contract for a Beyond Trust Remote Support Platform Renewal. An option to extend the contract for a further 24 months is included in the award.
HDD-MIN-58009	SpaMedica Ltd	Outsourcing of IVT	24/02/2025	31/03/2025	£935,000	Scheduled Care	No	N/A	Y	Following a competitive tender, SpaMedica Ltd were awarded a 2 month contract for Outsourcing of IVT. An option to extend the contract for a further 12 months is included in the award.
HDD-MIN-58024	MediServices Ltd	Insourcing of Neurophysiology	24/02/2025	31/03/2025	£348,000	Scheduled Care	No	N/A	Y	Following a competitive tender, MediServices Ltd were awarded a 2 month contract for Insourcing of Neurophysiology. An option to extend the contract for a further 12 months is included in the award.

HDD-OJEU-57213	Impact Medical Ltd	Hire of Mobile Lithotripter	01/02/2025	31/01/2028	£165,920	Scheduled Care	No	N/A		Following a competitive tender, Impact Medical Ltd were awarded a 36-month contract for the Hire of a Mobile Lithotripter. An option to extend the contract for a further 12 months is included in the award.

Consultancy											
Period Covered by this report				01/01/2025	28/02/2025						
Reference	STA/Competitive Tender/Direct Award	Supplier	Description	One off or Period		Value, exc Vat	Department	Professional Services	Date of Board Approval (if applicable)	Compliant	Comment
				Start	End						
											None to be reported in this period.

Breaches of Standing Financial Instructions						
Period Covered by this report			**01/01/2025**		**28/02/2025**	
Month/ Year	**Supplier**	**Description**	**Value, exc Vat**	**Directorate**	**Comment**	**Action Taken**
February	Solutions 4 Health Ltd	A twelve-month QM10 Specialist Smoking Cessation Information System Licence	£5,000	Public Health	In the month of February 2025, a retrospective purchase order was raised to Solutions 4 Health Ltd for the payment of a 12- month QM10 Specialist Smoking Cessation Information System Licence. The total value of the purchase order was £5,000.00. This breach of Standing Financial Instructions sits within the Public Health Directorate.	Breach Added to Procurement Workplan
February	K N Hakin Ltd	Review of Documents & Preparation of Reports	£19,600	Nursing	In the month of February 2025, a retrospective purchase order was raised to K N Hakin Ltd for the payment of a Review of Documents & Preparation of Reports. The total value of the purchase order was £19,600.00. This breach of Standing Financial Instructions sits within the Nursing Directorate.	Escalated for Re-Education, and Relevant Director Informed for Awareness and Action

Appendix 2: Overpayment of Salaries

	Period covered by this report: 1 Jan 25 – 28 Feb 25		
Ref	**Reason for Overpayment**	**Value (£)**	**Number of invoices**
1	Processing Error	750.03	1
2	Late Notification of Changes	36,178.93	17
3	Late Notification of Termination	24,420.32	14
4	Late Notification of Absence	4,725.25	2
		66,074.53	**34**

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

	Period covered by this report:		1 January 2025 to 28 February 2025
Ref	**Losses and Special Payments Category**	**Value (£)**	**Explanation**
	N/a		
	Total Losses (for approval)		

Recommendation: N/a

SECTION 28A ANNUAL VOUCHER FINANCIAL YEAR 2023-2024

CEREDIGION COUNTY COUNCIL

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

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2024

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

Scheme Re. No and Title of Expenditure project	Revenue Expenditure	Capital Expenditure	Total
	£	£	£
8507 - CER JF Plas Gwyn residential care home (formerly Minymor)	32,421.00		32,421.00
8505 - CER JF Bryn Place, Supported Living	127,137.00		127,137.00
	159,558.00	**0.00**	**159,558.00**

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

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



Signed: ……..

30/09/2024

Date: ……..

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

Certificate of Auditor appointed by the Audit Commission

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

I am/We are of the opinion that

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

Date: ……..

Auditor: ……..

Archwilio Cymru
Audit Wales

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Certificate of the Auditor General for Wales

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

We have examined the entries in this form and the related accounts and records of the receiving body in accordance with Certification Instruction A01 and have carried out the tests in Certification Instruction number HLG03 (23-24) (3-23) and obtained such evidence and explanations as we consider necessary.

~~Except for the matters raised in the attached qualification letter dated~~

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

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

Signature

Name (block capitals)

J BLEWITT

(on behalf of the Auditor General for Wales)

Date 28th February 2025

CF1 (5/16)

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

Auditor's certificate re NHS Wales Act 2006 S194 and S34 Money Transfers (HLG03)
(name of the funder's grant programme and, if applicable, project name)

The enclosed document Section 28A Annual Voucher Financial Year 23-24
(form number or if unnumbered, type of claim or return)

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

has been certified on the request of Ceredigion County Council
(the grant receiving body)

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

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

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

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

Agreed amendments incorporated in the attached claim

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

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

* have no overall effect on entitlement

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

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

** delete as appropriate*

Other matters for your attention

☑ none

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

Only an original of this covering sheet confirms that:

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

Auditor _____ *(Signature)* Date 28/02/25 CF2 ref CCC/HLG03/23-24
Audit Wales /Firm and sequential no.

CF2 (5/16)

CFN issued _____

Agreed amendments incorporated in the attached claim

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

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

☐ See supplementary sheet for further amendments.

7.2

12:20, 5 Mins

7.2 - Counter Fraud Annual Report 2024/25

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

For information

Attachments

7.2 SBAR Counter Fraud Annual Report.pdf

7.2 Counter Fraud Annual Report 2024-25.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	15 April 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Counter Fraud Annual Report 2024/25
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) throughout 2024/25.

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

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

Asesiad / Assessment

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 Annual Report 2024/25.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.2 In particular, the Committee will review the adequacy of:

	3.2.4 the policies and procedures for all work related to fraud and corruption as set out in National Assembly for Wales Directions and as required by the Counter Fraud and Security Management Service.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	3. Effective 4. Efficient
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Striving to deliver and develop excellent services 6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Counter Fraud Workplan 2023/24
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 ANNUAL REPORT 2024/25

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1 Introduction

NHS bodies in Wales must implement anti-fraud, bribery, and corruption measures in accordance with Welsh Government Directions on Counter Fraud Measures and the service agreement under section 83 of the Government of Wales Act 2006. This report has been written in accordance with such provisions and is produced annually to demonstrate how the directions and subsequent standards for delivery are achieved.

The Directions to NHS bodies identify functions and responsibilities in relation to Counter Fraud provision and prescribe through set standards for NHS bodies as to how best achieving compliance towards these directions. The Health Board is required to comply with NHS Counter Fraud Authority's fraud, bribery, and corruption standards for providers, and produces this annual report in compliance with the direction.

The report will seek to provide detail of the work carried out by the Health Board that relates to anti-fraud, bribery, and corruption over the preceding financial year. The Welsh Government directions and standards have been developed to support NHS organisations in implementing appropriate measures to counter fraud, bribery and corruption and are presented under the following work activity areas:

- Strategic Governance
- Inform & Involve
- Prevent & Deter
- Hold to Account

The report will demonstrate and highlight the work completed under the 4 areas of activity as presented within the Government Functional Standards 013 – Counter Fraud and NHS Requirements to meet those standards is available at:

Government Functional Standard 013 Counter Fraud | NHS Counter Fraud Authority | NHSCFA

The report will also reference the "Self-Review Tool" (SRT) as part of the Quality Assurance process, which presents an overall RAG rating for each of the key areas of activity. The report style follows a prescribed format as recommended within the NHS Counter Fraud Authority's annual report template.

Hywel Dda University Health Board Counter Fraud provision was resourced based on 2 FTE Local Counter Fraud Specialists (LCFS) overall:

- Ben Rees (Lead LCFS)

- Terry Slater (LCFS)

For ease of reference, the report follows the four key areas of action assessed through the NHS Protect Quality Assurance Framework which links to the National Counter Fraud Strategy for Wales. The report gives details of work carried out by the LCFS. The information referred to in this report contributes to the Counter Fraud strategy for the Health Board.

The Counter Fraud Work Plan provides a more detailed account of the specific tasks undertaken by the Counter Fraud Officers. This Work Plan is used to inform the Audit and Risk Assurance Committee (ARAC), on a regular basis, of progress made against the planned activity throughout the year.

Table to illustrate Resource position 2024/25

AREA OF ACTIVITY	Resource Allocated (days) 2024/25	Resource Used (days)
STRATEGIC GOVERNANCE	40	41
INFORM AND INVOLVE	85	92
PREVENT AND DETER	120	121
HOLD TO ACCOUNT	175	176
TOTAL	**420**	**430**

Area	Days used
Proactive work (Inform and Involve & Prevent and Deter)	213
Reactive work (Hold to account)	176

2 Management Summary

The main achievements highlighted in this report are as follows:

All key requirements of the Welsh Government Directions to NHS Bodies on Counter Fraud Measures have been achieved.

During 2024/25, the Counter Fraud Team carried over 12 active cases from the previous year, and received and recorded 55 new referrals; of which, 56 investigations were undertaken and closed. 11 cases will remain open and under review at the end of this financial year and will be carried over into the next. Of these 11, 7 are at the stage where a Voluntary Interview Under Caution (VIUC) has either been completed or awaiting completion.

Of the investigations that were closed, 4 criminal sanctions were applied, including 1 successful prosecution at Aberystwyth Magistrates Court and 3 Police Cautions. A further 12 civil sanctions were instigated, including the recovery of funds totaling £56,106 and 8 internal disciplinary referrals. Of the 8 internal disciplinary referrals, 2 members of staff resigned prior to the completion of proceedings and 4 members of staff received written warnings. This is in addition to the proactive activities undertaken and reported throughout the year.

It is noted that the number of referrals has increased from 37 during 2023/24 to 55 this year and this can be attributed to the introduction of mandatory training, an increase in pro-active work and a development of the Health Board's NHS Fraud Awareness.

It is important to note that not all referrals received were crimes, some of these would have been concerns or system weaknesses, which would have been reviewed and actioned accordingly. In addition, there have been referrals where an investigation has demonstrated that a crime had not occurred. In such scenarios, the LCFS will assess why the referrals were made and address any system weaknesses. An example of this involved a referral in connection with an employee not fulfilling their contractual hours. Upon review, the LCFS identified that the rostering system available to view by all staff had not been updated with a recently approved flexible working pattern, resulting in the assumption that the employee concerned was arriving to work late and leaving early.

In this case, the LCFS was able to demonstrate that a crime had not occurred, although poor management of rostering system caused others to raise a concern. This has prompted the identification of fraud risks associated with the management of rostering systems, which will be further explored and risk assessed in 2025/26.

In conjunction with the Health Board's Workforce and Organisational Development Directorate, all cases developed that were linked to a current employee were referred to the relevant workforce contact, and subsequent workforce reviews / disciplinary cases were completed following the sharing of intelligence around the Counter Fraud findings. Additionally, as a matter of professional routine practice, where investigations involved members of professional bodies, referrals were made to each respective body, allowing them the opportunity to consider undertaking their own investigations with regards to the conduct of the specific individual involved. Such relationships and professional working practices will continue through the current working period, and continued liaison will remain for cases carried forward.

Communication and awareness development have been utilised on a targeted basis throughout the year. Training was provided to high-risk staff groups such as Procurement, Medical and Nursing teams, which includes Overseas Nurses and Doctors, and the Estates and IT directorates. This sits alongside the mass awareness programme which utilised mass communications to deliver the counter fraud message via face-to-face awareness events, e-newsletters, social media, global email system, staff alerts and bulletin board.

There has been a notable increase in the number of staff contacting the Counter Fraud Team to request advice and assistance in relation to concerns around risk or system weaknesses. This meets the intended strategy of evolving the Team from being a contact to report 'when things go wrong', to a contact point to reach out to for mitigation advice and support.

The LCFS has continued to support the Corporate Governance Team in raising awareness around the requirements of the Standards of Behaviour Policy. Specifically, the requirement around Declaration of Interests and Gifts, Hospitality and Sponsorship.

The LCFS continue to work closely with NHS CFS Wales Regional Team to provide appropriate information and to liaise on all referrals with particular use made of the financial investigation capabilities of the Regional Team including use of Proceeds of Crime Act powers. Casework was reported on a quarterly basis for the NHS Counter Fraud Authority to monitor activity nationally.

Liaison between both internal and external auditors has been maintained, in conjunction with regular review of Audit Papers submitted by internal audit via ARAC. In addition, the Local Counter Fraud Champion and Board Secretary provides a governance link to the Counter Fraud Department, raising any concerns when appropriate.

Updates are presented and reviewed where audit reveals a potential fraud risk or system vulnerability for the Counter Fraud Team to assess. The key focus has been retained with fraud awareness and the improvement of early involvement of the Counter Fraud officers through partnership working as main priorities.

The application of recommendations identified at the conclusion of each Counter Fraud investigation is also considered essential in reducing the opportunities for loss through fraud; to this end, a greater emphasis has been placed on the monitoring and progression of Counter Fraud Recommendations during 2024/25, including the monitoring of Risk Themes and actions undertaken by directorates to address any weaknesses.

Greater communication between the LCFS and external organisations has continued to result in improved levels of intelligence, in accordance with Data Protection and legal sharing provisions, including greater collaboration between the Police and NHS Wales Shared Services Partnership (NWSSP) functions, such as Post Payment Verification (PPV). There has been an increase in partnership working between the Police and LCFS, which has resulted in the serving of 3 Police Cautions.

The Counter Fraud Team has taken a proactive approach to fraud risks throughout 2024/25, responding to emerging risks when required. This includes the identification and completion of several Local Proactive Exercises, which have been promoted throughout the year.

NHS Counter Fraud Authority Thematic Assessments linked to Procurement processes undertaken in Quarter 2 and 3 and reported to ARAC in October 2024, which involved Counter Fraud, in partnership with procurement, reviewing:

- 10 SFI breaches linked to ongoing contracts / requisitions.
- 6 contracts from a contract due diligence / contract management perspective.
- 10 requisitions which were not compliant with the No PO No Pay Policy.

Advice has also been provided for managers, patients, contractors, and staff when required, and the service is able to demonstrate that it is an asset for improving systems, as well as applying appropriate sanctions where those systems may have been abused.

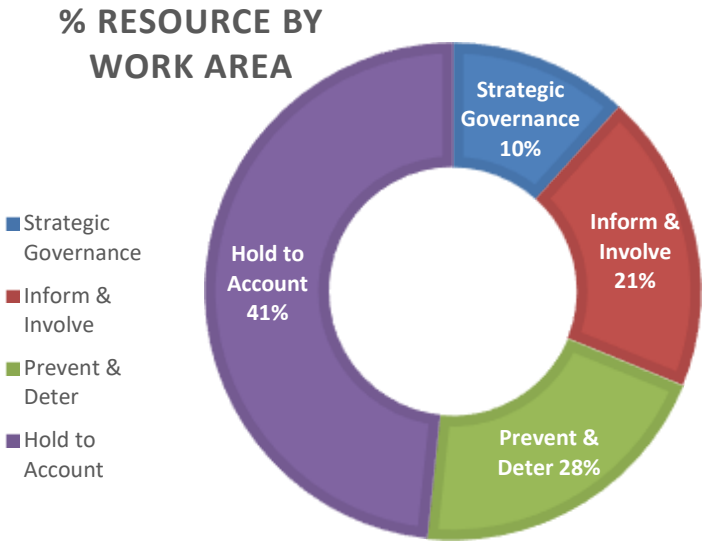
Policy and departmental documentation reviews have been completed as a matter of routine during all enquiries, and fraud proofing advice offered and implemented where required. A renewed focus on this type of counter fraud activity is being driven by the NHS Counter Fraud Authority.

Fraud alerts and staff alerts around Counter Fraud have been frequently issued, including fraud and drug alerts, utilising a variety of mediums to deliver such messages. These include staff briefings, global email, MS Sway newsletters, and occasionally social media platforms. The drug fraud alerts have also been subject to review and agreed actions through a structured delivery approach, with the LCFS sitting on the Local Intelligence Group for the region, alongside partners both internally and externally.

Applicable sanctions have been successfully utilised by the Counter Fraud team in its dealings with alleged fraud, bribery, or corruption. Evidence of criminal, civil and disciplinary sanctions can be demonstrated, ensuring that resource is put to best use. Sanctions are also essential in acting as effective deterrents.

