

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

Date of Meeting: **09:30, Thursday 13 August 2026**
Venue: **Microsoft Teams Meeting; HDD Picton - Dolau Cothi**

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

In Attendance: Ms Urvisha Perez, Audit Wales (VC)
Mr James Johns, Head of Internal Audit, NWSSP (VC)
Ms Sophie Corbett, Deputy Head of Internal Audit, NWSSP (VC)
Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary
Mr Huw Thomas, Executive Director of Finance
Mr Terry Slater, Local Counter Fraud Specialist, deputising for Mr Ben Rees, Head of Counter Fraud (part)
Miss Charlotte Wilmshurst, Assistant Director of Assurance and Risk
Dr Neil Wooding, Chair, Hywel Dda UHB
Mr Lee Davies, Executive Director of Strategy and Planning (part)
Mr Rob Elliott, Programme Director Major Infrastructure Projects (part) (VC)
Ms Eldeg Rosser, Director of Planning, Performance and Commissioning/Head of Capital Planning (part) (VC)
Mr Jonathan Arthur, Deputy Director of Health Sciences (part) (VC)
Mr Craig Baker, Cellular Pathology Service Manager (part) (VC)
Mr Andrew Carruthers, Chief Operating Officer (part)
Ms Anna Chiffi, Assistant Director of Nursing, Patient Safety, Quality (part) (VC)
Mrs Clare Pearce, Committee Services Officer (minutes)

Minutes Ref.	Item	Action
AC(26)129	Introductions and Apologies for Absence Cllr. Rhodri Evans, Audit and Risk Assurance Committee (ARAC) Chair, welcomed everyone to the meeting, including Dr Neil Wooding, Health Board Chair. Apologies for absence were received from: - Mr David Williams, Audit Manager, Audit Wales - Mr Ben Rees, Head of Local Counter Fraud Services - Professor Philip Kloer, Chief Executive - Mr James Severs, Executive Director of Allied Health Professions and Health Science	
AC(26)130	Declaration of Interests No declarations of interest were made.	
AC(26)131	Minutes of the Meetings held on 7 May and 23 June 2026	

Decision: RESOLVED – the Minutes from the meetings held on 7 May and 23 June 2026 were approved as an accurate record.

AC(26)132

Table of Actions

An update was provided on the Table of Actions from the meeting held on 23 June 2026. In terms of matters arising:

AC(25)171 – Mrs Joanne Wilson advised that the Standard Operating Procedure (SOP) remains a work in progress. However, it has been decided to mark this action as ‘Complete’ from an ARAC perspective, as implementation of the SOP will be assessed as part of the planned follow-up Internal Audit. The recommendation in relation to the SOP remains outstanding on the Audit Management and Tracking (AMaT) system.

AC(26)079 – Members heard that a couple of meetings have taken place, with another planned for 1 September 2026. Mr Huw Thomas anticipated that a further update would be available for the next meeting. A progress update on the Major Infrastructure Investment Programme Internal Audit specifically also appears later on the agenda. Mrs Wilson advised that the first meeting had examined the Major Infrastructure procurement and governance, and had involved Mr Lee Davies, Mr Rob Elliott and the Head of Procurement alongside the Executive Director of Finance and the Director of Corporate Governance. Assurance had been received, via the conversation, that processes were appropriate and working effectively. The meeting on 1 September would involve the Capital Equipping team. As indicated, an update will be provided to the next ARAC meeting.

HT

In response to a request from Dr Neil Wooding for further clarification, Mr Lee Davies explained that the update would seek to respond to ARAC’s request that procurement governance processes be reviewed. As part of this, it has been agreed to develop a new framework, which will take some considerable time. It is anticipated that the update will describe the intended process and work involved, which will allow the action to be closed; however, the work itself will continue. Members were also reminded that there is an Internal Audit report on Capital Equipping later on the agenda.

AC(26)105 and **AC(26)109** – Mr Maynard Davies requested and received confirmation that these items had been added to the Finance and Performance Committee (FPC) and Strategy and Planning Committee (SPC) Workplans respectively.

AC(26)133

Matters Arising not on Agenda

There were no other matters arising.

AC(26)134

Escalation Status Update Report

Mr Lee Davies introduced the report, which provides an update on developments since the previous ARAC meeting. It includes correspondence received from Welsh Government, with Members

noting that an Escalation Board meeting had taken place last week. As indicated in the report, the Health Board's Annual Plan remains unsupported by Welsh Government, with correspondence in relation to this appended. At the recent Escalation Board meeting, Welsh Government's expectation of a routemap to break-even was clearly articulated. The Health Board's financial position, along with Urgent and Emergency Care (UEC) remain their greatest areas of concern. Quality and Safety and 'Never' Events are also being closely monitored. The report seeks to provide a summary of the current progress and position. Mr Lee Davies reminded Members that ARAC's role in terms of escalation is around assurance that the appropriate arrangements and architecture is in place to progress de-escalation criteria. He felt that the report provides a reasonably straightforward synopsis. Whilst recognising that there is a degree of frustration that progress in certain areas has been slower than would be wished, the organisation has managed to achieve de-escalation in others.

Dr Wooding welcomed the update, whilst emphasising that the Health Board is clearly not meeting Welsh Government expectations. He suggested that organisations sometimes assume that gains will be incremental, when in fact they are often not. The cycle of improvement can be more frenetic, in nature. He noted that, following the approval of the UEC business case, the Health Board will be moving to 7-day operation in the autumn, which should deliver certain improvements. Dr Wooding enquired whether there is any indication of when Welsh Government expectations might be met. Taking UEC as an example, Mr Lee Davies indicated that the de-escalation criteria for this had been set; however, the position and wider influencing factors then change. For example, directives around 45 minute handovers are issued, which do not form part of the de-escalation criteria, although they which impact on the UEC system.

Whilst the Health Board has delivered the 1 hour handover target for 8 of the last 12 months, it has not delivered an improvement in the 12 hour performance target. Welsh Government has suggested that, if sufficient progress can be demonstrated on both these over the next few months, they may consider de-escalation. However, to do so would involve a significant step-change for the organisation. It will be necessary to discuss how to balance achieving these two specific demands. In the Health Board's Plan, this was a target for achieving by March 2027.