This year has also seen the Lead LCFS, and Fraud Champion engage on a regular basis, enabling greater discussion of Fraud Risks and collaboration between both the Counter Fraud Department and the Corporate Governance Directorate.

Area of Activity Overview



As per previous years, the 2024/25 work overview illustrates how a significant amount of work activity fell around the area of Hold to Account; however, there has been a slight decrease in time spent investigating crimes, with a shift towards more time being spent on proactive activities. It is hoped that this trend will continue, to a point where we are able to prevent more than we investigate.

3 Welsh Government Direction

The following grid identifies the key requirements under Welsh Government (WG) Directions July 2006 and outlines current activity within each section. The table illustrates that, in line with WG directions, supported through compliance with the standards for Wales, Hywel Dda University Health Board Counter Fraud provision is illustrating positive performance in delivery of its Counter Fraud Strategy.

Para.	Instruction	Action taken by health body
2 (1)	Each NHS body must take all necessary steps to counter fraud in the NHS in accordance with these Directions and in accordance with. (a) the NHS Counter Fraud and Corruption Manual; and (b) the policy statement "Applying appropriate sanctions consistently" published by the CFS, (c) and having regard to guidance or advice issued by the CFS.	**Achieved**
2 (2)	Each NHS body must require its Chief Executive and Director of Finance to monitor and ensure compliance with these Directions.	**Achieved**

Para.	Instruction	Action taken by health body
3 (1)	Each NHS body must co-operate with the CFS to enable the CFS efficiently and effectively to carry out its counter fraud functions and in particular each NHS body must, subject to the following paragraphs of this direction. (a) enable the CFS to have access to its premises. (b) put in place arrangements which will enable the CFS to have access, as appropriate, to the NHS body's staff; and (c) supply such information including files and other data (whether in electronic or manual form) as the CFS may require for the purposes of the CFS counter fraud functions.	**Achieved**
3 (2)	In the case of information required under paragraph (1)(c) in connection with the CFS responsibility for quality inspection, fraud measurement, National Proactive Exercises (NPEs) and fraud prevention reviews, inspections and instructions, an NHS body must respond to any request from the CFS as soon as reasonably practicable.	**Achieved**
3 (3)	In the case of information required under paragraph (1)(c) for the purposes of investigations relating to the CFS' counter fraud functions, an NHS body must respond to a request as soon as reasonably practicable and in any event within seven days from the date the request was made.	**Achieved**

Para.	Instruction	Action taken by health body
3 (4)	Nothing in paragraph 1(b) contravenes any right a member of staff may otherwise have to refuse to be interviewed.	**N/A**
3 (5)	Nothing in paragraph 1(c) or direction 7(f) obliges or permits an NHS body to supply information which is prohibited from disclosure by or under any enactment, rule of law or ruling of a court of competent jurisdiction or is protected by the common law.	**N/A**
3 (6)	Without prejudice to the generality of direction 2(1)(a), each NHS body must comply with the requirements specified in the NHS Counter Fraud and Corruption Manual concerning. (a) the arrangements for reporting fraud cases to the LCFS and to the NHS body's audit committee and auditors. (b) the arrangements for agreeing to undertake a criminal prosecution and to refer a matter to the police. (c) the confidentiality of information relevant to the investigation of suspected fraud. (d) the arrangements for the LCFS to report weaknesses in fraud related systems to the CFS and the NHS body's audit committee and auditors; and (e) the arrangements for gathering information to enable the Director of Finance to seek recovery of money lost through fraud.	**Achieved**
5 (1)	Each NHS body must nominate at least one person that it proposes to appoint as the body's LCFS within six weeks of the date on which these Directions come into force.	**Achieved**

Para.	Instruction	Action taken by health body
5 (2)	A person nominated under paragraph 5(1) may be either employed by the NHS body or a person whose services are supplied to it by an outside organisation.	**Achieved**
5 (3)	The name of the nominee must be notified to the CFSMS together with the information specified in the NHS Counter Fraud and Corruption Manual within 7 days of the nomination.	**Achieved**
5 (4)	Without prejudice to the generality of direction 2(1), before making a nomination each NHS body must consider any guidance issued by the CFSMS on the suitability criteria for an LCFS.	**Achieved**
5 (5)	After a nominee has. (a) been approved by the CFS as a person suitable for appointment. (b) successfully completed any training required by the CFS; and (c) been accredited by the Counter Fraud Professionals Accreditation Board, the NHS body may appoint the person as its LCFS.	**Achieved**

Para.	Instruction	Action taken by health body
5 (6)	Where an NHS body nominates a person, whose services are provided to it by an outside organisation, it must: (a) comply with the requirements of the CFS as to the suitability of the organisation in question. (b) satisfy itself and the CFS that the terms on which those services are provided are such as to enable the LCFS to carry out his functions effectively and efficiently and in particular that he will be able to devote sufficient time to that NHS body; and (c) give to the CFS a copy of the contract under which the services of the LCFS are supplied to it.	**N/A**
5 (7)	A further nomination must be made within 3 months of the date on which an NHS body learns that there is to be a vacancy for an LCFS.	**N/A**
5 (8)	The procedures in paragraphs (3) to (6) also apply to a person nominated under paragraph (7).	**Achieved**
6 (1)	Each NHS body must specify a job description for its LCFS which includes the operational and liaison responsibilities specified by the CFS.	**Achieved**
6 (2)	The job description under paragraph (1) must include a requirement that the LCFS must adhere to the CFPAB Principles of Professional Conduct as set out in the NHS Counter Fraud and Corruption Manual.	**N/A**

Para.	Instruction	Action taken by health body
6 (3)	An LCFS must report directly to the NHS body's Director of Finance.	**Achieved**
6 (4)	An LCFS must not undertake responsibility for or be in any way engaged in the management of security for any NHS body.	**Achieved**
7	Each NHS body must. (a) require that in addition to the job description mentioned in direction 6(1), the LCFS and the Director of Finance agree, at the beginning of the financial year, a written work plan which outlines the LCFS's projected work for that financial year by reference to the seven generic areas of counter fraud activity set out in the NHS Counter Fraud and Corruption Manual.	**Achieved**
	(b) enable its LCFS to attend the NHS body's audit committee meetings.	**Achieved**
	(c) require its LCFS to keep full and accurate records of any instances of fraud or suspected fraud.	**Achieved**
	(d) require its LCFS to report to the CFS any weaknesses in fraud related systems of the NHS body and any other matters which may have fraud related implications for the NHS.	**Achieved**

Para.	Instruction	Action taken by health body
	(e) ensure that its LCFS has all necessary support including access to the CFS secure intranet site to enable him efficiently and effectively to carry out his responsibilities.	**Achieved**
	(f) subject to any contractual or legal constraint, require all of its staff to co-operate with the LCFS and in particular that those responsible for human resources disclose information which arises in connection with any matters (including disciplinary matters) which may have implications in relation to the investigation, prevention, or detection of fraud.	**Achieved**
	(g) enable its LCFS to receive training recommended by the CFS.	**Achieved**
	(h) require its LCFS, its other employees and any persons whose services are provided to the NHS body in connection with counter fraud work to have regard to guidance and advice on media handling of counter fraud matters which may be issued by the CFS.	**Achieved**
	(i) enable its LCFS to participate in activities in which the CFS is engaged, including national anti-fraud measures, where he is requested to do so by the CFS.	**Achieved**
	(j) enable its LCFS to work in conditions of sufficient security and privacy to protect the confidentiality of his work.	**Achieved**

Para.	Instruction	Action taken by health body
	(k) enable its LCFS generally to perform his functions effectively, efficiently, and promptly.	**Achieved**

4 NHS Counter Fraud Authority Quality Assurance Standards

NHS Counter Fraud Authority (NHSCFA) undertake an annual review of the counter fraud activity completed within the Health Board. The LCFS is required to complete a Self-Review Tool (SRT).

All NHS funded services are required to provide assurance against the Government Functional Standards 013 – Counter Fraud and NHS Requirements. This should be overseen by the organisation's finance director and audit committee, and in line with the organisation's existing approach to assurance against counter fraud requirements.

The previous NHS specific Standards have been aligned to the new NHSCFA Requirements and the four areas of activity are:

Strategic Governance - (Organisational governance / Staff Resource / Training)

Inform and involve – (Fraud Awareness / development of Anti- Fraud Culture)

Prevent and deter – (Reducing opportunity / Policy review and improvement)

Hold to Account – (Detection and investigation of Fraud / Sanctions / Criminal Process)

Area of activity	RED / AMBER / GREEN
Strategic Governance	**GREEN**
Inform and involve	**GREEN**
Prevent and deter	**GREEN**
Hold to Account	**GREEN**

Overall level	GREEN

Declaration

I declare that the counter fraud, bribery, and corruption work carried out during 2024/25 has been self-reviewed against the Government Functional Standards 013 – Counter Fraud and NHS Requirements, and that the above rating has been achieved.

Organisation	**Hywel Dda University Health Board**
Director of Finance / Chief Financial Officer / Executive Board Member Signature	
Date	
Date of last Local Counter Fraud Assessment	**31 March 2025**

4.1 Inform and Involve

The LCFS have an on-going work programme with the NHS Counter Fraud Service (Wales) to develop an Anti-Fraud Culture within the NHS. There is an anti-fraud, bribery and corruption policy in place that outlines the responsibilities of staff in countering Fraud and corruption within HDdUHB.

Fraud awareness materials and presentations have been provided in a variety of different formats, to include an Induction leaflet and Mandatory ESR E-Learning package to new starters, Student placements, Medicine Safety Days, Finance, General Practitioners, Opticians, Pharmacists and Medical Staffing Groups, including Overseas Doctors.

Bespoke virtual and face to face Counter Fraud learning has been provided to targeted staff groups, identified as higher risk of contact with fraud, such as IT and the Estates Directorate, where a greater emphasis was placed on procurement related fraud risks. This training was delivered in partnership with the NWSSP Procurement team.

Evaluations of sessions have been conducted, with positive comments received regarding the value of receiving these awareness sessions. Evaluations and feedback have informed the tailoring of learning, to ensure that bespoke guidance can be offered.

Communications links have been enhanced and developed over this work period. The Counter Fraud Team now engages with employees via Viva Engage, Global messages and via Social Media Sites (via the communications team). The Team has also maintained and updated its intranet pages and has published digital newsletters via MS Sway throughout the year. This allows for a more interactive approach to delivering awareness, including utilising and embedding digital material into the documents.

This year's Fraud Awareness Week was delivered both face to face and online, with daily communications issued to both staff and the public, highlighting Fraud Risks, reporting mechanisms, and making awareness materials available.

Examples of key work areas and successful outcomes include:

- Several virtual and in person presentations conducted to staff and key contacts. Following the induction programme being taken online, the LCFS provided updated literature for dissemination.
- Current ESR Counter Fraud Mandatory Training compliance stands at 83.14%. The competency has seen a steady increase in overall compliance since its introduction in May 2021. However, as the competency is in its third year since being made mandatory, we may now start to see a drop off in compliance, due to the initial completers coming up to expiry, with the competency of 3675 staff due to expire in 2025. In view of this, at a recent Mandatory Training Review Group meeting, the decision was made to remove the requirement to renew compliance every three years.
- During 2024/25, the Counter Fraud Department has undertaken 33 awareness events, 14 deterrence exercises (including newsletters, global messages, or counter fraud activities) and 51 separate Fraud Prevention activities, which have been reported to CFS Wales throughout the year.
- The Fraud Awareness Week campaign was undertaken both in person and online, resulting in the circulation of promotional literature, placement of Fraud Reporting line details within key areas and presentations to various staff groups.
- The medicines management presentation continued online and successfully delivered to Health Board employees, raising awareness of Fraud and Health Board policies.

- Following a request by Learning and Development, the Counter Fraud Team has commenced a programme of Fraud Awareness to our Overseas Nurses and Doctors. This has resulted in presentations to every new starter in 2024/25. These sessions have not only included an input into our mission to reduce fraud within the NHS to an absolute minimum, but also provides details on identified fraud trends impacting overseas visitors, including known visa and rental type scams.

4.2 Prevent and Deter

The LCFS have effectively liaised with the Health Board's Communications Department when reporting cases or fraud trends, to ensure that a consistent approach is taken, and the message is sent out that fraud will not be tolerated within the Health Board. This resulted in the positive media coverage of a successful Fraud Case involving an overpayment of salary.

The LCFS provide reports on policy weaknesses in each case where fraud is established to both CFS Wales and relevant department within the Health Board, most recently working with Corporate Governance to review and update the Health Board's Standards of Behaviour policy.

Staff alerts displayed on the Health Board website and circulated through mass communications have also encouraged engagement and demonstrated real advantages to maintaining an anti-fraud culture. There has been a significant increase throughout the year in staff seeking advice and guidance to reduce the risk of fraud in their respective areas of work. This represents a shift from the Counter Fraud Team being viewed as a contact point for referral of information for investigation, to an asset to be utilised to prevent fraud from occurring.

The LCFS has also undertaken fraud-proofing of internal policies and procedures, both during the Global Consultation of such policies but also in response to fraud risks.

Following the recommencement of the Post Payment Verification (PPV) workplan, the LCFS has continued to monitor reports with the relevant Primary Care Lead officers. Further collaborative work is being undertaken with bi-monthly meetings at an all Wales and local level. This has resulted in the identification of Fraud Case and subsequent Civil Recovery.

The LCFS has undertaken several Pro-Active exercises, some of which were linked to identified risks, these included:

- Lease Car Usage.

- Procurement – Contract Splitting. This exercise has been rolled over into 2024/25 as part of the Counter Fraud Authority's National Thematic Exercise into Procurement.
- Declarations of Interest compliance.
- Right to work.
- Impersonating Medical Professionals.
- Roster compliance.

The Counter Fraud team has continued to participate in the National Fraud Initiative (NFI), updating privacy notices and submitting data for the 2025 exercise and carrying out checks across matched data reports. The work has also supported other Public Sector Organisations in their NFI activity and will continue to do so into the 2025/26 year.

Fraud Risk Assessments have been undertaken throughout the year, the findings of which have been discussed with relevant leads. Although these assessments produced low scores, they have identified current control measures, which can be tested by way of future pro-active exercises.

4.3 Hold to Account

The LCFS has continued to work with internal and external audit services, alongside payroll and workforce leads, to ensure that counter fraud work was carried out in accordance with the Counter Fraud Strategy.

The LCFS receives information from several sources and processes are in place to ensure referrals are prioritised and investigated. As part of the required reporting processes, all notified concerns are reported utilising the Counter Fraud Authorities crime reporting system, Clue3.

Clue3 ensures the effective and secure recording of sensitive information relation to ongoing investigation. The system will allow for users to accurately document the types of investigations being undertaken, outcomes and systems weaknesses at an all-Wales level. This will enable the Counter Fraud Authority to release more accurate benchmarking and trend analysis data in the future (it is anticipated that such data will be made available in 2025/26).

In addition, the system will allow users to record data associated with pro-active exercises undertaken at a local level, including any fraud risks identified and potential savings produced. This information will allow the Counter Fraud Authority to demonstrate a financial

value associated with Pro-active work, something which has been difficult to demonstrate over the years.

Update reports on current case positions have been supplied to ARAC on a bimonthly basis. The reports are discussed during the In-Committee section of the meeting, to ensure confidentiality of investigation and fairness to investigation subjects. An end of year report has been supplied alongside this report for discussion during the In-Committee meeting.

During 2024/25, the Counter Fraud Team carried over 12 active cases from the previous year, and received and recorded 55 new referrals; of which 56 investigations were reviewed and closed. 11 cases will remain open and under review at the end of this financial year and will be carried over into the next. Of these 11, 7 are at the stage where a Voluntary Interview Under Caution (VIUC) has either been completed or awaiting completion.

Of the investigations that were closed, 4 criminal sanctions were applied, including 1 successful prosecution at Aberystwyth Magistrates Court and 3 Police Cautions. A further 12 civil sanctions were instigated, including the recovery of funds totalling £56,106 and 8 internal disciplinary referrals. Of the 8 internal disciplinary referrals, 2 members of staff resigned prior to the completion of proceedings and 4 members of staff received written warnings. This is in addition to the proactive activities undertaken and reported throughout the year.

4.4 Strategic Governance

The Counter Fraud Work Plan agreed with the Director of Finance was presented to ARAC and quarterly monitoring reports submitted for information.

Meetings with Health Board Senior Managers have continued and the identification of further areas of risk from a local perspective, with the application of their professional experience within the Health Board, has been achieved.

The LCFS attended both Wales Counter Fraud Conferences, where further training was received in accordance with CFA requirements.

Submission of the return for NHS Counter Fraud Authority Quality Assurance Assessment was made within the due deadline. Throughout the year, quarterly returns for WG and NHS Counter Fraud Authority in relation to investigation statistics were provided.

The necessary support has been received from the Health Board, allowing LCFS to perform their functions effectively. Continued training for specialist delivery has been maintained for all staff.

Regular contact has been maintained between the Lead LCFS and Fraud Champion throughout the year, ensuring a top-down approach to developing an effective Counter Fraud Culture within the organisation.

5 Conclusion

The Health Board's Counter Fraud provision has demonstrated compliance with the requirements of the Welsh Government Directions to NHS Bodies on Counter Fraud Measures.

The overall green rating from the Quality Assurance assessment (SRT), demonstrates the continued efforts from the LCFS in working in an innovative way to achieve a balance of both reactive and proactive work to meet the NHS Counter Authority's Standards.

A key strategy from previous years has been to change the view amongst the wider Health Board of the Counter Fraud Team, from being a reactive unit for referral and investigation, to a proactive unit purposed to prevent fraud and reduce fraud risk. This is showing signs of taking effect, with increased contact seeking advice and assessment. This strategy will continue, whilst being mindful that the message around the importance of investigation should not be lost.

The Counter Fraud Team can demonstrate a continued trajectory of improvement across the service, with continued success shown across key measurables. Key areas of work for next year will be to maintain focus on inform and involve, continuing to raise awareness of Fraud, Bribery and Corruption and further embedding a counter fraud culture fostered over preceding years as well as further developing work associated with Prevent and Deter, including building on Fraud Risk Analysis, identifying specific Fraud Risk based proactive exercises and recording outcomes on Clue3 against the Government Functional Standards 013 – Counter Fraud and NHS Requirements.

The Health Board's counter fraud provision has demonstrated compliance with the requirements of the Welsh Government Directions to NHS Bodies on Counter Fraud Measures.

Ben Rees
Lead Local Counter Fraud Specialist
Hywel Dda University Health Board
For presentation to Audit and Risk Assurance Committee: 15 April 2025.

Appendix - Case and Sanction Information Overview

Case Information	Number
Cases carried forward from previous year	12
Cases opened during period	55
Cases closed in period	56
Cases ongoing	11

Sanction Imposed	Number
Disciplinary referrals	8
Civil	12
Criminal	4

7.3

12:25, 5 Mins

7.3 - Counter Fraud Work Plan 2025/26

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

For approval

Attachments

7.3 SBAR Counter Fraud Work Plan.pdf

7.3 Counter Fraud Work Plan 2025-26.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:	15 April 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Counter Fraud Work Plan 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Ben Rees, Head of Counter Fraud

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

NHS bodies in Wales must implement anti-fraud, bribery and corruption measures in accordance with Government Directions on Counter Fraud Measures and the service agreement under section 83 of the Government of Wales Act 2006. As well as the Welsh Government directions, NHS bodies are also obliged to demonstrate compliance with NHS Counter Fraud Authority Requirements of the Government Functional Standard GovS 013: Counter Fraud.

This document provides to Audit and Risk Assurance Committee the Counter Fraud Work Plan which sets out the intended actions for 2025/26. The Work Plan is devised to address identified fraud risks and to ensure compliance with both the Government Functional Standards 013 - Counter Fraud (GovS 013) and Welsh Government Directions to NHS Bodies on Counter Fraud Measures.

The workplan refers to a draft Self-Review Assessment, which has been undertaken and which has been submitted to the Committee as a separate item.

Cefndir / Background

Main Report:
To evidence the provision of services within a sound governance framework and provide a basis and strategic direction for counter fraud work in 2025/26.

Asesiad / Assessment

Main Report:
The Work Plan presented covers all aspects of applicable standards and directions as well as encompassing work around identified fraud risks. Contingency is built into the Plan to ensure response to emerging fraud risks.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is requested to **APPROVE** the Counter Fraud Work Plan 2024/25.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.2 In particular, the Committee will review the adequacy of: 3.2.4 the policies and procedures for all work related to fraud and corruption as set out in National Assembly for Wales Directions and as required by the Counter Fraud and Security Management Service.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	3. Effective 4. Efficient
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Striving to deliver and develop excellent services 6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	2024/25 Counter Fraud Annual Report
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.

Counter Fraud Work Plan 2025/26

Benjamin Rees
Head of Counter Fraud Services

15 April 2025

Introduction

The Health Board employs 2 full time Accredited, Local Counter Fraud Specialists (LCFS) within the Counter Fraud Team to operationally deliver the obligations for countering fraud bribery and corruption. Each LCFS is employed on a permanent full-time basis, which after annual leave deductions allows for 440 working days per annum.

In line with the Welsh Government Directions on Counter Fraud Measures, the counter fraud work undertaken by the Counter Fraud Team is set around four key principles:

Key Principle 1: Strategic Governance – to ensure that Strategic Governance arrangements are in place to ensure that Anti-Crime measures are embedded at all levels across the organisation. Good communication with Senior Staff within key staff areas as well as regular attendance and oversight from the Audit and Risk Assurance Committee will continue.

Key Principle 2: Inform and Involve – to raise awareness of fraud risks against the Health Board with the overall aim to have a workforce that is fraud aware, vigilant, and intolerant of fraud bribery and corruption in the NHS. Effective use of multi-media channels to reach staff across the Health Board will be vital to effective delivery of this principle.

Key Principle 3: Prevent and Deter – to utilise all available means to identify and mitigate anomalies indicative of fraud and to produce a 'fraud-proofed' environment to discourage individuals who may be tempted to commit fraud against the NHS and ensure that opportunities for fraud to occur are minimised.

Key Principle 4: Hold to Account – to ensure that all suspicions of fraud are investigated in a timely, professional manner and that all appropriate sanctions and redress actions are applied to send the message that fraud against the Health Board will not be tolerated.

NHS bodies in Wales must implement anti-fraud, bribery, and corruption measures in accordance with Government Directions on Counter Fraud Measures and the service agreement under section 83 of the Government of Wales Act 2006. As well as the WG directions, NHS bodies are also obliged to demonstrate compliance with the Government Functional Standards 013 - Counter Fraud (GovS 013). A self-review assessment against each of the standards is completed on an annual basis using a RAG rating system. Areas that will require development have been identified as:

NHS Requirements Government Functional Standard 013 Counter Fraud (GovS 013) Component 3, Requirement 3 – Fraud bribery and corruption risk assessment. This is an area that has continued to be developed throughout 2024/25 and a review of the current reporting mechanism for reporting and recording Fraud Risks has been undertaken in partnership with Assurance and Risk.

The Government Functional Standards and NHS Requirements to meet those standards are available in full at https://cfa.nhs.uk/government-functional-standard/NHS-requirements.

This work plan has been developed to maintain the areas of work in which the Health Board is already strong, improve in the areas of potential weakness and ensure overall alignment to the GovS 013 standards. Where a Work Plan action is directly applicable to a Standard Component, these have been referenced (GovS 013 component X).

INFORM AND INVOLVE			
	TASK/OBJECTIVE	**GOVERNMENT FUNCTIONAL STANDARD**	**PROPOSED DELIVERY**
1	Design and deliver a programme of counter fraud awareness presentations to staff at all levels within the Health Board, including participation in the Health Board induction and Managers' Passport programme, with the aim of ensuring that the organisation is proactive in raising fraud awareness and building an anti-fraud culture. Review and maintain materials and media used. Evaluate presentations, collate results, and amend presentations in line with feedback received.	GovS 013 component 11	Throughout the Year
2	Undertake a suitable exercise to identify the level of fraud awareness within the organisation utilising compliance data associated with ESR Mandatory Training and further develop communications / learning in areas of low compliance.	GovS 013 component 11	Q1

COUNTER FRAUD WORK PLAN 2025/26

INFORM AND INVOLVE			
	TASK/OBJECTIVE	**GOVERNMENT FUNCTIONAL STANDARD**	**PROPOSED DELIVERY**
3	To develop and maintain the counter fraud information contained on the Health Board intranet site and Newsletter, to include details of successfully prosecuted Counter Fraud cases – both local and national.	GovS 013 component 11	Q2 and Q4
4	Enhance awareness of the Health Board's "Counter Fraud" Policies, and promote the correct lines for reporting fraud, bribery, or corruption (including the freephone Fraud, Bribery and Corruption Reporting Line, online reporting tool and local reporting mechanisms).	GovS 013 component 11	Throughout the Year
5	Engage with the Health Board's Learning and Development department to monitor compliance and promote the Counter Fraud mandatory E-Learning package.	GovS 013 component 11	Throughout the Year
6	Arrange for pay-slip messages to be utilised during the year as appropriate.	GovS 013 component 11	As Appropriate
7	Publish a Counter Fraud Newsletter and Viva engage posts to raise awareness of key issues and Fraud risks.	GovS 013 component 11	Throughout the year
8	Utilise findings from fraud risk assessments to inform delivery of counter fraud training to business areas of higher risk of exposure to fraud.	GovS 013 component 7 and 12	Throughout the Year
9	Undertake targeted surveys of staff to measure awareness of: Counter Fraud, Bribery and Corruption Policy and Response Plan. Fraud, Bribery and Corruption incident reporting routes; and Policy and procedures relating to Conflicts of Interests, Gifts and Hospitality.	GovS 013 component 4, 7 and 12	Q1

COUNTER FRAUD WORK PLAN 2025/26

INFORM AND INVOLVE			
	TASK/OBJECTIVE	**GOVERNMENT FUNCTIONAL STANDARD**	**PROPOSED DELIVERY**
10	Engage with the NHS Counter Fraud Services Wales / The Counter Fraud Authority to develop awareness materials focusing on identified trends, with a view of disseminating the information to staff via global messaging systems.	GovS 013 component 11	Q1 and 2
	TOTAL DAYS ALLOCATED		**85**

PREVENT AND DETER			
	TASK/OBJECTIVE	**GOVERNMENT FUNCTIONAL STANDARD**	**PROPOSED DELIVERY**
11	Review key organisational policies, procedures, and documents, to ensure that they are adequately robust in terms of counter fraud. The communication of revised policies, procedures, and documents as appropriate, emphasising the organisational commitment to countering fraud.	GovS 013 component 3 and 10	As Appropriate
12	Conduct risk analysis in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology. Record and manage assessed risk in line with the Health Board's Risk Management policy and include on the risk registers where appropriate.	GovS 013 component 3	Throughout the Year
13	Develop a fraud risk profile from risk assessment work to effectively evaluate, evidence, and measure the effectiveness of counter fraud work in mitigating and reducing fraud risk or expenditure and influencing of policy and procedure aimed at reducing fraud.	GovS 013 component 2 and 5	Throughout the Year

COUNTER FRAUD WORK PLAN 2025/26

PREVENT AND DETER			
	TASK/OBJECTIVE	**GOVERNMENT FUNCTIONAL STANDARD**	**PROPOSED DELIVERY**
14	Review existing fraud risk assessments with Risk Owners.	GovS 013 component 2, 3 and 5	Throughout the Year.
15	Use National Fraud Initiative data, which matches payroll records to creditors and suppliers, to undertake a proactive exercise to measure compliance with the conflicts of interest policy.	GovS 013 component 10 and 12	Q1
16	Maintain regular contact with the Head of Internal Audit (NWSSP Audit and Assurance)	Service level requirement	Throughout the Year
17	Record and respond to ad-hoc requests for assistance received.	Service level requirement	Throughout the Year
18	Action Fraud Prevention Notices issued by NHS Counter Fraud Authority and/or Counter Fraud Services Wales as and where appropriate.	GovS 013 component 3	As Appropriate
19	Issue fraud alerts to all appropriate staff.	GovS 013 component 11	As Appropriate
20	Maintain regular liaison with the Post Payment Verification Location Manager (NWSSP Primary Care) and Primary Care leads to ensure that any contractor visits which result in the identification of anomalies are reported to the LCFS.	Service level requirement	Throughout the Year
21	Participate in mandatory national proactive exercises, as instructed by NHS Counter Fraud Authority, Auditor General for Wales and/or the Cabinet Office (e.g., NFI).	GovS 013 component 10	Throughout the Year
22	Participate in thematic fraud risk evaluation exercises as instructed by the NHS Counter Fraud Authority.	GovS 013 component 10	As Required

COUNTER FRAUD WORK PLAN 2025/26

PREVENT AND DETER			
	TASK/OBJECTIVE	**GOVERNMENT FUNCTIONAL STANDARD**	**PROPOSED DELIVERY**
23	Conduct proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery, and corruption. Results of this work will be recorded on Clue3, evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery, and corruption. Any losses, recoveries or savings are to be identified and reported (data metrics). Areas of work will be linked to both locally and nationally identified risks which will be evidenced within Clue3 by way of referencing a Risk Assessment, FPN or Investigation.	GovS 013 component 10	Throughout the Year
24	Membership of Local Intelligence Network and attendance at meetings.	Service level requirement	As Required
25	Provide outturn reports for managers to recommend appropriate action following any weaknesses identified through investigative work. Monitor and report findings to the Director of Finance / Audit and Risk Assurance Committee.	Service level requirement	As Required
26	Periodically review the Risk Register for entries which may have a fraud or corruption bearing.	GovS 013 component 3 and 10	Throughout the Year
	TOTAL DAYS ALLOCATED		**130**

COUNTER FRAUD WORK PLAN 2025/26

HOLD TO ACCOUNT			
	TASK/OBJECTIVE	**GOVERNMENT FUNCTIONAL STANDARD**	**PROPOSED DELIVERY**
31	Conduct investigations into all allegations of economic crime as required, in line with the requirements of the NHS Counter Fraud Authority Counter Fraud Manual, and all relevant guidance and legislation.	GovS 013 component 9	As Required
32	Appropriate use of Clue3, the prescribed case management system, in line with NHS Counter Fraud Authority and NHS CFS Wales requirements.	GovS 013 component 6 and 8	As Required
33	Assist the NHS CFS with information as required for any regional or national fraud cases. Ensure comprehensive information to enable risk exercises to be carried out effectively is submitted in a timely manner.	GovS 013 component 9	As Required
34	Ensure the application of sanctions in line with legislation and the policy document 'Applying Appropriate Sanctions Consistently.'	GovS 013 component 6 and 9	As Required
35	Identify and maintain appropriate records and, wherever possible, seek financial redress/recovery in respect of any proven loss to the Health Board, having due regard to the circumstances of each case.	GovS 013 component 6 and 8	As Required
36	Review professional competencies and capabilities of accredited staff nominated to undertake the full range of counter fraud work to assess requirements for professional development opportunities.	GovS 013 component 9	Q1
37	Undertake review of information held, stored, and processed in relation to case files and evidence store.	Service level requirement	As required
38	Provision of information via Clue3 and secure information exchange channels to enhance national intelligence sharing.	GovS 013 component 6 and 9	As Required

COUNTER FRAUD WORK PLAN 2025/26

HOLD TO ACCOUNT			
	TASK/OBJECTIVE	**GOVERNMENT FUNCTIONAL STANDARD**	**PROPOSED DELIVERY**
39	Maintain an appropriate and correct interaction with NHS CFS Wales regarding the conduct and progression of an investigation.	GovS 013 component 9	As Required
	TOTAL DAYS ALLOCATED		**185**

STRATEGIC GOVERNANCE			
	TASK/OBJECTIVE	**GOVERNMENT FUNCTIONAL STANDARD**	**PROPOSED DELIVERY**
40	Attendance at all Fraud Forum meetings held by CFS Wales.	Service level requirement	As Required
41	Maintain regular contact with the Health Board's Fraud Champion.	GovS 013 component 1	Throughout the Year
42	Completion and agreement of the annual work plan and annual report with the Director of Finance or nominated deputy.	GovS 013 component 2	Q4
44	Regular meetings/liaison with Director and/or Assistant Director of Finance	GovS 013 component 1	Throughout the Year
45	Preparation for and attendance at Audit Committee meetings.	GovS 013 component 1	As Required
46	Full participation in the quality assurance process as directed by NHS Counter Fraud Authority	Service level requirement	Q4 and As Required

COUNTER FRAUD WORK PLAN 2025/26

STRATEGIC GOVERNANCE			
	TASK/OBJECTIVE	**GOVERNMENT FUNCTIONAL STANDARD**	**PROPOSED DELIVERY**
47	Undertake additional training as required by the Health Board or NHS Counter Fraud Authority.	Service level requirement	As Required
48	Ensure that all Fraud, Bribery, and Corruption investigative and proactive activity, including all outcomes, recoveries and system weaknesses identified during investigations and/or proactive prevention and detection exercise are recorded on Clue3.	GovS 013 component 8	Q1 and Throughout the Year
49	Provide regular reports and *ad hoc* information to NHS Counter Fraud Authority and Welsh Government as required	Service level requirement	Throughout the Year
50	Review the Health Board's Counter Fraud Policy and Response Plan to ensure up to date and relevant contents as well as alignment to Government Functional Standards.	GovS 013 component 4 and 7	Q1
51	Provide relevant data to CFS Wales on a quarterly basis to allow for the reporting and analysis of reported incidents of fraud, bribery and corruption, the value of identified fraud losses, the value of fraud recoveries, the value of fraud prevented, criminal sanctions and disciplinary sanctions.	GovS 013 component 6	Quarterly.
52	Record and report on Investigation Recommendations to both Department leads and the Audit Committee, tracking relevant recommendations via the Corporate Governance Team, who will assist in tracking recommendations and reporting back compliance to the committee.	GovS 013 component 1, 5, 8 and 10	Throughout the Year
	TOTAL DAYS ALLOCATED		**40**

SUMMARY TOTALS

COUNTER FRAUD WORK PLAN 2025/26

	STRATEGIC AREA OF ACTIVITY	RESOURCE ALLOCATED (in days)
A	**INFORM AND INVOLVE**	85
B	**PREVENT AND DETER**	130
C	**HOLD TO ACCOUNT**	185
D	**STRATEGIC GOVERNANCE**	40
	TOTAL	**440**

Conclusion

Key areas of work for this year will be a focus on Inform and Involve and awareness raising to further embed the culture fostered over preceding years, as well as further developing areas of work associated with Prevent and Deter, including building on Fraud Risk Analysis, identifying specific fraud risk-based proactive exercises and recording outcomes on Clue3.