Mrs Eleanor Marks expressed specific concern around the Health Board's ability to meet requirements around the financial position, highlighting that a Plan will never receive approval until it delivers financial balance. Mrs Marks noted the figures relating to the run-rate are concerning, and she requested assurance regarding financial recovery and an indication of the main issues of concern for the Executive Team. With regard to the first query, Mr Thomas noted that the current run-rate is static at approximately £5m per month. If it is assumed that this month is similar, to deliver the

£41m year-end position required by Welsh Government would require a run-rate for the rest of the year of around £2m. Whilst theoretically possible, he suggested that this is unlikely. With the potential to deliver a £41m deficit position looking increasingly untenable. Given that the window for making savings is rapidly closing, a more realistic year-end position is a deficit of approximately £60m. There are potentially more savings schemes available to the organisation; however, it was felt that these would not materially change the position. In addition, the level of investment in UEC required to deliver the performance targets is in the region of £300-350k per month. It would be for the September 2026 Public Board to formally consider and approve any change in the year-end forecast, following discussion and recommendation by FPC. Such a change would be indicated at the mid-year Accountability Meeting with Welsh Government on 16 September 2026, which Mr Thomas anticipated would be a challenging discussion.

Whilst recognising that this is not necessarily a discussion for ARAC, Mrs Marks enquired around the actions being taken to eliminate or reduce the financial deficit, not just manage the reputation, which is in some ways less worrying than the actuality. In response, Mr Thomas emphasised that the focus is on mitigations, not capitulation. As part of this, there needs to be consideration of cash coverage by Welsh Government, and whether this will be based on a position of £41m or £60m. The Health Board is seeing new cost pressures, including growth in Primary Care prescribing costs and in Continuing Health Care (CHC) long-term care costs. It is limited in its scope to influence either of these. Where it does have the ability to make more material savings is in variable pay costs, which would impact on services. With regard to reputation, Mr Lee Davies highlighted that judgements are made on a reputational basis. He suggested that actions which could be taken are around making further progress on converting non-recurrent savings to recurrent savings; however, this would not necessarily impact on the current year's financial position. In terms of an earlier question around the main issues of concern for the Executive Team, Mr Lee Davies indicated that their priorities were as follows:

- Delivering the financial plan
- UEC
- Fragile services/Clinical Services Plan

He suggested that a discussion as a Board may need to take place, to ensure that this reflects the collective view and, should this be the case, to determine how best to communicate this to the wider organisation. Mr Lee Davies highlighted, however, that certain priorities impact on each other (eg UEC on the financial position, as described above) and on other service areas. It may be necessary to broaden the conversation around which are lesser priorities; although this will inevitably be challenging, particularly when other clinical services are involved.

LD

In response to a query around the likelihood of the improvement programme being delivered in its totality, Mr Lee Davies emphasised that the organisation's focus must be on delivering its Plan. He felt that, in the last few years, HDdUHB has set out carefully considered Plans, which it has broadly delivered. This year is proving more challenging; however, the effort must continue. Cllr. Evans enquired who makes decisions around capacity constraints (personnel). Mr Lee Davies advised that these decisions are made by Executive Directors and the Executive Team, guided by organisational priorities, Planning Goals, etc. Members heard that, whilst there is already significant resource already directed to the three priorities mentioned above, there are gaps elsewhere. Balanced against this is the assertion by Welsh Government that HDdUHB has seen the highest pay growth in Wales in recent years, particularly at Bands 7–9. Mr Huw Thomas suggested that this would likely lead to challenges if the organisation was to suggest further staff resource is required. He noted, however, that requests for additional staff are relatively low at present, which would not seem to reflect there being a need for more staff, unless requests are being moderated at source.

Dr Wooding stated that firstly, the Health Board should work on the basis that Welsh Government will not cover any cash shortfall, meaning that the organisation needs to be more radical in its approach to savings and take more urgent action in this regard. Secondly, it is suggested that staff are working exceptionally hard, but it could be argued that as a Health Board we are not prioritising what is important. Mr Thomas emphasised that he would not wish to give the impression that he or the Executive Team are comfortable with potentially amending the financial position to a £60m deficit. He felt that there is, perhaps, a cultural issue within the NHS whereby such situations have become normalised. Mr Thomas reported a suggestion that the local authorities are likely to underspend this year. There is clearly something that they are able to achieve through the choices that they are making, which the Health Board is not able to achieve. It is recognised that local authorities provide different services and can impose certain measures without incurring the type of detrimental effect a health board may. However, there is also the question of reflecting in the size of the organisation the financial settlement it receives. Mr Thomas' main concern was around the cash position.

Whilst noting the Health Board's three stated priorities mentioned earlier, Mr Winston Weir noted that these do not necessarily align with Welsh Government expectations around better planning and the quality and safety of services. He welcomed, however, the definition of priorities and suggested an approach of setting shorter-term goals which contribute to achieving these, and reviewing progress regularly; whilst also taking a longer-term, overarching view. Mr Weir also noted that it has become somewhat of a pattern for the Health Board to work extremely

hard to achieve a financial position by year-end, then find itself in an equally challenging place from 1 April the following year. He queried how this cycle might be broken. It was emphasised, however, that the challenging financial situation is not unique to the Health Board; it is widespread through public services. Finally, Mr Weir echoed Dr Wooding's suggestion that the organisation should assume there will be no cash coverage for a shortfall.

Lee Davies highlighted that the implicit assumption within the Health Board's Plan is that Welsh Government will cover the shortfall associated with a financial deficit of £41m. This is an assumption shared by other health boards across Wales, equating to a sizeable sum. However, to address this presents a harsh reality; balancing the competing and incompatible priorities and expectations of the organisation would lead to challenging decisions. The delays in taking these challenging decisions is impacting in terms of requirements for savings. It is likely that the Health Board will be in an even more difficult position from next year onwards.