Overall, this work plan has been developed in response to identified fraud risks, offences under the Fraud Act 2006, the new offence of Failure to Prevent Fraud under the Economic Crime and Corporate Transparency Act 2023, and in line with the Health Board's obligations derived from the Welsh Government Directions on Counter Fraud Measures and the Welsh Government Directions on Counter Fraud Measures. The actions contained therein are aimed at reducing fraud, bribery, and corruption within the Health Board to an absolute minimum and embedding an anti-fraud culture.

It is recommended that the Committee ***approve*** the work plan as presented.

Huw Thomas
Director of Finance

Ben Rees
Head of Counter Fraud Services

7.4

12:30, 5 Mins

7.4 - NHS Counter Fraud Authority Draft SRT Return

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

For information

Attachments

7.4 SBAR Counter Fraud SRT.pdf

7.4 Draft Review of NHS Requirements Government Functional Standards.pdf

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	15 April 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Counter Fraud Draft review of NHS Requirements Government Functional Standards
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

NHS bodies in Wales must implement anti-fraud, bribery, and corruption measures in accordance with Government Directions on Counter Fraud Measures and the service agreement under section 83 of the Government of Wales Act 2006.

As well as the Welsh Government directions, NHS bodies are also obliged to demonstrate compliance with NHS Counter Fraud Authority Requirements of the Government Functional Standard GovS 013: Counter Fraud. A self-review assessment against the standards is completed on an annual basis using a RAG rating system.

This report provides to the Audit and Risk Assurance Committee the Counter Fraud Draft review of NHS Requirements Government Functional Standards.

The report will present a breakdown as to how each requirement is met and the review rating applied. The Assessment provides an overall rating of Green, with one identified area of improvement.

Please note – the Counter Fraud Authority has imposed a word count limit; as such, abbreviations have been used throughout.

Cefndir / Background

To evidence the provision of services within a sound governance framework in line with the Government Functional Standards 013 – Counter Fraud and NHS Requirements.

Asesiad / Assessment

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

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is requested to **RECEIVE FOR INFORMATION** this draft report, prior to it being submitted via the Counter Fraud Authority.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.2 In particular, the Committee will review the adequacy of: 3.2.4 the policies and procedures for all work related to fraud and corruption as set out in National Assembly for Wales Directions and as required by the Counter Fraud and Security Management Service.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	3. Effective 4. Efficient
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Striving to deliver and develop excellent services 6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Counter Fraud Workplan 2024/25
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.

COUNTER FRAUD, BRIBERY & CORRUPTION

HYWEL DDA UNIVERSITY HEALTH BOARD

Review of NHS Requirements Government Functional Standards - 013 Counter Fraud

Overall Rating – GREEN

To be submitted to the Counter Fraud Authority.

Counter Fraud Functional Standard Return – Organisational Information	Comments
Name of the organisation	HYWEL DDA UNIVERSITY LHB
Annual budget of the organisation	Over £1 billion.
Staff headcount at the organisation including contracted employees	10,000 to 15,000
Organisation code	7A2
Organisation / provider type	Health Board
Co-ordinating Commissioner for this provider	WALES
Region	WALES
NHS England Region	WALES
The STP / ICS that the organisation belongs to	WALES
Name of the member of the executive board or equivalent body responsible for overseeing and providing strategic management	Mr Huw Thomas
Name and email of the Local Counter Fraud Specialist	Mr Benjamin Rees
Email of the Local Counter Fraud Specialist	Benjamin.Rees2@Wales.nhs.uk
Name of the counter fraud provider organisation (including in-house)	In House
Counter Fraud provide type	WALES
Name of the Chair of the Audit Committee	Rhodri EVANS
Email of the Chair of Audit Committee	Rhodri.Evans7@wales.nhs.uk
Pro-active days used	254
Reactive days used for counter fraud work	176
Total days used for Counter Fraud work	430
Cost of Counter Fraud staffing per financial year – Pro-active	£116,319
Cost of Counter Fraud staffing per financial year – Reactive	£80,599
Total costs for Counter Fraud work	£196,918
Number of referrals received during the most recent financial year	55
Number of cases opened during the most recent financial year	55
Number of cases closed during the most recent financial year	56
Number of cases open as at 31/03/2024	11
Amount of fraud losses identified during the most recent financial year	£64273
Amount of fraud losses recovered during the most recent financial year	£64273
Amount of fraud losses prevented from reactive work during the most recent financial year	£64273
Number of criminal sanctions applied during the year	4
Number of civil sanctions applied during the year	12
Number of disciplinary sanctions applied during the year	8 referrals made.

Functional Standard		Rating	Comments
NHS Requirement 1A	A member of the executive board or equivalent body is accountable for provision of strategic management of all counter fraud, bribery, and corruption work within the organisation. The accountable board member is responsible for the provision of assurance to the executive board in relation to the quality and effectiveness of all counter fraud bribery and corruption work undertaken. The accountable board member is responsible for ensuring that nominations to the NHSCFA for the accountable board member, audit committee chair and counter fraud champion are accurate and that any changes are notified to the NHSCFA at the earliest opportunity and in accordance with the nominations process.	**GREEN**	The UHB's Chief Executive Officer (CEO) and Director of Finance (DoF) are responsible for ensuring there are appropriate arrangements to counter fraud, and that procedures for dealing with suspected cases are complied with. The DoF is the delegated person responsible for providing strategic management on all aspects of economic crime. This is evidenced by the preparation of the antifraud, bribery and corruption work plan, agreement of the annual Self Review Tool (SRT), along with counter fraud annual report and progress reports presented on a quarterly basis to Audit & Risk Assurance Committee (ARAC). Additional to this, the LCFS presents regular updates and briefings directly to the DoF and Assistant DoF when required with clear lines of communication between all parties, allowing the DOF to engage with Exec Directors on issues involving their portfolios, ensuring appropriate action is taken where necessary. All LCFS Nominations are reviewed and approved by the DOF.
NHS Requirement 1B	The organisation’s non-executive directors, counter fraud champion or lay members and board/governing body level senior management are accountable for gaining	**GREEN**	There are clear communication lines with the Senior Health Board Management and Independent Members (IMs) by way of

Functional Standard		Rating	Comments
	assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation. The counter fraud champion understands the threat posed and promotes awareness of fraud, bribery, and corruption within the organisation. Board level evaluation of the effectiveness of counter fraud, bribery and corruption work undertaken is documented. Where recommendations have been made by NHSCFA following an engagement, it is the responsibility of the accountable board member to provide assurance to the board surrounding the progress of their implementation. The organisation reports annually on how it has met the requirements set by NHSCFA in relation to counter fraud, bribery and corruption work, and details corrective action where requirements have not been met.		regular attendance at Audit Committees (AC) which provides an opportunity for members to be updated on matters and provide input on direction. At these meetings regular update reports are presented, including any identified risks. Learning arising from LCFS work around risk reduction and investigation outcomes are shared with relevant leads and updates provided via the AC. Any arising actions are reviewed and monitored by the AC in subsequent meetings. Standards are reviewed on a regular basis and cross referenced against work undertaken. The annual report is presented to the DOF for approval and is presented to the AC for approval and assurance of meeting the standards. Additionally, as part of the Quality Assurance process, the HB undertakes a self-review (SR) to assess continued compliance. A Fraud Champion has been nominated..
NHS Requirement 2	The organisation aligns counter fraud, bribery, and corruption work to the NHSCFA counter fraud, bribery, and corruption strategy. This is documented in the organisational over-arching strategy or counter fraud, bribery, and corruption policy, and is submitted upon request. The counter fraud work plan and resource	**GREEN**	The HB has a Counter Fraud Policy & Response Plan (CFPRP) in place which includes the overall strategic aims of counter fraud work and operational response aligned to the NHSCFA counter fraud, bribery, and corruption strategy.

Functional Standard		Rating	Comments
	allocation are aligned to the objectives of the strategy and locally identified risks.		In addition, the Health Board has in operation a Standards of Behaviour Policy which incorporates professional behaviour with reference to Fraud, Corruption, and the Bribery Act. Awareness work around requirements is carried out by both the Corporate Governance Team and LCFS. Proactive work is undertaken utilising databases such as the National Fraud Initiative (NFI) to assist in measuring compliance levels. Having proactively promoted the polices there has been a demonstrable increase in returns / compliance. An annual work plan is developed in line with key objectives of the strategy, alignment to national standards and includes response to nationally and locally identified risks. The CFPRP are reviewed (within the policy review cycle) and agreed by DoF and AC.
NHS Requirement 3	The organisation has carried out comprehensive local risk assessments to identify fraud, bribery, and corruption risks, and has counter fraud, bribery and corruption provision that is proportionate to the level of risk identified. Risk analysis is undertaken in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology and is recorded and managed in line with the organisation's risk management policy	AMBER	Risk assessments(RA) are carried out in line with the HB Risk Management Policy. The HB DATIX system has a fraud specific module allowing managers to add fraud risks(FR). The LCFS receives updates to new or existing themes. The annual CF plan is informed by RA. The work plan is reviewed and agreed by the DoF and Audit

Functional Standard		Rating	Comments
	and included on the appropriate risk registers, and the risk assessment is submitted upon request. Measures to mitigate identified risks are included in an organisational work plan, progress is monitored at a senior level within the organisation and results are fed back to the audit committee (or equivalent body). For NHS organisations the fraud risk assessments should also consider the fraud risks within any associated sub company of the NHS organisation.		Committee (AC), who monitor progress and receive updates on Fraud risks. The level of pro-active resource is approved by the DoF & AC. Arrangements have been agreed and will be embedded in next review cycle to improve. These include: • NHSCFA is to develop a national FR directory for use at a local level to undertake RA. Assessed risks will be included on the Finance Risk Register and an organisational fraud risk profile will be developed. • Actions and recommendations arising from a RA will be fed back to ARAC by way of an in-committee paper & outstanding actions recorded & monitored. • Fraud RA's will consider fraud risks within any associated sub company of the HB.
NHS Requirement 4	The organisation has a counter fraud, bribery and corruption policy and response plan (the policy and plan) that follows NHSCFA's strategic guidance and has been approved by the executive body or senior management team. The plan is reviewed, evaluated, and updated as required, and levels of staff awareness are measured.	**GREEN**	The HB has a CF Policy & Response Plan in place which includes the overall strategic aims of counter fraud work and operational response aligned to the NHSCFA counter fraud, bribery, and corruption strategy. In addition, the HB has a Standards of Behaviour Policy which incorporates professional behaviour with reference to fraud, corruption, and the Bribery Act 2010. Executive approval of policies is provided

Functional Standard		Rating	Comments
			via the Policy Review Process. The CF policy is available to all staff and highlighted within the CF intranet page and policy library. The Policy is actively promoted within the HB's programme of awareness. A mandatory online training package is in place, reinforcing key messages and local policies, measuring compliance, and identifying areas of improvement. Areas of work undertaken are communicated to ARAC by way of committee papers. Awareness is also raised by way of CF newsletters, social media posts and bespoke training, including to high risk groups.
NHS Requirement 5	The organisation maintains an annual work plan that is informed by national and local fraud, bribery and corruption risk assessment identifying activities to improve capability and resilience. This includes (but is not limited to) defined objectives, milestones for the delivery of each activity and measurable areas for improvement in line with strategic aims and objectives. The plan is agreed, and progress monitored by the audit committee (or equivalent body).	**GREEN**	The HB has a CF Policy & Response Plan in place which includes the overall strategic aims of counter fraud work and operational response aligned to the NHSCFA counter fraud, bribery, and corruption strategy. An annual work plan is developed in line with key objectives of the strategy, alignment to national standards and includes response to identified risks. The resource within the annual work plan is proportionally allocated according to risk based need in the context of 4 strategic areas of counter fraud work.

Functional Standard		Rating	Comments
			The plan is presented to ARAC, who review & agree in conjunction with the DoF. Progress against the plan is monitored and evaluated throughout the year with regular meetings with DoF and regular reporting to ARAC. Objectives and activity are planned around milestones in year to allow progress to be monitored. Policy reviews are undertaken and reviewed for fraud risk. Recommendations are made, recorded, and implemented. National CF guidance is reviewed & utilised for improvement.
NHS Requirement 6	The organisation identifies and reports on annual outcome-based metrics with objectives to evidence improvement in performance. This should be informed by national and local risk assessment, national benchmarking, and other comparable data. Proactive and reactive outcomes and progress are recorded on the approved NHS fraud case management system. Metrics should include all reported incidents of fraud, bribery and corruption, the value of identified fraud losses, the value of fraud recoveries, the value of fraud prevented, criminal sanctions and disciplinary sanctions.	**GREEN**	Clue3 has allowed the LCFS to record all investigations, documenting the types of offences, subjects, outcomes, system weaknesses. Further to these details of local proactive exercises are being recorded, documents financial values, which will allow the LCFS / CFA to identify cost savings associated with pro-active work. This is currently in operation and data is being reported to CFS Wales on a quarterly basis. Benchmarking data is expected to be produced in 2024/25.
NHS Requirement 7	The organisation has well established and documented reporting routes for staff, contractors, and members of the public to report incidents of fraud, bribery, and	**GREEN**	The HB has well documented reporting routes for any party to report incidents. Reporting routes are formalised in the CF

Functional Standard		Rating	Comments
	corruption. Reporting routes should include NHSCFA's Fraud and Corruption Reporting Line and online reporting tool. All incidents of fraud, bribery and corruption are recorded on the approved NHS fraud case management system. The incident reporting routes are publicised, reviewed, evaluated, and updated as required, and levels of staff awareness are measured.		and Bribery Policy & Response Plan. This includes NHSCFA Reporting Line and Online Reporting Tool. The reporting routes are publicised on the Health Board's intranet and internet sites and are included within the CF awareness programme. The effectiveness is evaluated by use of statistical referral data and this is reported to DoF and ARAC. Staff awareness is measured via surveys. Mandatory CF training is in operation for all staff groups. The HB has in place an 'All Wales NHS staff to Raise Concerns Procedure', which provides reassurance to staff those concerns will be recorded, reviewed, and actioned. The LCFS has received referrals for investigation as a result, allowing the identification, recording and management of Fraud Risks. All cases are recorded appropriately via the NHSCFA, and case updates provided to both the DOF & ARAC.
NHS Requirement 8	The organisation uses the approved NHS fraud case management system to record all incidents of reported suspect fraud, bribery, and corruption, to inform national intelligence and NHS counter fraud functional standard return submission by the NHSCFA. The case management system is used to record all fraud, bribery, and corruption investigative activity, including all	GREEN	The HB currently utilises Clue3 to record all investigations and LPE's, which allows for the reporting of crimes & case management in line with CPI. It also allows the reporting of system weaknesses alongside documented intelligence surrounding the subject of concern but has