Mr Thomas highlighted that HDdUHB is dealing with the legacy of decisions made decades ago. It is operating an extremely capital-intensive business, and changing configuration in a such a model is challenging. The Health Board's current configuration includes three of the smallest 20 hospitals in the UK and presents financial challenges. It also contributes to volatility in performance and less than optimal performance. Whilst this has been described, it has not been addressed, in terms of discussing potential configuration change. Mr Maynard Davies agreed that the current configuration is not what would be chosen if a healthcare system for Hywel Dda was being designed now. However, when a patient presents themselves or is admitted, the Health Board is obligated to assess, treat and expend money on them. Healthcare is also a political issue, which presents an additional pressure, since any government will be judged on NHS performance. Mr Maynard Davies also suggested that it is unfair to compare a public sector organisation, which is funded on an annual basis, with a private sector business, which would have access to loans they could pay back over several years. Finally, he noted that the Health Board has, in the last couple of years, had some fairly substantial unexpected non-recurrent savings, for example from Wellsky. He emphasised that such instances cannot be assumed or expected in the future.

With regard to local authority spending, Mrs Marks highlighted that these organisations cannot overspend. However, if an underspend is indeed likely, she would very much like to see it being invested in social care. Mrs Marks felt that it was important to focus the conversation on the Health Board's patients and public. Whilst recognising the need to prioritise financial balance, she expressed concern that the preoccupation with this can, on occasion, lead to fewer conversations on quality, safety and patient experience. Mrs Marks also suggested that there is a need for further work in

communications, to ensure a healthy public who understand their own wellbeing and can take steps to look after themselves.

Cllr. Evans enquired regarding contingencies for failure to meet trajectories and at what point the Board intervenes, and agrees a different course of action. He noted in particular that there is an imminent Accountability Meeting with Welsh Government. Mr Thomas highlighted that the financial position is cumulative across the year, limiting the organisation's scope to shift the position in-year. If it is not possible to deliver Welsh Government expectations this year, the Health Board will need to develop a recovery plan and trajectory to do so next year or over several years. Performance trajectories and metrics are areas which offer opportunities for improvement, the organisation's ability to influence finances is more constrained. Building on this, Mr Lee Davies explained that updated performance trajectories have been developed and submitted to Welsh Government, and that improvements are already being seen. Further improvements are also expected, around Planned Care, for example. There will be a continued reflection on how best to balance priorities and competing demands, including the trade-offs which might be necessary to facilitate improvements in UEC.

Decision: The Committee:

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

The Committee agreed to **ALERT** the Board in relation to the Escalation Status Update Report, given its concerns around the organisation's ability to achieve Welsh Government expectations, including around financial position. Also, that aggregate deliverability remains a material concern until the portfolio is demonstrably sequenced, resourced and feasible, with any trade-offs reflected in Board prioritisation decisions.

Ms Urvisha Perez introduced the Audit Wales Update report. In terms of financial audit work, the audit of the 2025/26 Health Charities Annual Report and Accounts is underway, and will be reported in the new year. In terms of performance audit work, the local Cancer Services Review report was issued in early July 2026; however this is still awaiting clearance. Audit Wales colleagues are meeting with the Chief Operating Officer today to discuss the findings, and the report is expected to be agreed in time for the October 2026 ARAC meeting. The Estates Management Review report was also issued earlier this week, and should also be ready for the October meeting. The audit brief for this year's Structured Assessment has been issued and field work is underway. Ms Perez reminded Members that the Structured Assessment will focus on the Health Board's 2025/26 Annual Plan, how effectively it was developed and delivered, and whether it is achieving its intended outcomes. The remainder of this year's work is in the latter stages of planning, including the local review of Eye Care Services and Diabetes review, which will focus on the management of diabetes. The report includes links to relevant national outputs, including Planned Care and Emergency Care insight pieces. Also, links to the updated Audit Wales Code of Audit Practice and an article on the new Auditor General, Catherine Mealing-Jones.

Cllr. Evans queried the reason for the delay in finalising the Cancer Services Review report. Mrs Wilson emphasised that this was attributable to the Health Board, not to Audit Wales. The management response which had been drafted required further work. As has been indicated, Mr Andrew Carruthers is meeting with Audit Wales colleagues today, and the finalised report will be considered at the next meeting. With regard to the Structured Assessment, Dr Wooding noted that the Well-Led Framework sits in similar territory and enquired whether there has been any alignment. In response, Ms Perez advised that Audit Wales are involved in the national Well-Led discussions. As mentioned above, a different approach is being taken to Structured Assessment this year, which will focus on the Annual Plan. However, Members were assured that Audit Wales will keep a watching brief on Well-Led developments which might influence future Structured Assessment exercises. Mrs Wilson agreed that the approach this year is fundamentally different to previous Structured Assessments, which have focused on the overarching governance processes, with this year's focus on planning.

Noting that a number of national reports have been published since the previous meeting, Mr Maynard Davies enquired whether there is anything of import for the Health Board to draw out. Ms Perez suggested that the organisation may wish to reflect on the content of insight pieces on Planned and Emergency Care. With regard to the Estates Review report due for consideration at the October 2026 meeting, Cllr. Evans enquired regarding any headline findings. Whilst emphasising that the report has not yet been cleared and finalised, Ms Perez advised that there are a

number of themes in common with the Internal Audit report which appears later on the agenda, and outlined various of these. Mrs Wilson indicated that she and Mr Lee Davies have seen a draft. Whilst certain minor amendments are required, it is not anticipated that the Health Board will contest any of the recommendations. A formal management response will be prepared prior to publication.

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

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

AC(26)136

Review of Cancer Services

DEFERRED to 15 October 2026 meeting

AC(26)137

Deep Dive Review of the Arrangements to Manage Estates

DEFERRED to 15 October 2026 meeting

AC(26)138

Financial Assurance Report

Mr Terry Slater joined the Committee meeting.

Mr Thomas presented the Financial Assurance Report, noting that this is of the usual format. The only item he wished to highlight was the active work underway with NHS Wales Shared Services Partnership (NWSSP) to address the challenge of invoices on hold. This is a specific issue impacting on Public Sector Payment Policy (PSPP) compliance. Positive work has already taken place in Cwm Taf Morgannwg UHB, which suggests that a system already being utilised in HDdUHB (Scan for Safety) could be used to good effect.

Noting the three 'Advise' items highlighted within the report, Cllr. Evans enquired whether there were any specific areas requiring ARAC's focus. With regard to these, Mr Thomas indicated that breaches of Standing Financial Instructions (SFIs) are managed via education of the individuals involved. In overpayments of staff salaries, a reduction in the repayment period has been seen, with more proactive recovery, which is positive. Write-offs and losses largely relate to drugs wastage, which has been discussed previously. This wastage is difficult to avoid, given the need to stock what are expensive drugs on small sites which do not have high patient throughput.