Functional Standard		Rating	Comments
	outcomes, recoveries and system weaknesses identified during the course of investigations and/or proactive prevention and detection exercise.		no functionality to record outcomes of proactive prevention and detection exercises. The HB supports all investigations of fraud, bribery, and corruption with adherence to legislative requirements and the guidance outlined in the CF manual & case file toolkit. This being evidenced in the investigation plans and recorded actions undertaken. As well as recording cases, Clue3 provides an opportunity to record outcomes of both proactive/reactive work. Outcomes will be recorded, & data utilised. Clue3 will include a formula to standardise the calculation and reporting of identified fraud loss and ongoing savings/preventions values – to be utilised from 2024/25 onwards.
NHS Requirement 9	The organisation employs or contracts in an accredited, person (or persons) nominated to the NHSCFA to undertake the full range of counter fraud, bribery, and corruption work, including proactive work to prevent and deter fraud, bribery and corruption and reactive work to hold those who commit fraud, bribery, or corruption to account. The organisation will ensure that any changes to nominations are notified to the NHSCFA at the earliest opportunity and in accordance with the nominations process.	**GREEN**	The HB employs 2 full time LCFS. Both LCFS are qualified, nominated & accredited. Both conduct the full range of anti-fraud, bribery & corruption work on behalf of the HB. All work is undertaken in line with the CF work plan devised around the 4 strategic areas and organisational risks. The LCFSs continue to receive relevant training to enhance their abilities to deliver the role effectively. The LCFS undertakes all interviews under caution in accordance with Code C of the Police and

Functional Standard		Rating	Comments
	The accredited nominated person (or persons) must demonstrate continuous professional competencies and capabilities on an annual basis by examples of practical application of skills and associated training to include (but is not limited to), obtaining witness statements, conducting interviews under caution, and maintaining up to date knowledge of legal and procedural requirements.		Criminal Evidence Act 1984 and retains documented details surrounding interviews completed and witness statements obtained in accordance with Achieving Best Evidence. Witness statements are reviewed in line with issued guidance to ensure best practice. Relevant training will be undertaken in line with emerging risks.
NHS Requirement 10	The organisation undertakes proactive work to detect fraud using relevant information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action, including local exercises and participation or response to national exercises. Results of this work are evaluated and where appropriate feed into improvements to prevent and deter fraud, bribery, and corruption. Relevant information and intelligence may include (but is not limited to) internal and external audit reports, information on outliers, recommendations in investigation reports and NHSCFA led loss measurement exercises. The findings are acted upon promptly.	**GREEN**	The HB undertakes proactive work to detect fraud using relevant info, RA's & intel to identify anomalies indicative of fraud, bribery & corruption(FBC), undertaking proactive work, investigations & participation in national exercises where necessary. This work & its result are recorded, evaluated & where appropriate fed into improvements to prevent & deter FBC. Relevant info & intel are utilised to identify & investigate instances of fraud. Information is obtained by way of communication & sharing of information with both internal/external partners, including. Internal/external audit, Payroll, Finance, Procurement, PPV, Primary care & NHSCFA/CFS Wales.

Functional Standard		Rating	Comments
			Utilising Audit reports, RA's, NHSCFA alerts / bulletins / circulars and guidance allowing CF to undertake measurement exercises and acting on findings. Where anomalies are identified the HB carries out proactive exercises/investigations/RAs to address. Recommendations are reported to ARAC & fed into improvements in the detecting of anomalies.
NHS Requirement 11	The organisation has an ongoing programme of work to raise awareness of fraud, bribery, and corruption and to create a counter fraud, bribery, and corruption culture among all staff, across all sites, using all available media. This should cover the role of the NHSCFA, LCFS and the requirements and national implications of Government Counter Fraud Functional Standard providing a standardised approach to counter fraud work. Content may be delivered through presentations, newsletters, leaflets, posters, intranet pages, induction materials for new staff, emails, and other media, making use of the NHSCFA's fraud awareness toolkit as appropriate. The effectiveness of the awareness programme is measured.	**GREEN**	The HB has a programme of work (in line with work plan) to raise awareness of CF. Key methods of delivering this are by way of presentations and a mandatory CF e-learning package, supported by newsletters & intranet pages, all of which promote, • The NHSCFA reporting line & online reporting tool, • The Health Board's CF strategy & the role of the LCFS. Awareness materials, including animations & posters are utilised to raise awareness amongst HB employees, primary care, contractors and public. The CF Dept provides an input into the HB's induction programme, Medicines Management & Managers Passport. Attendance at sites have also added to enhancement of an

Functional Standard		Rating	Comments
			anti-fraud culture. Internal & External Web pages have also been updated, alongside frequent use of global messages & social media. Bespoke training is offered to departments & tailored training has been delivered to high-risk areas. Sessions are evaluated through feedback. Statistics are maintained & analysed to assess awareness levels.
NHS Requirement 12	The organisation has a managing conflicts of interest policy and registers that include gifts and hospitality that is proactively communicated to all staff. The managing conflicts of interest policy and registers that include gifts and hospitality is fully implemented and is demonstrably effective. The organisation measures levels of awareness of the managing conflicts of interest policy and registers that include gifts and hospitality among staff. The results are used to determine where further awareness raising needs to be undertaken.	GREEN	The HB has a Standards of Behaviour Policy which incorporates professional behaviour (including, declarations of interest, gifts, hospitality, and sponsorship) with reference to fraud, corruption, and the Bribery Act 2010. This is reinforced by the CF Bribery & Corruption Policy and SOP's. Relevant records / lists are maintained for review. Awareness work around requirements is carried out by both the Governance Team and LCFS. Proactive work is undertaken utilising NFI to assist in measuring compliance levels. Having proactively promoted the polices there has been a demonstrable increase in returns / compliance. Awareness in this area is also delivered by way of presentations, communications & mandatory online training. An increase in FRA will assist in developing actions / proactive exercises to

Functional Standard		Rating	Comments
			mitigate risks, such as actively promoting declarations of interest and Fraud awareness to high-risk groups of staff. Nil return of declarations are expected of high risks roles.

Counter Fraud Functional Standard Return - ACC Declaration
I declare that the anti-fraud, bribery, and corruption work carried out during the year to date has been self-reviewed against the NHS CFA requirements for anti-fraud, bribery, and corruption. As the Audit Committee Chair, and in line with the audit committee's responsibility for the strategic assurance and oversight of counter fraud work as described in section 5.6 of the NHS Audit Committee Handbook, I confirm that the information contained in this self-review for HYWEL DDA UNIVERSITY LHB reflects the work reported and considered by the Audit Committee. **Submitted by:**

Counter Fraud Functional Standard Return – DOF Declaration
I declare that the anti-fraud, bribery, and corruption work carried out during the year to date has been self-reviewed against the NHS CFA requirements for WALES anti-fraud, bribery, and corruption. As the responsible member of the executive board or equivalent body I confirm that by ticking this authorisation box the information contained in this self-review for HYWEL DDA UNIVERSITY LHB is correct and complete.

Submitted by:

Counter Fraud Functional Standard Return Declaration

Please ensure that this Functional Standard Return has been fully completed. If your director of Finance and/ or audit committee chair have not authorised or reviewed the functional standard return you will not be able to submit it. Once you have submitted the functional standard return, no further changes are possible.

Submitted by: lcfs12510

8

12:35, 0 Mins

8 - Assurance and Risk

8.1

12:35, 10 Mins

8.1 - Risk Assurance Report

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

For assurance

Attachments

8.1 SBAR Risk Assurance Report ARAC April 2025.pdf

8.1 Appendix 1 - Risk Assurance Report April 2025.pdf

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	15 April 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Risk Assurance Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joanne Wilson, Director of Corporate Governance / Board Secretary
SWYDDOG ADRODD: **REPORTING OFFICER:**	Charlotte Wilmshurst, Assistant Director of Assurance and Risk Rachel Williams, Head of Assurance and Risk

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide assurance to the Audit and Risk Assurance Committee (ARAC) on the effectiveness of the Risk Management Framework, and the implementation of the Risk Management Strategy.

Cefndir / Background

ARAC's terms of reference state that one of its principal duties is to review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical.

Asesiad / Assessment

The attached report (Appendix 1) aims to provide assurance by outlining the risk management activity that has taken place since the previous report presented to ARAC in December 2024 on the effectiveness of the Risk Management Framework, and the implementation of the Risk Management Strategy.

The Risk Management Framework was approved by the Board in July 2022 and sets out the components that provide the foundation and organisational arrangements for supporting risk management processes in Hywel Dda UHB.

The revised Risk Management Strategy was approved by the Board in March 2024. It provides a supportive framework that ensures the integration of risk management into policy making, planning and decision-making processes, and sets the 3 proposed key risk management objectives for the next 18 months:

- Define the organisation's risk appetite and tolerance statement;
- Support operational and corporate functions to strengthen their risk management arrangements; and

- Strengthen the assurance that the Board receives on risk management activities.

This report will provide ARAC with a high-level summary of each Directorate's escalation status in relation to their risk management processes.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to **TAKE ASSURANCE** on risk management arrangements and processes in order to report progress to the Committee, including the revised performance management arrangements.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.4 The Committee's principal duties encompass the following: 2.4.1 Review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical. 2.4.3 Work with the Quality, Safety and Experience Committee, the People Organisational Development and Culture Committee, Strategic Development and Operational Delivery Committee and Sustainable Resources Committee to ensure that governance and risks are part of an embedded assurance framework that is 'fit for purpose'.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Included within the report
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Datix Risk Module
Rhestr Termau: Glossary of Terms:	Included within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Director of Corporate Governance / Board Secretary

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts from this report however late or non-reporting of risks could mean that the UHB is not addressing any gaps in control and exploiting opportunities to achieve value for money.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from this report however late or non-reporting of risks could mean that the UHB is not addressing any gaps in control in relation to patient quality and care.
Gweithlu: Workforce:	No direct impacts from this report however late or non-reporting of risks could mean that the UHB is not addressing any gaps in control in relation to workforce issues and risks.
Risg: Risk:	Risk implications are inherent within the report.
Cyfreithiol: Legal:	No direct impacts from this report however late or non-reporting of risks could mean that the UHB is less likely to defend itself in a legal challenge which could lead to larger fines/penalties and damage to reputation.
Enw Da: Reputational:	No direct impacts from this report however late or non-reporting of risks could mean that the UHB is less likely to defend itself in a legal challenge which could lead to larger fines/penalties and damage to reputation.
Gyfrinachedd: Privacy:	No direct impacts from this report
Cydraddoldeb: Equality:	No direct impacts from this report

Purpose of the report

The purpose of the report is to provide assurance to the Audit and Risk Assurance Committee (ARAC) on the effectiveness of the Risk Management Framework, approved by Board in June 2022, and the implementation of the Risk Management Strategy, approved by Board in March 2024.

The overall aim of risk management is to:

- Ensure conformity with applicable rules, regulation and mandatory obligations;
- Provide assurance to the Board and the Audit and Risk Assurance Committee (ARAC) that risk management and internal control activities are proportionate, aligned, comprehensive, embedded and dynamic;
- Support decision-making through risk based information; and
- Provide effective and efficient strategy, operations and compliance activities.

The Health Board's Risk Management Strategy provides a supportive framework that ensures the integration of risk management into policy-making, planning and decision-making processes, and specifically:

- To improve the quality of service and protect patients, carers, staff and others who come in to contact with the Health Board;
- To create awareness through the Health Board about the importance of recognising and managing risk in a timely manner and providing staff with the appropriate knowledge, skills and support;
- To promote positive risk taking in the context of clinical care and in controlled circumstances;
- To provide a robust basis for strategic and operational planning through structured consideration of key risk elements;
- To enhance partnership working with stakeholders in the delivery of services;
- To improve compliance with relevant legislation and national best practice standards; and
- To enhance openness and transparency in decision-making and management.

Risk Management Framework

The risk management framework is made up of the **risk architecture**, **strategy** and **protocols** (RASP), which wraps round the Health Board's risk management process.



In order to provide the Committee with assurance that the goals are being met and that the risk management framework is effective, this report will outline the risk management activity that has taken place since the previous report as presented to ARAC in December 2024.

The report will also aim to provide assurance to ARAC on the effectiveness of internal escalation framework in respect to risk management and will include detail on Directorates' escalation status in line with the 3As assessment approach, complementing the Audit Tracker paper. Data will be assessed as at the most recent month-end position to align with the escalation framework (February 2025).

Risk Management Process

The Health Board's risk management process is recorded via the Datix Risk Register Module (Datix) and reported via risk register reports to both assurance and management meetings. Datix enables risks to be recorded at either Corporate, Directorate or Service level (definitions of which can be found in the Risk Management Framework), ensuring that risks are reported to, and scrutinised at, the most suitable forums.

The Health Board has an escalation process in place to ensure that risks which require escalation or de-escalation are done via the appropriate approval process, also detailed within the Risk Management Framework.

Risk management processes are currently under review as a result of the operational Organisation Change Process (OCP) currently underway. These changes will ensure that risks are:

- appropriately aligned to the new Clinical Care Groups (CCGs) structures, and corresponding executive functions due to become operational from 1 April 2025;
- owned by correct service leads in line with new management hierarchies; and
- appropriately sighted and escalated as part of the revised operational governance arrangements within the CCGs (and corresponding executive function governance arrangements).

The Assurance and Risk team have also taken the opportunity to update Datix to incorporate improvements to the existing risk management process for operational risks, namely in relation to the strengthening of target risk scores (TRS) and supporting rationale. This system additionality will encourage risk owners to consider the effectiveness of their risk action plans to better manage their risk within a specified timeframe in order to provide trajectories as to when they can be met.

At the time of writing the report, work has commenced on updating Datix to reflect revisions to management hierarchies and operational structures, and aligning risks to the revised Board sub-committee structures as agreed by Board at its meeting in January 2025. Work has also begun to update the format of risk register reports to capture these changes. The risk performance dashboards will also be updated to reflect the changes in Quarter 1 of 2024/25, dependant on the resource availability of the Performance Team.

Risk Architecture

Risk architecture is the organisational arrangements for risk management which details the roles, responsibilities and the lines of communication for reporting on risk management. These are currently being updated in light of the change to the Clinical Care Group operational structure to reflect revised management hierarchies and governance arrangements, as detailed above.

Three Lines of Defence for Risk Management

The Health Board operates within the widely accepted "Three Lines of Defence" model, which provides a simple and effective way to delegate and coordinate risk management roles and responsibilities within an organisation, to ensure the appropriate responsibility is allocated for the management, reporting and escalation of risk.