In response to a query around mention of the 'CTM receipting reminder pilot', Mr Thomas explained that this is a system being used by Cwm Taf Morgannwg UHB, as mentioned above. Referencing NHS payments, Mr Maynard Davies noted that these were particularly low in May and June 2026, and requested clarification of the reasons for this. Mr Thomas explained that this results from the scrutiny the Finance team has been applying to contracts, particularly with SBUHB. He emphasised that this reflects the good due diligence put in place. Returning to the issue

of invoices on hold, it was queried whether, given the sums involved in certain of these, delays in payment could be challenging to the companies involved. In response, Mr Thomas indicated that issues are, on occasion, escalated, due to the impact on companies' cash flow. However, numbers are relatively small.

Welcoming the Purchase to Pay Improvement Plan described in Appendix 4, Mr Maynard Davies noted that ARAC's support is being sought and requested further clarification. He was advised that the requirement of ARAC was not significant; beyond continued scrutiny and support for the issuing of any potentially challenging messaging. Mr Maynard Davies' final query was around the Oracle system, which is due for replacement. He enquired when, and the mitigations in place to manage any disruption to payments, etc. in response, Mr Thomas assured Members that replacement of the Oracle system is being managed at a national level. The main issue in relation to this is the fact that any replacement will cost significantly more than the current system. Scrutiny of this matter will be via FPC.

Mrs Marks queried whether, beyond straightforward payment contracts, contract management is as robust as it should be. Mr Thomas acknowledged that it is not, and is likely a weakness in terms of non-pay management. He emphasised that the issue is less to do with procurement and more to do with the managing of contracts. Members heard that the Health Board is due to trial usage of generative Artificial Intelligence (AI) to scrutinise contracts, invoices and submissions by managers, and provide a more comprehensive view of contracts on a regular basis. Currently, it is defining which contracts would need to be reviewed on a monthly, quarterly and annual basis. It is hoped that the system will ensure that invoices are compliant with the terms of the original contract. Mr Thomas emphasised that HDdUHB is not an outlier across Wales in this regard. However, addressing it is one of his objectives for this year. It was agreed that details regarding contract management would be provided as part of the report to the next meeting.

HT

Referencing discussions at another committee he had attended, Dr Wooding noted that certain other health boards are responsible for delivering services to some HDdUHB patients. He enquired how it is ensured that HDdUHB patients are treated equally and equitably with the local population being served by that health board. Mr Lee Davies explained that the majority of such services are commissioned via the Joint Commissioning Committee (JCC). HDdUHB is represented on the JCC and receives reports on its activities. Whilst information is shared, whether this allows sufficient assurance to be taken as a Health Board regarding equity is less clear.

Mr Lee Davies did feel that this is an area requiring further consideration. Members were advised that treatment is on the

basis of waiting lists, so there should be no intentional prioritisation of more local patients. However, there may be instances where distance is an issue. For example, in cardiac cases, it will be quicker and easier to fill an unexpected space for a procedure with a patient already in a local hospital. The Health Board has sought to address this to some extent by placing eligible cardiac patients geographically closer, in Prince Philip Hospital (PPH); however, this is only a mitigation. Members heard that in the past, a regular report on this topic was submitted to the Quality, Safety and Experience Committee (QSEC), and it was suggested that this should be revisited. Related to this is the issue of whether information transfer and sharing between health boards is sufficiently effective, which it was suggested should be discussed at the Digital, Data and Innovation Committee (DDIC).

SD

HT

Cllr. Evans noted that breaches of SFIs via use of retrospective Purchase Orders is a consistent issue in terms of process compliance. He enquired whether there are challenges with specific departments, or whether the issue is more widespread. Whilst Mr Thomas' preference would be for breaches to be zero, he emphasised the need for transparency. The amounts involved are relatively small, and compliance is being addressed via education. He assured Members, however, that the success of remedial actions, and potential for other options is being reviewed.

Dr Wooding queried the classification of a Hybrid Print and Post system as digital. It was explained that it is a hybrid solution, which also involves text messaging and the NHS App. In response to a suggestion that the organisation should be maximising use of digital solutions, Mr Thomas indicated that it is currently operating on a 'opt in' rather than an 'opt out' basis for text messaging. This could, potentially be inverted. He suggested, however, that discussions are moving into the sphere of the Patient Services Centre, noting that the business case for this is due for consideration at the Public Board meeting in November 2026. Mr Maynard Davies reported that SBUHB issues both text messages and hard copies of appointment letters, without an option to select.

Decision: The Committee:

- **SCRUTINISED** the award of contracts listed
- **DISCUSSED** losses as detailed and **APPROVED** the loss in excess of £5,000
- **DISCUSSED** the P2P action plan as detailed and **APPROVED** the three themed approach, including potential access withdrawal for persistent non-compliance
- **DISCUSSED** the breaches of Standing Financial Instructions (SFIs) as detailed
- **DISCUSSED** the staff overpayments as detailed and **TOOK ASSURANCE** that actions to control them are sufficiently embedded.
- **TOOK ASSURANCE** from the actions taken to:
 - Improve Purchase To Pay (P2P) compliance

- Manage breaches of Standing Financial Instructions (SFIs)
- Manage Single Tender Actions (STAs)

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

AC(26)139

Counter Fraud Update

Mr Terry Slater introduced the report, which was as presented, and invited comments or queries.

In response to a query around how the Counter Fraud team is promoting the Fighting Fraud Strategy, Mr Slater advised that the team is contributing to more meetings and events. These include further education courses and Royal College of Nursing meetings. This seeks to communicate anti-fraud messaging as early as possible and at as many levels as possible. Cllr. Evans enquired whether this strategy actively prevents fraud, or whether the aim is simply to be proactive. Mr Slater stated that it is challenging to evidence impact, although Mrs Wilson suggested that there is a 'ripple effect' from individual cases, for example. She highlighted that HDdUHB is fortunate to have two very experienced Counter Fraud Specialists.

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

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

Mr Terry Slater left the Committee meeting.

AC(26)140

Internal Audit Plan Progress Report

Mr James Johns presented the Internal Audit Plan Progress Report, which provides the usual update on progress in delivering the Internal Audit Plan. Section 2 of the report details the single audit finalised since the previous meeting, which is included on the agenda. In terms of a progress update on this year's audit programme, a number of other audits are work in progress. For others, including follow-ups, various issues and concerns had been raised regarding their timing. This matter had been discussed with the ARAC Chair and Director of Corporate Governance. It had been agreed to reschedule and/or defer four planned audits, and the report's appendix outlines proposed timings for these. Mr Johns explained that this alters the Internal Audit Plan previously approved by the Committee, with the changes being submitted for approval.

Mrs Wilson advised that the two audits where deferral is proposed are Ionising Radiation (Medical Exposure) Regulations (IRMER) and Continuing Health Care (CHC) Direct Payments. IRMER compliance has recently been reviewed by the regulator, meaning that an internal audit would be duplication of effort. For CHC, new national guidance regarding direct payments is due; however, has

not yet been issued, making it inappropriate to test compliance. Two other audits have been rescheduled for later in the year at the Health Board's request. Members will note under the next agenda item that correspondence has been issued to Executive Directors from the ARAC Chair indicating that there will be no further changes to the audit programme.

Endorsing this approach, Mr Weir enquired whether deferral of two audits will release audit time to enable others to be brought forward. Mrs Wilson advised that this action has already been discussed and executed. She emphasised that all changes were made at the Health Board's request, not Internal Audit's. Cllr. Evans also informed Members that he and Mrs Wilson are meeting with the Head of Internal Audit on a regular basis to receive updates and assurance around delivery of the audit programme and ensure value for money.

Decision: The Committee:

TOOK ASSURANCE with regard to the delivery of the Internal Audit plan and from the outcomes of the finalised audit reports
APPROVED the proposed updates to the plan

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

AC(26)141

Correspondence Regarding Audit Participation and Implementation of Recommendations

Cllr. Evans drew Members' attention to two items of correspondence issued to Executive Directors, from himself as ARAC Chair, and from Mrs Marks as QSEC Chair. He suggested that ARAC needs to be more robust in policing the implementation of audit recommendations. He is due to meet with the Chief Executive to discuss this matter and would provide an update at the next meeting.

RE

Dr Wooding agreed that there should be limited tolerance for deficiencies in implementing audit recommendations. He emphasised that this is a responsibility of all staff, making it a performance issue. Noting that the Executive Directors are often viewed as answerable, he suggested that any other individuals involved should also be required to explain to ARAC why sufficient progress has not been made. Mrs Wilson emphasised that all recommendations, not only those made by Internal Audit, are included on the Audit Tracker hosted on AMaT. Whilst it is recognised that certain areas have specific challenges, these should be accounted for within management responses and when agreeing recommendations. Members were reminded that compliance with audit recommendations does feature in the internal escalation process, meaning that functions can potentially be escalated on this basis.

Decision: The Committee **NOTED** correspondence regarding audit participation and implementation of recommendations.

AC(26)142

Capital Equipping (Limited Assurance)

Ms Eldeg Rosser joined the Committee meeting.

Ms Sophie Corbett introduced the Capital Equipping Internal Audit Report. This audit had reviewed arrangements for procuring equipment for capital schemes, focusing on compliance with key requirements of procurement regulations, Standing Orders and Standing Financial Instructions. The audit identified that the capital equipping process has not been formally defined or documented. As a result, there was no clear framework setting out when procurement activity should be supported or led by NWSSP procurement services. This lack of clarity has resulted in inconsistent engagement with NWSSP, with procurement support evident in some, but not all, of the schemes and purchases that Internal Audit reviewed.

The audit identified three key implications of this. Firstly, instances where the procurement route applied was not appropriate, based on the aggregate value of expenditure by supplier and scheme. Secondly, declarations of interest had not been completed for any of the sample procurements undertaken by the capital equipping team, reducing assurance that potential conflicts have been appropriately considered and managed. Thirdly, procurement exceeding £25k is routinely reported to the Health Board's non-pay group through NWSSP procurement services. However, those procurements where this team was not involved are not captured within the reporting process. Collectively, these issues increase the risk of non-compliance with procurement requirements and weaken governance, oversight and assurance arrangements relating to capital equipment procurement. Based on the findings, an overall opinion of Limited Assurance has been concluded.

Noting the findings, Cllr. Evans stated that these are disappointing and do not represent a positive start to the year's audits. Mr Lee Davies thanked the Internal Audit team for their report. He indicated that the timing of the audit had been challenging, with a key member of staff leaving the team. Members heard that Ms Eldeg Rosser had recently taken over line management of what is a small team. He wished to emphasise that they do a good job in ensuring capital projects are delivered and equipped. Taking all of this into account, however, the audit has identified areas requiring improvement, including variations in practice, and Ms Rosser will be taking these as a starting point. Ms Eldeg Rosser welcomed the audit and its findings. She advised that a workshop is planned for the middle of September 2026, which should provide the clarity required regarding formalising and documenting the required process. She recognised that effective engagement with the procurement team will be vital in delivering on the report's recommendations.

Agreeing that the Limited Assurance rating is disappointing, Mr Maynard Davies suggested that there are similarities between this and work in relation to the Major Infrastructure Programme, which has already generated discussion around procurement and improving engagement. He queried whether the Capital Equipping aspect could also be encompassed in these ongoing discussions, suggesting that the principles involved are broadly the same. This would avoid unnecessary duplication of effort, and would enable learning to be shared. Mr Thomas did not feel that ensuring effective engagement with the Procurement team will be an issue. There is a resourcing aspect, given that this will increase their workload and potentially reduce that of the Capital team. In response to a query around whether the proposed completion dates are realistic, should Mr Maynard Davies' suggestion be implemented, Members were advised that it should be deliverable. Mrs Wilson emphasised the importance of this work, given that there are new procurement regulations which are significantly different in terms of transparency, openness, and modification orders. Another major consideration is the fact that breaches are not just on an individual basis, but also cumulative. Returning to the comment around completion dates, Mr Thomas noted that, whilst certain actions are already in train, there will be a transition required to a new way of working, which will need to be managed.