Risk Management (1st line)

The Health Board has 568 open risks on the Datix Risk Module as of 28 February 2025 (October 2024: 577), split as follows:

Risks per Risk Level



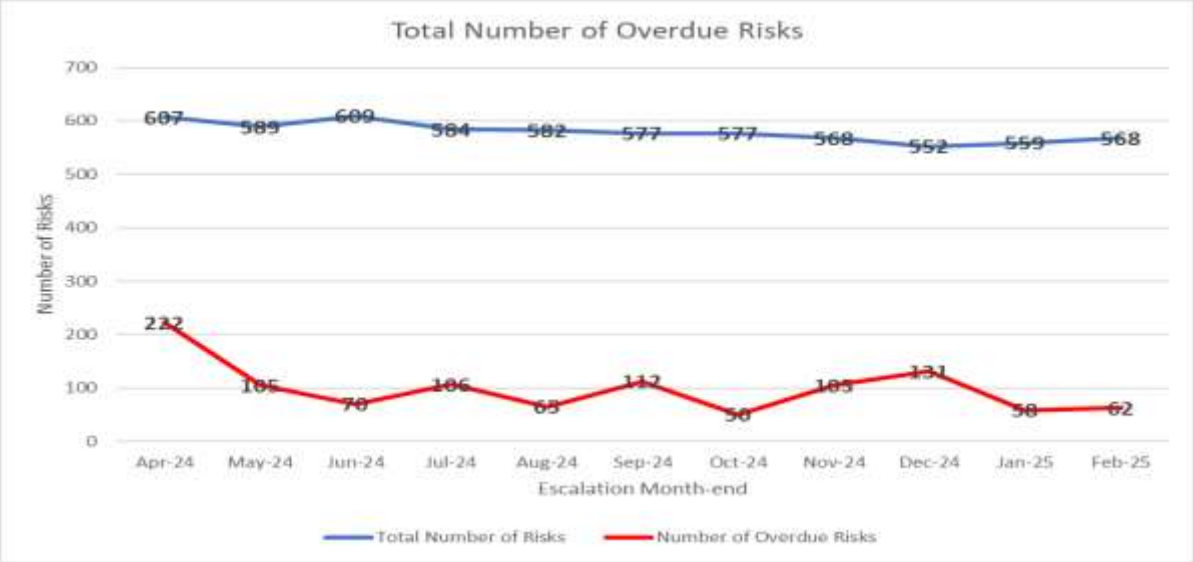
The table overleaf provides a summary of open risks per Directorate, in line with the structure as per internal escalation framework:

Area	Total number of risks as at 28 Feb 2025	%age of all Health Board risks as at 28 Feb 2025	Number of Overdue risks as at 28 Feb 2025	Total number of overdue risk actions as at 28 Feb 2025	%age of overdue risk actions as at 28 Feb 2025
Director of Operations					
Director of Operations *(including Central Operations, Acute Service, and USC: Health Board wide)*	13	2%	3	2	6%
Facilities	134	24%	14	11	7%
Mental Health and Learning Disabilities	34	6%	2	2	2%
Oncology	5	1%	0	1	6%
Pathology	27	5%	4	6	14%
Radiology	15	3%	0	5	12%
Planned Care *(including Audiology & Endoscopy)*	73	13%	1	0	0%
Unscheduled Care: Bronglais General Hospital	10	2%	8	14	45%
Unscheduled Care: Withybush General Hospital *(including Stroke and COTE)*	16	3%	3	1	5%
Unscheduled Care: Prince Philip Hospital (*including Diabetes and Respiratory)*	17	3%	2	2	7%

Area	Total number of risks as at 28 Feb 2025	%age of all Health Board risks as at 28 Feb 2025	Number of Overdue risks as at 28 Feb 2025	Total number of overdue risk actions as at 28 Feb 2025	%age of overdue risk actions as at 28 Feb 2025
Unscheduled Care: Glangwili General Hospital *(including Cardiology, Gastro and Renal)*	33	6%	8	2	5%
Women and Children	30	5%	4	8	22%
Director of Primary, Community and Long Term Care					
Ceredigion *(including Palliative Care)*	3	1%	0	0	0%
Carmarthenshire	12	2%	0	0	0%
Pembrokeshire	5	1%	0	2	33%
Medicines Management	12	2%	0	1	6%
Primary Care Management *(Long Term Care and Chronic Conditions)*	2	0%	0	1	50%
Primary Care *(All other Primary Care services)*	22	4%	1	2	5%
Director of Finance					
Finance	2	0%	0	2	29%
Digital	24	4%	2	2	7%
Director of Nursing					
Nursing	15	3%	3	6	20%
Director of Public Health					
Public Health	12	2%	1	4	25%
Director of Strategy and Planning					
Strategic Planning	5	1%	0	1	20%
Director of Therapies and Health Sciences					
Therapies	39	7%	5	14	15%
Director of Workforce and Organisational Development					
Workforce and Organisational Development	2	0%	0	0	0%
Medical Director					
Medical	6	1%	1	2	33%
Corporate Services					
Governance	0	0%	0	0	0%
CEO Directorate	0	0%	0	0	0%
Total:	**568**		**62**	**91**	

Timeliness of Risk Reviews

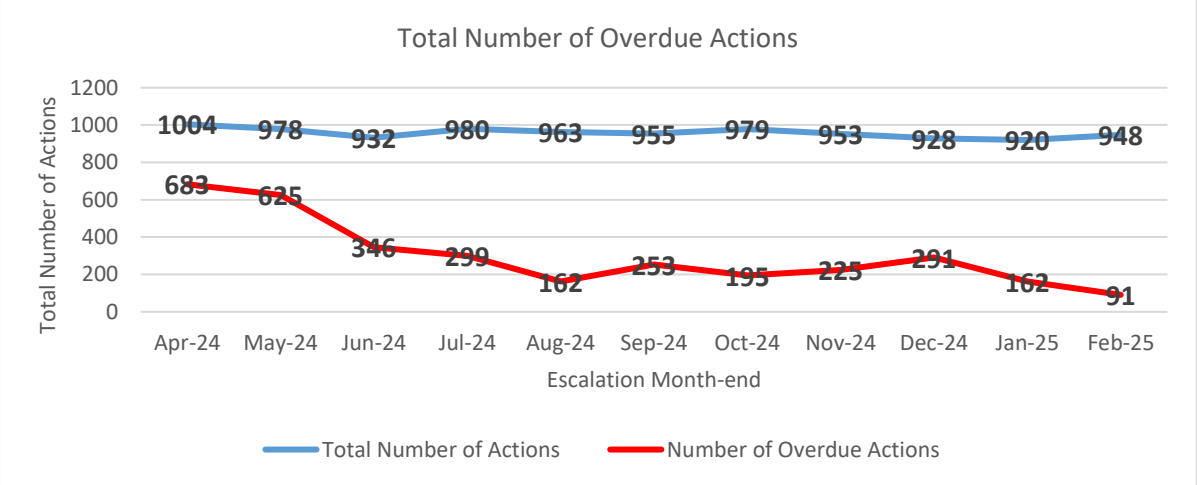
Since the introduction of the internal escalation framework, there has been an overall improvement in the timeliness of risk reviews, with 11% overdue for review as at 28 February 2025. However, the trend in performance since April 2024 suggests that timeliness of risk reviews is inconsistent, with fluctuations in the number of overdue risks over the calendar year which may be reflective of operational demands across the Health Board (see graph overleaf).



For those 62 risks noted as overdue, 55 have recently lapsed (i.e., not overdue by more than one month) (October 2024:43), 5 risks have just passed their review date of January 2025, and 2 risks are overdue by 4 months. This data demonstrates there has been an overall improvement in the timeliness of risk reviews since the internal escalation process was introduced, with the majority of risks now being reviewed within expected timeframes (April 2024: 222), however recognising inconsistencies across the year.

Risk Action Plans

The internal escalation framework has also significantly reduced the number of overdue risk actions, as 683 risk actions were overdue in April 2024. Further improvement is required in relation to the completion, review and quality of risk actions as 91 actions (10%) were noted as being overdue as at 28 February 2025 (October 2024: 195 (20%)).



Although the trend in reviewing overdue actions has significantly improved, actions remain which may have either been assigned unrealistic or unachievable timescales, or are not being updated fully during risk reviews.

The number of overdue or long-standing risk actions may also reflect the difficulties currently faced by management including staff absences and workforce challenges, in

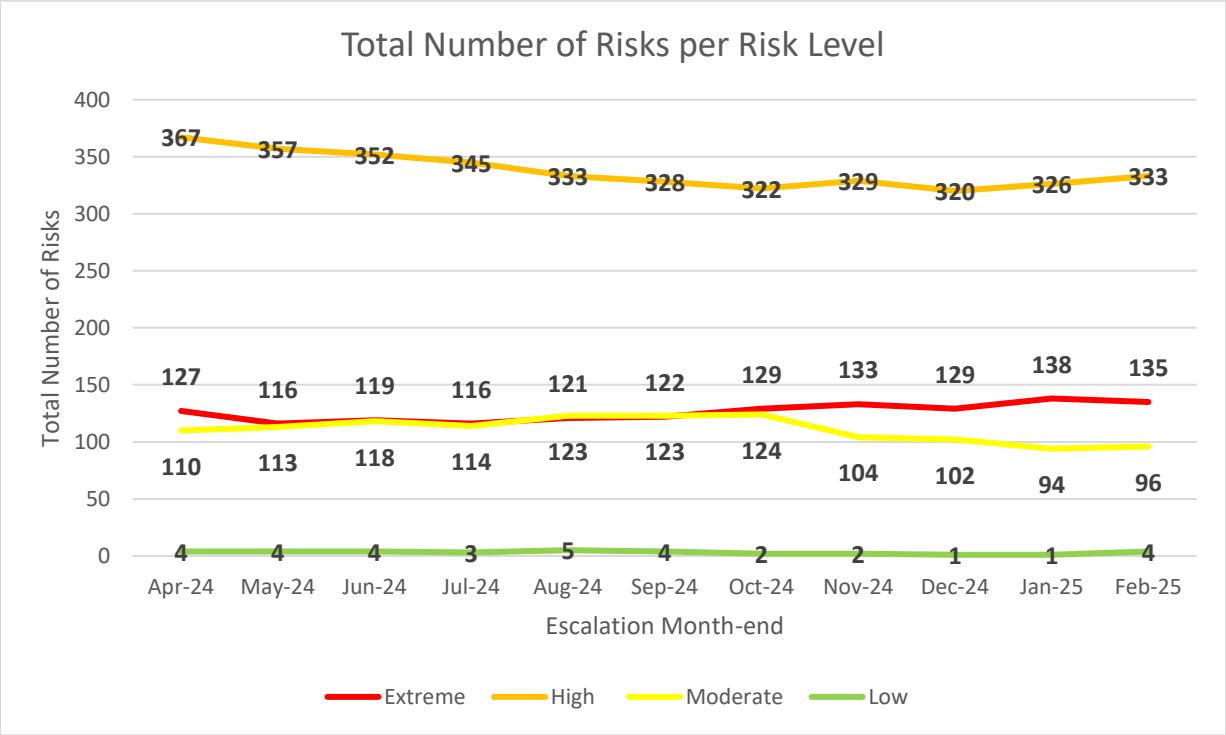
addition to the number of action plans that are reliant on additional funding to progress, which results in these actions not being updated due to a lack of any notable progress to report.

Risk leads are advised to provide realistic revised action dates where original dates have lapsed, with sufficient narrative noted in the progress update noting the reasons behind any delays and justification for the new date. The timeliness of risk reviews, along with the progression of risk actions, are key components in determining the levels awarded under the governance domain of the escalation framework.

Risk Profile

The average age of a risk as noted on Datix is 3 years and 9 months, with 129 (22%) of risks open as at February 2025 having been identified as a risk pre-Covid (October 2024: 163 (28%)). 69% of these risks are aligned to Estates and Facilities Directorate, and primarily relate to the condition of the Health Board's ageing estate and equipment, and the financial climate. Other notable Directorates with open risks identified pre-2020 include Planned Care; Primary, Community & Long Term Care; Pathology; Radiology; and Central Operations, as a result of insufficient staffing, lack of IT solutions and lack of funding.

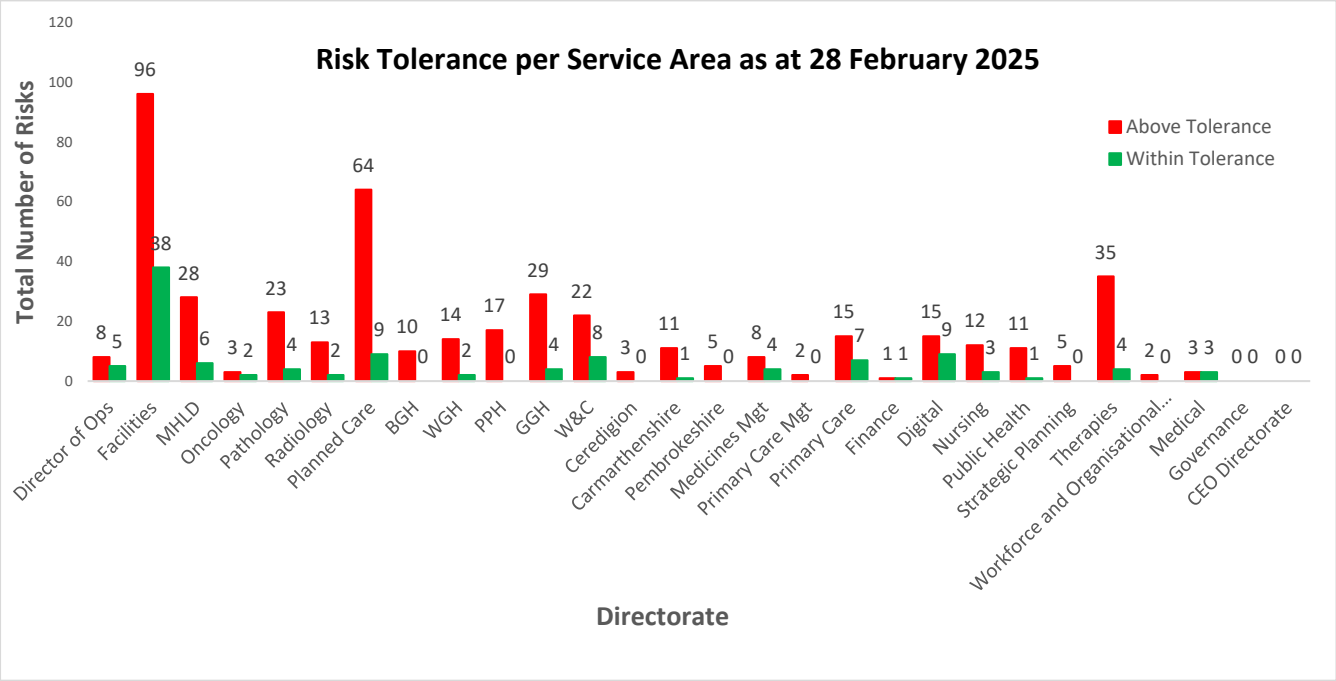
The following graph shows the trend in the number of extreme, high, moderate and low-level risks since the introduction of the internal escalation framework. This data demonstrates that the risk register is dynamic in nature with risks being reviewed and re-scored during this period.



Whilst there is a decrease in the number of high (amber) risks since April 2024, there is a corresponding increase in the number of extreme (red) risks since summer 2024, indicating that the organisation may be taking risks beyond its capacity (the maximum level of risk to which the organisation should be exposed, having regard to financial and other resources).

Risk Treatment

The graph below illustrates the number of risks assigned per Directorate, and highlights how many are within the current Board-accepted tolerance level (as discussed and agreed by the Board at its meeting on 27 September 2018), and how many are in excess of these thresholds.



As at 28 February 2025, 455 (80%) risks **exceed** current Board tolerance thresholds (October 2024: 76%), further indicating that the Health Board is carrying risk beyond its capacity. Facilities, Planned Care and Therapies continue to carry the highest number of risks above tolerance, with Mental Health and Learning Difficulties (MHLD), Pathology, Glangwili General Hospital (GGH) and Women & Childrens also contributing significantly towards the number of risks above the current tolerance thresholds. Detail around the revised approach to risk tolerance is included later in this report.

Directorates across the Health Board are responsible for identifying risks that affect their services, with the Assurance and Risk Team providing technical risk management advice to support the consistency in risk scoring across the organisation. Risk management training is provided to managers and service leads to address gaps in knowledge and increase risk awareness across the organisation.

The Health Board's approach to risk tolerance has been reviewed with the Executive Team and presented to Board in March 2025, with further work to be undertaken with services to implement an agreed approach to ensure that the appropriate risk treatment is adopted.

Oversight of Risk (2nd Line)

The Health Board's internal escalation framework includes an assessment of directorates performance in governance on a monthly basis. One key metric in the Health Board's internal escalation process under the Governance domain is **how**

Directorates are managing risks in terms of the scale, significance, timeliness and quality, with levels awarded ranging between 1-3 to highlight progress being made:

Level	Definition
3	No assurance that the Directorate is managing their risks appropriately in terms of the scale, significance, timeliness and quality of response (less than 80% of risks and risk actions are reviewed within required timescales)
2	Limited assurance that the Directorate is managing their risks appropriately in terms of the scale, significance, timeliness and quality of response (80-89% of risks and risk actions are reviewed within required timescales)
1	Reasonable assurance that there are no significant concerns within the Directorate (90% of risks and risk actions are reviewed within required timescales)

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

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

Escalation meetings are held for Directorates where an Alert status has been awarded for three or more domains, chaired by the Director of Finance and report to the Targeted Intervention Working group. For those Directorates which are awarded a level 3 for Governance, but are not awarded an overall Alert status, meetings are arranged between the Director of Corporate Governance and relevant service leads to discuss concerns and determine next steps for de-escalation.