Mrs Marks welcomed the fact that the team is embracing the audit findings and has committed to enact recommendations. She enquired whether there has been consideration of a retrospective examination of procurements. Also, given deficiencies around declarations of interest, how assurance can be taken that individuals have not influenced decisions. Agreeing, Cllr. Evans queried whether a proactive Counter Fraud exercise should be commissioned, to review contract awards. He emphasised the need to take action and share good practice. Dr Wooding raised three issues: whether areas where there is a potential for fraud are risk profiled; whether there is a culture of complacency and where the organisational or collective intelligence is to coordinate purchases, to ensure good value for money and avoid unnecessary duplication.

In response to the third query, Mr Thomas advised that the Health Board has a central asset register for this purpose. He also wished to highlight that Capital and Estates have appeared in a number of Executive Director portfolios in recent years, and are now being assumed into one. This offers a positive opportunity to improve consistency and address issues. The suggestion of a Counter Fraud exercise should be considered; however, is probably a discussion for the In-Committee session. Ms Rosser wished to emphasise that orders and requisitions have been raised in line with contracts and frameworks. She acknowledged, however, that further evaluation may be required and would be happy to engage with any exercise of this type considered necessary.

In terms of the declarations of interest process, this is established for all procurements going through NWSSP; however, there is a gap which has been identified. General declarations of interest completed by staff have been checked from a line management perspective, which has not indicated any additional risks to date. Ms Rosser recognised that Capital Equipping would benefit from risk profiling, given that the team is involved not only in procuring for large schemes, but also in the procurement of individual items of equipment. She felt that the document due for development in September will encompass all the routes, tasks and involvement. Referencing Mr Maynard Davies' suggestion, Ms Rosser agreed that it would be beneficial to align conversations around both the Capital Equipping and Major Infrastructure Programme.

Cllr. Evans thanked Ms Rosser and the team for their work. He enquired whether Internal Audit is content with the management response and proposed actions. Ms Corbett confirmed that this was the case, and wished to emphasise that, whilst there were instances where the appropriate procurement route had not been followed, based on aggregate spend, the actual procurements undertaken were compliant with the route followed. There were positive findings and Ms Corbett was confident that the team is on the correct trajectory to address the issues identified. Mr Lee Davies also reminded Members that there is governance in place for every capital scheme, such as Pentre Awel. It is important to provide them with clarity regarding processes to protect them also.

Decision: The Committee **NOTED** the Capital Equipping (Limited Assurance) Internal Audit report.

The Committee agreed to **ADVISE** the Board in relation to the Capital Equipping (Limited Assurance) Internal Audit report, given its findings; however, were assured by the management response and planned actions.

AC(26)143

Progress Update on Major Infrastructure Investment Programme Internal Audit

Mr Rob Elliott joined the Committee meeting.

Mr Lee Davies reminded Members of discussion around this internal audit in May 2026, at which time a progress update had been requested. Presenting the report, Mr Rob Elliott suggested that it is relatively self-explanatory. Concern had been expressed regarding actions identified in the management response which did not have a completion date. This has been addressed and the actions in question are now included on the AMaT system. Completion of actions has been independently verified, providing the required assurance.

Cllr. Evans thanked Mr Lee Davies and Mr Elliott for their attention to the issues raised by ARAC. It was confirmed that those actions still in progress will remain open on AMaT until completed.

Decision: The Committee:

- **TOOK ASSURANCE** on the current status of completed recommendations
- **TOOK ASSURANCE** that specific completion dates are now established for all future actions

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

AC(26)144

Progress Update on Human Tissue Authority Internal Audit

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

Introducing the report, Mr Craig Baker indicated that it presents a high-level summary of progress in relation to this audit, which had assessed various aspects of compliance against Human Tissue Authority (HTA) requirements. Audit findings had suggested that governance processes within the mortuary could benefit from further strengthening. These findings were actioned by December 2025. Internal audit colleagues returned to follow-up the audit in February 2026, with their report issued in April 2026. This had concluded that all recommendations had been actioned.

Noting that a number of discussions revolve around actions and recommendations which remain outstanding, Dr Wooding welcomed this assurance and thanked the team for their work.

Decision: The Committee **TOOK ASSURANCE** that all internal audit recommendations and findings have been actioned and fully implemented within the defined timelines, resulting in the audit being formally closed.

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

AC(26)145

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

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

Ms Anna Chiffi introduced the report, which is as presented, and describes the actions taken during the past 12 months, since the Community and Integrated Medicine Clinical Care Group (CIM CCG) was formed. Whilst the number of open recommendations remains high, there have been improvements in terms of completed recommendations. It should be noted that the total number of reports and recommendations has increased significantly; these mainly relate to Emergency Care and Emergency Departments (EDs). It has been confirmed that Risk 1027 (Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity) remains the overarching corporate risk. As described in the report, the CCG has also

introduced regular meetings with its Assurance and Risk Business Partner. The first meeting took place last month, and has already demonstrated significant improvement from a risk perspective. These meetings have been scheduled on a monthly basis, to facilitate a more consistent approach.

Progress has also been made in terms of governance procedures, with monthly performance and quality meetings and integrated performance and quality meetings as a single meeting, rather than separate. The latter includes a unified, dedicated section within the agenda to focus purely on risk and audit actions. Finally, OCP1 has facilitated improved leadership capacity through the appointment of general managers and heads of nursing, meaning more strength in local ownership of the actions. With OCP2 due to provide the central business function and the stability below those structures to provide greater assurance, the CCG is optimistic that this will strengthen further over the next 4-5 months.

Ms Chiffi noted, however, that challenges clearly remain. At the end of June 2026, there were 53 overdue recommendations, with 39 overdue for more than six months. She hoped that the report highlights that certain of these recommendations are challenging to close within the CCG, because they are dependent on external actions. The AMaT system does not always clearly distinguish when CIM CCG actions are complete and other, transformational or organisational actions, remain outstanding.

Cllr. Evans queried why the CCG has not been escalated to Level 4, especially as the situation has not improved. Mrs Wilson confirmed that July figures have shown a further deterioration. She noted that the CCG has been categorised as Level 3 for 12 months, for the reasons explained in the report. In determining the escalation level, the operational pressures under which the CCG is functioning have been taken into consideration. The situation has not improved to the desired level, which has been discussed with the Chief Operating Officer and Executive Director of Finance. In order to allow discussions with CCG staff, it has been determined that it will not be escalated to Level 4 this month; however, it was recognised that further escalation was likely.

Mr Andrew Carruthers highlighted that CIM encompasses a significant number of reports, resulting in a significant number of recommendations. There is also a great deal of duplication between recommendations, particularly as there can be separate reports for the four acute sites. He felt that there should be an assessment of whether certain of these could be closed as they are complete or whether others can ever be closed as they are written. The language of some recommendations make them challenging to regard as completed. An example in the Discharge audit is a recommendation to embed a consistent approach to discharge planning across the Health Board and local authorities. Mr Carruthers would suggest that, now a Memorandum of Understanding has been agreed with all three local authorities

represents a consistent approach. The challenge is how the Health Board can evidence that it is embedded. He would welcome an exercise, such as has been used before, to review all recommendations and determine whether they could be closed and/or are achievable as written.

Mrs Marks queried whether it is actually the case that teams are writing as risks something that is an ongoing organisational problem or challenge, which will generate risks, recognising that it is unclear how one can be separated from the other. Secondly, given the number of risks, whether staff have sufficient capacity, both to undertake the actions required and to update risk registers. Dr Wooding felt that the number of undischarged recommendations suggests a high degree of dysfunction in this specific area of the organisation. He recognised that there are significant operational pressures, which can distract and prioritise other tasks over and above addressing recommendations.

However, these recommendations are made for good reason and are intended to assist the organisation in improving. Taking the example mentioned earlier around the discharge process: this is extremely important because there are inconsistencies both in relation to local authorities and in how staff discharge individuals within each hospital. Dr Wooding suggested that challenges are not, therefore, limited to demand and resource; they also involve management and organisation. Improving the efficiency of the organisation depends on such issues being addressed. He emphasised that there are talented and capable people working within the CCG, who are delivering a fantastic job. His concern was, however, that this specific matter is not being treated with sufficient seriousness.

Mr Weir thanked the team for the report and explanation, noting in particular the risks being clustered under the overarching risk of 1027, around demand exceeding support. He enquired whether the CCG is anticipating that specific business cases or developments will address these fundamental issues and risks. With regard to the suggestion of dysfunction, Mr Weir highlighted that this very state can be caused by having to manage high numbers of risks relating to the same issue. This often impedes the ability to address the underlying cause. He felt that there needs to be clarity around the main priorities for the CCG which are manifesting as operational key risks, and how the Board can support them to address these.

In response to Mr Weir's query, Ms Chiffi indicated that the most influential business case is around implementing clinical streaming hubs and the 7-day model, which should make a significant difference. A key element of this will be ensuring that patients are signposted and allocated to the correct point to access care. This will mean that, rather than patients presenting at the 'front door' in an unscheduled manner, more effective coordination will be possible from a workforce perspective, from a resource

perspective and from an estate perspective. It is often the case currently that the volume of patients attending exceeds the space required to assess and treat them. Introducing a much more structured process will make a major impact.

The Community by Design principles will also assist, by supporting and educating patients in the community to make the correct choices in accessing care appropriately. In addition, there is ongoing work with the Primary Care Clusters. Ms Chiffi noted that further consideration is required around how there can be greater collaboration with Clusters, how the Primary Care/ Secondary Care interface can be supported, and how specialist support for Primary Care clinicians can be ensured, to avoid unnecessary re-admissions of patients. There is a great deal of transformational work ongoing. As this progresses and embeds, change and improvements will be seen. There are, however, no specific business cases outstanding.

Mr Maynard Davies reported that he and Mr Carruthers had recently visited Glangwili Hospital (GGH) ED. Whilst there had been relatively few ambulances waiting outside, inside it had been extremely busy, with patients in beds and chairs. The whole premise of the UEC business case is to change this situation. He suggested that one of the key statements in the report is towards the end: 'The successful reduction of a number of the CCG's highest-rated risks is dependent upon the availability of appropriately skilled staff, the delivery of sustainable service models, and the resolution of system-wide capacity constraints across the Health Board.' All of these are concerns which are being discussed in other committees. He hoped that the sustainability element will be addressed by the 7-day model. With regard to staff, however, Mr Davies enquired whether the issue is insufficient staff, or whether staff do not have the required skills. He suggested that it is important to establish those issues which are within the Health Board's gift to address and those, for example, which need addressing in collaboration with partners.

Mrs Marks wished to focus on governance. She understood that, under OCP1, staff were recruited into posts responsible for these areas. She enquired, therefore, regarding the capacity and governance for those people who should be managing these risks. To help frame the discussion, Mrs Wilson indicated that, in terms of escalation, risks are Level 2 it is the position relating to audits and inspections that is more concerning. In response to Mr Davies' query regarding staff, Ms Chiffi advised that both are an issue. Even if the Health Board was operating on fewer sites, it would require more staff to operate a 24/7 model. There is currently a 20% vacancy ratio across emergency staff rotas. This manifests itself in various different ways, including senior decision-making capacity and availability at the 'front door'; performance; quality and safety; financially in terms of variable pay. Work is needed around right-sizing the ED workforce; however, there are also opportunities in terms of developing the skill mix. The

business case does begin to consider the latter, by way of a non-traditional model.

With regard to Mrs Marks' query, Mr Carruthers confirmed that a number of senior roles are in place, accountable for overseeing and driving elements of this work. He felt that there are two issues requiring further reflection: Firstly, how better to tie in these recommendations with the actions being taken to improve and deliver services, so that everyday service delivery is discharging them. He will be meeting with the Executive Director of Nursing, Quality and Patient Experience and Medical Director to take this forward as part of the overall future approach to UEC.

Secondly, in dealing with the operational pressures at the start of the year, the issue of addressing recommendations had been deprioritised and the position was not where the CCG would like to be. Taking steps to align actions to 'business as usual' should help to ensure that recommendations are discharged, even if there is a delay in updating them. Whilst mindful that all parts of the organisation are experiencing pressure, Mr Carruthers suggested that CIM is probably where it manifests itself most, with the numerous urgent priorities. This does result in challenges in terms of capacity. His response, though, is to suggest that workstreams can be better aligned, to address some of these challenges. Mrs Marks highlighted that managing these risks and actions is part of the job of senior managers. Currently, Members cannot take assurance that they are being managed effectively. Whilst agreeing with and accepting this, Mr Carruthers did feel that there are actions being taken that are invisible, but which take up significant amounts of management time. For example, the time spent by general managers trying to cover a rota gap in acute medicine or ED to ensure safe service provision for the week ahead.