The Assurance and Risk Team provide focussed support for those Directorates at level 3 to aid their de-escalation, and to prevent those awarded level 2 status being escalated. A summary of each Directorate's performance for the Governance domain since April 2024 can be found in the following table:

Service	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025
Director of Operations	1	1	3	3	3	2	3*	3	3	2	3
Facilities	3	3	3	3	2	2	2*	2	2	3	3*

Mental Health & Learning Disabilities	2	2	2	3	3	3	3*	3	3	3	3*
Cancer & Oncology	2	2	2	2	2*	2	2*	2	1	1	1
Pathology	2	2	1	1	1	2	3*	3	3	3	3*
Radiology	2	2	1	1	1	2	2	3	3	2	1
Planned Care (incl. Audiology and Endoscopy)	2	2	3	3	3	3	3*	3	3	3	3*
Bronglais Hospital	2	2	2	2	1	1	1	1	1	1	3
Glangwili Hospital	2	2	1	1	1	1	1	1	1	1	1
Prince Philip Hospital	2	2	1	1	1	1	1	1	1	1	1
Withybush Hospital	3	3	2	1	1	1	1	1	1	1	2
Women & Children	3	3	3	3	3	3	3*	3	2	3	3*
Carmarthenshire County	1	1	1	1	1	1	1	1	1	1	1
Ceredigion County	2	2	2	2	1	1	1	1	1	1	1
Pembrokeshire County	1	1	1	1	1	1	1	1	1	1	1
Primary Care	2	2	1	1	1	1	1	1	1	3	3*
Primary Care Management	N/A	N/A	2	2	1	1	1	1	2	2	1
Medicines Management	3	3	1	1	1	1	1	2	2	2	2*
Director of Therapies and Health Sciences	2	2	1	1	1	1	1	1	1	1	1
Director of Finance	2	2	2	2	2*	2	2*	2	2	2	2*
Director of Nursing	2	2	2	2	2*	2	1	2	2	1	1
Director of Public Health	2	2	1	1	1	1	1	1	1	1	1
Director of Strategy and Planning	2	2	1	1	1	1	2*	2	2	2	2
Director of Workforce & OD	1	1	1	1	1	1	1	1	1	1	1
Medical Directorate	2	2	2	2	1	2	2*	2	2	2	3
Corporate Services	2	2	1	1	1	1	1	1	1	1	1

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

Whilst the table above notes 9 Directorates awarded a Level 3: Alert Status under the Governance domain, the level has predominantly been awarded in relation to additional factors considered such as the implementation of external recommendations, compliance with Welsh Health Circulars and Ministerial Directions, and the timely review of policies. Directorates have demonstrated an improvement in risk management since the implementation of the internal escalation framework, with risks being reviewed within required timeframes. The data in February 2025 highlighted that in instances where risks have become overdue for review, none have been by more than one month. Whilst 80% of Bronglais' risks were overdue, and therefore met the Level 3 escalation criteria for risk management (<80% of risks were reviewed within required timescales), none were overdue by more than one month and reflective of operational site pressures at the point of data extraction. Similarly, 23% of the risks assigned to the Director of Operations were overdue, however none by more

than one month. It is recognised that these risks will be re-aligned as a result of the OCP within the Operations Directorate. 33% of risk actions assigned to the Medical Directorate were noted as being overdue, therefore meeting the Level 3 escalation criteria ((<80% of risk actions were reviewed within required timescales).

The existing Performance Framework has been further developed for 2025/26, details of which were presented to Board at its meeting in March 2025, which combines content from previous frameworks and reflects the organisational structural changes following the introduction of the new Clinical Care Groups (CCGs) as of 1st April 2025. The escalation process has been enhanced to realign accountability to Executive Directors and CCG Directors, and a more stringent process identified for those areas that are escalated and not making the required improvements. The Assurance and Risk Team will be reviewing existing escalation criteria within the Governance domain to ensure metrics are consistent, relevant and where possible, more qualitative in nature.

Risk Themes

Risk owners are able to assign multiple 'themes' to their risks, which allows the Health Board to share risk information on specific areas, such as health and safety, information governance and workforce with the relevant subject matter experts within the Health Board. They in turn can offer specific support and guidance to risk owners in the management of risk and identify trends and areas of concern. Each risk theme is aligned to a specific and relevant committee or sub-committee, in order to provide assurance that processes are in place to deliver a holistic approach to risk management. This further enables the Health Board to better identify and define its risk appetite, risk capacity and total risk exposure in relation to each risk, and to group similar risks or generic type of risk.

Each risk theme has assigned owners based on their subject matter expertise, who receive notifications when risks are added to the system and are also provided with the relevant thematic risk register on a bi-monthly basis. Upon receipt, theme risk owners are required to review themed risks to ensure that:

- they have been correctly allocated;
- review the risk, controls and planned actions from an expert perspective; and
- provide oversight and guidance to the relevant manager of any further controls that need to be undertaken to manage the risk to an acceptable level.

Theme owners are provided with a thematic risk register in order to identify trends, or risk clusters, and to consider whether there are gaps in controls in the Health Board's control framework, and to determine whether further action is required to prevent risks from materialising.

The Assurance and Risk Team have received feedback from themed risk leads since the previous Risk Assurance report as follows:

- Leads for the Medical Devices theme undertake regular thematic analysis of equipment risks across the Health Board to identify areas of priority and focus; and

- Leads for the Information Governance theme utilise the thematic risk register to maintain oversight and offer support as required to risk leads and discussed regularly at Information Governance Sub-Committee (IGSC).

Independent Assurance (3rd line)

The third line of defence are those who provide independent assurance over the risk management arrangements in place, and where appropriate can advise on control strategies. Audit Wales's Structured Assessment 2024 report was presented to ARAC in December 2024, with management responses received at its meeting in February 2025. The report presented to ARAC in December 2024 found that the Health Board continues to have a mature approach to overseeing strategic and corporate risks and risk management arrangements.

On 11 March 2025, Welsh Government considered the Health Board's escalation status and in recognition of governance improvements, related to improved Board stability and an increased degree of confidence in the organisation's governance, the Health Board was de-escalated for Governance from level 4 (targeted intervention) to level 3 (enhanced monitoring). Risk management is one of the criteria considered in the governance domain and therefore reflects confidence across the Health Board's governance framework, including its risk management framework.

Committee and Reporting Structures

Effective risk management requires a reporting and review structure to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place. The Health Board's risk reporting structure is outlined in Appendix 2 of the Risk Management Strategy.

1. The Board

The Board is responsible for oversight of the Health Board's principal risks, which are those that affect its ability to achieve its strategic objectives. The 6 strategic objectives are included within the Board Assurance Framework (BAF):

1. Putting people at the heart of everything we do	**4.** The best health and wellbeing for our communities
2. Working together to be the best we can be	**5.** Safe, sustainable, accessible, and kind care
3. Striving to deliver and develop excellent services	**6.** Sustainable use of resources

Principal risks are reported to the Board 3 times a year, with the last report provided in November 2024 as part of the BAF Dashboard. The 15 principal risks were reviewed and updated in February 2025 ahead of presentation to Board in March 2025, with no changes in risk scores. The Health Board will be looking to refresh its strategic objectives in 2025/26, upon which the BAF will be refreshed and the associated principal risks.

The Board is also responsible for oversight of corporate risks, which are defined as significant risks that affect the Health Board's ability to deliver the healthcare services in the 'here and now'. Corporate risks are reported to the Board 3 times a year, with

the last report provided in January 2025. The Health Board has 21 corporate risks as at February 2025.

The formal Executive Team reviews the corporate risk register on a monthly basis, and the principal risk register on tri-monthly basis, ahead of Board reporting. The Executive Team is able to:

- Approve or escalate new risks for addition to corporate/principal level;
- Approve the closure or de-escalation of corporate/principal risks to directorate level.

The table below summarises the changes to the Corporate Risk Register (CRR) since the previous report presented to ARAC in December 2024:

Risk ref	Risk Title	Risk Score Feb-25	Status of risk	Date of change on CRR
1531	Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	**15**	Decrease in risk score from 20 to 15	14/02/25
1812	Risk of non-compliance with Medical Examiners (Wales) regulations to the failure to fully resource internal processes	**8**	De-escalated	08/01/25
1842	Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 24/25 due to demand exceeding capacity	**12**	Decrease in risk score from 15 to 12	10/01/25
1664	Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	**16**	Decrease in risk score from 20 to 16	19/02/25
2000	Risk of the Health Board significantly underspending in excess of its statutory Capital Resource Limit for 2024/25	**12**	New risk	09/01/25

All changes are included in risk reports to the Board and Committees.

2. Board Committees and Sub-Committees

Terms of References (TORs) are in place for each committee at the Health Board, outlining their responsibility to review and to seek assurance that risks aligned to Committees are being effectively managed across the Health Board and report any areas of significant concern. Committees receive corporate risk reports 3 times a year, prior to them being reported to Board. Operational risks on Datix that are at Directorate level and above tolerance are also reported to the Board Committees 3 times a year. Risks are also reported to sub-committees, each of whom have delegated authorities from the parent committee, who received update reports at each meeting.

Work is currently underway to realign all open risks to the new Board Committee governance structure which will be implemented on 1 April 2025. This, along with other system changes on Datix Risk Module, will result in risk reporting to committees being postponed until June 2025.

3. Service and Directorate Level Monitoring Arrangements

Risks are discussed by services and directorates at quality governance meetings for operational areas, or senior management meetings. These forums allow for the discussion of existing risks in detail by service leads and relevant Directors, and the identification of any new or emerging risks, with the frequency of these meetings varying dependant on the service, either monthly or bi-monthly. Local governance arrangements are considered when awarding the escalation status for Governance.

Where there are no formal governance arrangements in place, or meetings are stood down, the Assurance and Risk team send formal governance reports to risk leads and management within those Directorates via e-mail for information and action where appropriate.

Operational governance arrangements are currently being finalised to support the changes to the Clinical Care Group operational structure, however risk management will continue to be included as standard items for discussion at formal local governance meetings.

Risk Management Strategy

The Risk Management Strategy (the Strategy), approved by Board in March 2024, sets out the Health Board's risk management policy statement and objectives in respect of strengthening risk management for the next 18 months.

The Strategy aims to support a dynamic and systematic approach to risk management, and to ensure prompt and comprehensive identification, assessment and management of risks that threaten the delivery of its strategic objectives and day-to-day operations.

The Strategy contains the following three objectives for 2024, with progress against each objective detailed below:

1. Implement and embed the UHB's refreshed risk appetite statements Appetite and Tolerance Statement

We will further develop the Health Board's risk appetite by:

- *Developing an implementation strategy to embed revised risk appetite statement across the UHB;*
- *Reviewing our approach to risk tolerance and how it aligns to the refreshed risk appetite statements (approved by Board in January 2024);*
- *Providing practical support to services in the utilisation of refreshed risk appetite statement; and*
- *Reviewing the risk appetite statement after 6 months with the Executive Risk Group (ERG) to ensure it remains fit for purpose and support effective decision making.*

The risk appetite statements (approved by Board in January 2024, were reviewed and refreshed by the Executive Team in December 2024 as part of the required annual review, and approved by Board at its meeting in January 2025.

Risk tolerance is the *organisation's readiness to bear the risk after risk treatment in order to achieve its objectives.*

A proposed revised approach to risk tolerance was included in the CEO report to Board at its meeting in March 2025 for approval. Following discussions at Formal Executive Team (FET) in February 2025, it was agreed that risk tolerance would be removed from the risk management process. The new approach links proposed actions to their anticipated impact on risk score, and shows the risk score trajectory over time. As such, the new approach will utilise the target risk score (TRS) to demonstrate the lowest level of risk exposure that the Health Board is willing to tolerate, following the completion of all the planned actions aligned to each risk. The TRS represents the ultimate level of risk achievable, given the available means and resource. Once the TRS is achieved, if the risk continues to exist, it should then be tolerated / accepted unless further actions are identified or made possible (eg through additional funding or capacity).

The TRS where possible should be quantified and aligned to performance targets, with a set timescale for achieving the reduction to the TRS. The utilisation of trajectories could be used to provide assurance that the right actions are being taken to reduce the risk to its TRS.

Where barriers to the achievement of the TRS are noted, this should be escalated appropriately via management structures in order to support decision-making. Risk leads will therefore be required to set realistic TRS, and an expected date for which they will achieve it.

The decision to 'tolerate' should be informed by metrics and the ability to support further actions, and the Board will be asked to accept any risks where the Health Board is unable to treat within its available means.

Work continues to develop an integrated impact assessment (IIA) process for the Health Board. This will incorporate an assessment of risk appetite and ensure that the Board are cognisant of making decisions that are within or even above their risk appetite.

2. Support the strengthening of operational risk management arrangements

We will do this by:

- *Ensuring risk management arrangements and systems are realigned to the new Operations Directorate structure (when approved), and systems used to capture this process are appropriately updated;*
- *Supporting corporate and operational directorates via quality and business meetings and Directorate Improving Together sessions to identify, assess and manage risks and improve outcomes;*
- *Reviewing current partnership risk management arrangements with key partners and to utilise learning to develop a plan for all partnerships to strengthen these arrangements which will support the UHB to achieve its objectives;*

- *Reviewing the training needs analysis and provision of risk management training to implement the operationalisation of revised risk appetite statements across the UHB;*
- *Implement the new Once for Wales Concerns Management system when it has been developed and is ready to be rolled out; and*
- *Providing practical support to services with operational risk management arrangements via business partnering arrangements to ensure risk management outcomes inform and prioritise organisational decision making.*

Work is currently underway to realign the current Datix risk register systems to the new structures and hierarchies to support the implementation of the revised arrangements within the Operations Directorate from April 2025. Refresher training will be scheduled for colleagues across the Health Board for Q1 2025/26 to inform them of changes made, and relevant procedural documents will be updated to reflect these changes during the same time frame. Notable system changes include:

- Updated risk management ownership levels to reflect revised operational management structures;
- Updated naming conventions to mirror new structures; and
- Inclusion of a rationale for TRS for operational risk, and expected date of achievement of TRS.

The Assurance and Risk team operates within a business-partnering approach to support operational and corporate teams to meet their obligations in respect of risk management. Each Directorate is assigned a dedicated Assurance and Risk Officer (ARO), who are either fully qualified risk professionals with the Institute of Risk Management (IRM) or working towards accreditation via the Health Board's Annex 21 process.

AROs prepare risk reports and attend relevant service governance meetings, in addition to meeting risk leads to facilitate and support discussions on risk management. Performance dashboards are also in place which allow staff across the organisation access to a summary of all Health Board risks.

The Assurance and Risk Team provide both system and technical risk training to operational managers and risk leads across the Health Board, with guidance issued on Risk Management within the Manager's Passport Programme. Relevant materials are also available to further support colleagues via the Assurance and Risk Sharepoint site.

A desktop review of the Health Board's key partnerships has been undertaken by the Corporate Legal Team, however further work is required in this area which is being taken forward by the Executive Director of Public Health. Ascertaining whether we feel appraised of relevant risks with our partnership organisation that could impact our organisation was one area of focus during the risk maturity self-assessment (further detail included under Objective 3 later in this report). While key people are aware of areas of potential risk with partnerships, there are currently no defined approaches and processes for addressing risk with all our key partners. Guidance on risk management with partners will be included when reviewing the Risk Management Framework during Q2 of 2025/26.

The Health Board completed a Readiness Report for the new Once for Wales Concerns Management system in which it stated it would not be migrating to the new system, and would continue to use the current Datix Web system which has been extended to 30 November 2027. This allows the Health Board to continue using the existing Datix Risk Module system, whilst it continues to consider alternative options.

3. *Understand how established risk management processes currently contribute to the overall health of the UHB (i.e achievement of objectives, delivery of plans and performance), and how this can be strengthened.*

We will do this by:

- *Engaging with relevant teams across the UHB to establish how risk information is currently utilised within their areas to support the achievement of the delivery if our objectives and performance targets to inform our risk maturity assessment, and how this could be strengthened; and*
- *Engaging with service leads across the UHB to assess the risk culture within the organisation to identify areas of improvement to support individuals in undertaking risks in an informed manner to support the achievement of our objectives and performance targets.*

Risk Maturity

A risk maturity self-assessment was undertaken during quarter 3 of 2024/25, in accordance with the Orange Book (a recognised risk management standard for the public sector), and undertaken on an annual basis. This is the second year that the Health Board has completed a risk maturity assessment, with learnings taken from the assessment completed in 2023/24 incorporated into this years' processes and Risk Management Strategy. This year, feedback has been obtained from the Executive Team at Formal Executive Team meeting held in February 2025. In addition, risk leads and thematic subject matter experts across the Health Board were given the opportunity to provide feedback via the completion of a questionnaire, many of whom circulated to colleagues within their services. Detail on responses obtained are included in the summary of the assessment below.

The assessment framework includes 7 overarching questions relating to risk management, namely:

- Leadership;
- Risk strategy and policies;
- People;
- Partnership;
- Processes;
- Risk handling; and
- Outcomes.

Each of the above were assessed using the scoring mechanism detailed below:

Level	Description
1	Awareness and understanding
2	Implementation planned and in progress

3	Implementation in all key areas
4	Embedding and improving
5	Excellent capability established

The 7 overarching questions, along with a summary of the outcomes of the self-assessment are detailed in the tables below:

Leadership	Level Awarded 2024/25	Level Awarded 2023/24
Do executives and independent members promote risk management?	**3**	**3**
Findings		
Executive Directors act as role models in order to apply risk management consistently across the organisation. Monthly Executive Team meetings are in place, along with regular reporting of the BAF and CRR to Board, as well as forming part of the internal escalation process, demonstrates a positive risk attitude being adopted by senior leadership. A review of operational structures undertaken during 2024/25, and its implementation from April 2025 has enabled new operational governance arrangements to underpin them will support the consistent application of risk management. Feedback obtained from the Executive Team highlighted that the organisation could better utilise existing risk management processes to identify and seize opportunities and support innovative solutions.		
Next Steps		
To promote the use of risk management in order to identify and seize opportunities, in addition to managing risks via: • the introduction and embedding of the integrated impact assessment (IIA) tool; and • development of risk training materials for the wider Health Board with more focus on the identification of opportunities. This will inform the refreshed objectives included within the review of the Health Board's Risk Management Strategy due in Quarter 2 of 2025/26.		

Risk Strategy and Policies	Level Awarded 2024/25	Level Awarded 2023/24
Is there a clear risk strategy and risk policies?	**3**	**3**
Findings		
Risk strategies and policies are in place and communicated, supported by a framework of processes across the Health Board. ARAC receives Risk Assurance reports at every other meeting which provide assurance on the effectiveness of the Health Board's risk management framework and highlights the progress being made against the Risk Management Strategy. However, 11% of respondents felt that they were poorly informed in relation to key organisational objectives and priorities facing their specific area within the Health Board.		
Next Steps		
To consider as part of the training needs analysis how operational management can improve local induction processes in relation to risk management training and the awareness of local objectives and priorities.		

To review and update existing risk training materials to ensure current Health Board objectives are included.

This will inform the refreshed objectives included within the review of the Health Board's Risk Management Strategy due in Quarter 2 of 2025/26.

People	Level Awarded 2024/25	Level Awarded 2023/24
Are people equipped and supported to manage risk well?	2	1

Findings

There has been an increase in the level awarded in relation to this question for 2024/25. A Level 1 was awarded in 2023/24, recognising the need to obtain feedback from the wider organisation to understand the risk culture and risk maturity in order to fully assess whether staff felt equipped and supported to manage risk well.

As part of the risk maturity assessment for 2024/25, feedback was requested from key risk leads and themed risk subject matter experts via a questionnaire, and sent to colleagues across both operational and corporate functions. The questionnaire was also forwarded by risk leads to colleagues within their services, providing feedback from a cross-section of staff of various seniority across the organisation. Directorates with a high response rate to the questionnaire included Mental Health and Learning Disabilities, Primary Care, and Nursing, Quality and Patient Experience. It is recognised that not all Directorates, therefore additional opportunities could be identified to further enhance risk awareness across the wider organisation. The questionnaire will remain open throughout 2025/26 with the aim to increase response rates across the organisation.

While staff are generally aware of the organisational objectives and risk management strategies and policies, and felt appropriately supported by the Assurance and Risk team, 70% of 27 respondents confirmed that they had not received risk management training specific to their area of work as part of local induction processes. From feedback received, which ranged from current risk leads, and colleagues who are not currently assigned risks on Datix, respondents tended to show less awareness of risk management processes in less senior roles within the organisation.

The Health Board has a dedicated Assurance and Risk Team in the Health Board, providing technical risk guidance, training and support to functions across the organisation with the aim to develop and improve risk capability.

Next Steps

To review the risk management training needs analysis undertaken by operational managers to strengthen local induction processes, and support the identification of training needs for new starters within their teams.

To develop a communications plan in order to further promote awareness of risk management arrangements across the wider organisation utilising tools available within the Health Board, including Viva Engage and Sharepoint.

To continue to capture feedback from the wider organisation throughout 2025/26 to identify further opportunities to enhance risk awareness across the organisation on an ongoing basis.

Partnerships	Level Awarded 2024/25	Level Awarded 2023/24
Are there effective arrangements for managing risk with partners?	1	1

Findings

Whilst senior leadership within the organisation are aware of areas of potential risk with partnerships, there are currently no defined approaches and processes for addressing risk with all our key partners. Respondents noted that they did not feel fully appraised of relevant risks with our partner organisations which could impact on the Health Board.

A desktop review of the Health Board's key partnerships has been undertaken by the Corporate Legal Team, with further work required to established risk management arrangements with these organisations.

Next Steps

Develop guidance for appropriate risk management arrangements with key partners of the Health Board as part of the revised Risk Management Framework.

Processes	Level Awarded 2024/25	Level Awarded 2023/24
Do the organisation's processes incorporate effective risk management?	3	3

Findings

Risk management processes have been implemented across all areas of the Health Board, recognising that their application within all areas may be inconsistent. The processes underpin the Health Board-wide Risk Management Framework. Thematic risk processes also in place, acting in a 2nd line capacity, with the Assurance and Risk team undertaking work during 2024/25 with risk theme leads to ensure these processes are fully understood and embedded, and can be used to improve organisational outcomes.

Work commenced in 2024/25 in the development of an Integrated Impact Assessment (IIA) tool with colleagues across the Health Board, with risk incorporated alongside quality, workforce and other key domains.

Feedback received from the wider organisation highlighted that existing risk management processes do not necessarily result in the identification and seizing of opportunities, or support innovation.

Next Steps

To promote the use of risk management through risk management training.

To implement and embed an organisational IIA with colleagues from the wider organisation to ensure that risk management is an integral part of the organisations' core processes such as planning and delivery.

Risk Handling	Level Awarded 2024/25	Level Awarded 2023/24
Are risks handled well?	2	2

Findings

Whilst risk management actions contribute to the development of the Health Board's Annual Plan to support its strategic direction, there is limited evidence that risk management is effective in all relevant areas. This is demonstrated through stagnant risk scores, and 76% of risks currently on the Health Board's risk register are scored as either extreme, or high.

Further work is required to develop and enhance the role of risk management actions in its contribution to effective planning and target setting, and the encouragement of greater efficiency, which will be considered during the refresh of the Health Board's strategic objectives during 2025/26.

A revised approach to the application of risk tolerance is also anticipated for 2025/26 to improve the role of risk management in its contribution to effective planning and target setting, along with the improved mitigation of identified risks in a timely manner. This approach was included within the Chief Executive Officers' report to Board at its meeting in March 2025.

Next Steps

To refresh the Board Assurance Framework following refresh of the Health Board's strategy and strategic objectives.

To update underpinning systems to support the revised application of risk tolerance, and update risk training materials to reflect these changes to better articulate what capacity the Health Board has to handle risk.

Outcomes	Level Awarded 2024/25	Level Awarded 2023/24
Does risk management contribute to achieving outcomes?	2	1

Findings

The Health Board has the ability to track progress against its objectives, however there is recognition that the environment within which it is currently operating may significantly impact on its ability to achieve strategic and operational outcomes.

The Executive Team noted at its meeting in early March 2025 that whilst Directorate Improving Together sessions demonstrates that the organisation is able to hold regular and meaningful conversations on risks which it faces, along with an improved focus on risk management, it remains unclear whether this has translated into improved outcomes. However, there are early positive signs that the Health Board is moving in the right direction, with an improved financial position, and the de-escalation from Targeted Intervention (Level 4) status to Enhanced Monitoring (Level 3) in relation to Child and Adolescent Mental Health (CAHMS), Planned Care,

and Leadership and Governance, reflecting the progress made in these areas. The Health Board remains in Targeted Intervention (TI) in relation all other domains as at the time of writing this report.
Next Steps
To refresh the Health Board's strategic objectives, and corresponding principal risks.

The outcomes and identified next steps of the assessment will inform the Risk Management Strategy which will be reviewed in Quarter 2 of 2025/26, and presented to ARAC in August 2025 for endorsement, prior to its submission to Board for Approval in September 2025.

Next steps

As outlined within this report, the following key actions will be undertaken, with progress provided to ARAC in the next Risk Assurance Report in August 2025:

- To utilise findings from the 2024/25 risk maturity assessment to inform the refreshed Risk Management Strategy objectives ahead of presentation to ARAC in August 2025; and
- To review and refresh the Risk Management Framework.

9

12:45, 0 Mins

9 - For Information

9.1 **12:45, 0 Mins**

9.1 - ARAC Workplan 2025/26

For information

Attachments

9.1 Audit Work Programme 2025-26.pdf

HYWEL DDA UNIVERSITY HEALTH BOARD – AUDIT & RISK ASSURANCE COMMITTEE DRAFT ANNUAL WORK PLAN 2025/26

The proposed work programme is aligned to the requirements of the 2012 Revised NHS Wales Audit Committee Handbook, Draft Terms of Reference and example agenda and timetable.

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	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**			✓			✓		
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**	✓							
Annual Review of Standing Orders and Standing Financial Instructions	**JW**	✓							✓
Scheme of Delegation	**JW**	✓							
Annual Review of Terms of Reference/membership	**Chair/JW**			✓					
All Wales NHS Audit Committee Chairs' Meeting Update	**Chair**			✓	✓	✓	✓	✓	✓
Review of any other sources of external assurance to ensure approp planning & coordination and that the Board is informed accordingly of any issues relating to compliance, risks of non-compliance & recommendations	**All**	✓	✓	✓	✓	✓	✓	✓	✓
Provide assurances through where a significant activity is shared with another organisation (eg NWSSP, JCC)	**HT/SM**	✓	✓	✓	✓	✓	✓	✓	✓
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	**Audit Wales/AC**	D		✓					
Planned Care Review	**Audit Wales/AC**	D		✓					
Review of Arrangements for Capital Programme Prioritisation	**Audit Wales/LD**			✓					
Cancer Services in Wales: A review of the strategic approach to improving the timeliness of diagnosis and treatment	**Audit Wales/AC**	✓		✓					
Deep Dive - Review of Investment in Digital Systems	**Audit Wales/HT**				✓				
Review of the Management of Outpatients	**Audit Wales/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
Deep Dive - Review of the Arrangements to Manage Estates	**Audit Wales/JS**								
Review of Cancer Services	**Audit Wales/AC**								
Review of Radiology Services	**Audit Wales/AC**								
INTERNAL AUDIT									
Internal Audit: Audit Plan Progress Report	**JJ**	✓	✓	✓	✓	✓	✓	✓	✓
Review and approve Annual Internal Audit Plan	**JJ**	✓							✓
Review of Internal Audit Reports including results & the adequacy of executive & management responses to any issues identified and ensuring that they are acted upon	**JJ**	✓	✓	✓	✓	✓	✓	✓	✓
Review and approve Internal Audit terms of reference (charter) and the effectiveness of internal audit	**JJ**	✓							
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 Working	**JJ/PK/JW**	D	✓						
Cleanliness/Cleaning Standards Follow-up	**JJ/AC**	D	✓						
Withybush Hospital (WGH) RAAC	**JJ/AC**	D	✓						
Continuing Healthcare – Database Maintenance and Finance Processes	**JJ/JP**	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	**JJ/LD**	D	✓						
Discharge Management Follow-up	**JJ/AC**			✓					
Primary Care Strategy including Managed Practices	**JJ/JP**			✓					
Contract Management	**JJ/HT**			✓					
Medical Workforce (Medical Locums Planned Care)	**JJ/MH**								
Digital Strategy Partner (In-Committee)	**JJ/HT**								
CLINICAL AUDIT									
Review annual forward clinical audit plan and terms of reference	**SD**	✓		✓			✓		
Review the effectiveness of clinical audit – consider recs from the ECPG on suggested areas of activity for review by internal audit	**SD**	✓					✓		✓
FINANCIAL FOCUS									
Review risks and controls around financial management (via Financial Assurance Report)	**HT**	✓		✓	✓	✓	✓	✓	✓
Review Annual Summary of Single Tender Actions (STAs)	**HT**			✓					
Receive Post Payment Verification (PPV) report	**HT**			✓			✓		
Receive PPV annual report	**HT**			✓					
Receive Primary Care PPV report	**JP**			✓			✓		
Annual statement of financial procedures	**HT**							✓	
Review of Schedule of Losses & Compensation*	**HT**								
Receive reports which record the basis of decisions where the HB awards additional funding to contractors outside the terms of the contract *	**HT**								

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									
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**						✓		
Review the Health Board's assessment against NHS Protect Qualitative Assessment Reviews*	**CFO**								
ASSURANCE AND RISK									
Audit Tracker	**JW/CW**			✓		✓		✓	
Risk Assurance Report	**JW/CW**	✓			✓		✓		✓
Risk Assessment Procedure	**JW**			✓					
Scrutiny of Outstanding Improvement Plans *	**JW/CW**								
DEEP DIVE									
TBC *									
FOR INFORMATION									
ARAC Work Programme 2025/26	**Chair**	✓		✓	✓	✓	✓	✓	✓
National Internal Audit Reports *									
REVIEW OF THE MEETING									
Matters & Risks for Escalation to the Board	**Chair/JW**	✓		✓	✓	✓	✓	✓	✓

* To be included on agenda as applicable

Initials

AC – Andrew Carruthers	**HT – Huw Thomas**	**LG – Lisa Gostling**
AG – Ardiana Gjini	**IMs – Independent Board Members**	**MH – Mark Henwood**
CH – Carly Hill	**JJ – James Johns**	**NLl – Nicola Llewellyn**
CW – Charlotte Wilmshurst	**JP – Jill Paterson**	**PK – Philip Kloer**
CFO – Counter Fraud Officer	**JW – Joanne Wilson**	**RE – Rob Elliott**
CSO – Committee Services Officer	**KJ – Keith Jones**	**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**

Audit Committee Tasks		15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
Prepare Schedule of meeting dates	**JW/CSO**						✓		
Agenda Setting Meeting with Chair & Exec Lead (at least 1m prior to mtg)	**Chair/JW**	✓	✓	✓	✓	✓	✓	✓	✓
Disseminate agenda & papers 7 days prior to meeting	**CSO**	✓	✓	✓	✓	✓	✓	✓	✓
Minutes and action log to be circulated within 7 days of the meeting	**CSO**	✓	✓	✓	✓	✓	✓	✓	✓
Produce ARAC Update Report for Board	**Chair/JW/ CSO**	✓	✓	✓	✓	✓	✓	✓	✓
Monitor agreed actions from previous meetings	**CSO**	✓	✓	✓	✓	✓	✓	✓	✓
Develop & monitor annual work plan linked to corporate objectives, assurance framework and Local and national priorities for Audit	**Chair/JW**	✓	✓	✓	✓	✓	✓	✓	✓
Ongoing Development of IMs (Briefings/Training/Development sessions)	**Chair/JW**	✓	✓	✓	✓	✓	✓	✓	✓
Annual Report on Committee's activity for onward submission to the Board – timed to support AGS	**Chair/JW**		✓						
Process for regular and rigorous self assessment of Committee's effectiveness	**Chair/JW +IMs**			✓			✓		
Annual bi-lateral meeting between Chair & LCFS *	**CFO**							✓	
Independent Members private discussions with Internal & External Audit, HIW and LCFS *	**All IMs**							✓	
Assess performance of Internal Audit *	**Chair/IMs**							✓	
Assess performance of External Audit *	**Chair/IMs**							✓	

* Separate meeting

10

12:45, 0 Mins

10 - Any Other Business

11

12:45, 0 Mins

11 - Review of Meeting

11.1

12:45, 0 Mins

11.1 - Matters and Risks for Escalation to the Board

For discussion

12

12:45, 0 Mins

12 - Date and Time of Next Meeting

9.30am, 8 May 2025 (Review of Draft Annual Accounts and Accountability Report)
9.30am, 24 June 2025