Dr Wooding welcomed the helpful discussion and thanked those involved. He recognised that there is a great deal of work taking place to address outstanding recommendations. He highlighted the need, however, to manage down risks, meaning that the action plan to be agreed every year should be a risk mitigation strategy. Dr Wooding agreed that everyday service delivery should be reconciled with the management of risks, because this equates to effective service delivery. He suggested, however, that the central risk (Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity) would remain a risk regardless of staff numbers. This means that the focus should largely be on management of the risk and risk appetite. Without the ability to control demand, this will always be on the risk register. In terms of work, Dr Wooding suggested that what would mitigate and manage down a number of risks is the ability to relieve some of the constant pressure and demand on services, including the volatility and scope of that demand. A strategic approach is required, in addition to a transactional one. This would include consideration of actions impacting in the longer-term, such

as educating the public to recognise where best to access care. He emphasised that discussions such as this are important in identifying ways to make a difference and resolve issues. They also add more urgency and agency, even when solutions are challenging to identify.

Welcoming Members' feedback, Mr Carruthers indicated that he intends to consider it in more depth and review how he oversees this area from an Executive perspective. He would consider the UEC programme of work, the performance position and how these can be aligned to discharge recommendations, with the aim of seeing a reduction in real time over the course of the next two or three months. This should allow the forecast of when actions and recommendations will be completed. As suggested, he felt that there are a number which have probably already been addressed.

Mrs Marks emphasised the importance of this, given the impact of failure to comply with recommendations on external assessments of Health Board performance, such as the overall Head of Internal Audit Opinion. Also, the need for the owners of these risks and recommendations to take ownership of them and responsibility for addressing them. With regard to governance, Cllr. Evans queried whether existing arrangements are sufficiently effective and whether issues are being escalated appropriately. He also requested clarification around the actual number of overdue risks and actions. In response to the latter, Mrs Wilson advised that there are 124 reports with 426 recommendations overdue (29%). 67 of the 124 do not have a management response and 101 do not have revised completion dates. There are five new reports which need adding to AMaT, which will further increase the number of recommendations. Cllr. Evans expressed concern that, without management responses and completion dates, these recommendations and actions cannot be tracked, and assurance cannot be taken that they will be addressed.

Ms Chiffi wished firstly to respond to an earlier comment around the OCPs and governance. Whilst acknowledging that the responsibility and accountability sits at a system level (put in place by OCP1) without the supporting structure provided by OCP2, the responsibility is falling to Heads of Nursing, for example. This means that such staff are being pulled into more operational challenges, impacting on capacity. The new way of working moves towards a Cluster based model, with clearer oversight and greater integration. This will allow the Heads of Nursing to have a more strategic overview of governance arrangements. It will also, from an operational perspective, release the Service Delivery Managers from the day-to-day operational pressures, to focus on the core business of the 13 specialties within the CCG.

Ms Chiffi felt that the challenge faced by the CCG over the last 12 months has been substantial. Firstly, in bring Community and Integrated Medicine together; then from December 2025, bringing in additional aspects from Primary Care, Long-term Care and

Chronic Disease Management. All of these have significantly different working cultures, which have needed to be aligned. The new way of working has strengthened expectations around ownership of individual governance arrangements, and these have been more robustly embedded. The level, extent and quality of information is much improved. In addition, the CCG is optimistic that work and actions being undertaken in areas such as 45 minute handovers will have an impact on certain of the wider actions which form part of risks and recommendations.

Mrs Marks and Cllr. Evans emphasised that they do not doubt the pressure staff are under, and recognise that the challenge is balancing the numerous demands. Ms Chiffi's comprehensive response was welcomed. From a Committee and assurance perspective, however, Dr Wooding suggested that the current situation is unacceptable, and consideration needs to be given as to whether sufficient measures are in place to address this. Mr Carruthers was of the opinion that governance arrangements under the new way of working are appropriate. He felt, however, that there is much involved beyond process, such as culture. Overall, there are far clearer expectations around delivery, with greater oversight of performance. He envisaged improvements across Quarter 2 and recovery into Quarter 3. With effective arrangements in place, the issue now is outcome generation.

In response to a query around whether mechanisms will be fully embedded and improvements evident by the end of Quarter 3, Mr Carruthers indicated that he would be expecting significant improvements by that point. Cllr. Evans emphasised that actions must be achieved by completion dates, with it noted that even if dates are amended, the original date will form part of the record and the action will remain as outstanding. It is also vital that management responses and completion dates are agreed, within a month, for those reports and recommendations without these. With regard to potential duplication between risks, whilst Risk 1027 remains the overarching risk, others will be reviewed to establish whether they can be amalgamated.

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It was agreed an update would be provided to the December 2026 or February 2027 meeting. It was also agreed that Cllr. Evans and Mrs Marks would meet with the Chief Executive.

Decision: The Committee:

- **NOTED** the progress made in strengthening governance arrangements within the Community and Integrated Medicine Clinical Care Group
- **NOTED** the continuing risks associated with overdue recommendations, high-rated risks and resource-dependent mitigating actions.

The Committee agreed to **ADVISE** the Board in relation to the Update on Status of Risks and Audits: Community and Integrated

Medicine report, with a further update to a future meeting requested.

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

AC(26)146

Risk Assurance Report

Miss Charlotte Wilmshurst presented the Risk Assurance Report, which aims to provide assurance on the effectiveness of the Risk Management Framework and implementation of the Risk Management objectives. With regard to the latter, the objectives for the coming year have been defined; principally implementation of a new risk management system, with the current one due to expire in November 2027. In terms of the number of risks, there are 672 open risks, driven by aging infrastructure, demand and capacity pressures, workforce and service fragility, financial constraints, equipment issues, and digital limitations. These risks are mainly held by Estates and Facilities, CIM, Planned and Specialist Care and Operational Allied Health Professions and Health Sciences. There are 80 overdue risks, 12% of the risk profile, with a full breakdown included in the report. As reported, the only CCG escalated to Level 3 in terms of risk management is CIM. Two functions met the Level 2 escalation criteria in relation to risk management: Planned and Specialist Care and Director of Finance.

In response to a query around whether risk management maturity is improving, Members were reminded that an annual assessment is undertaken in this regard. Steps are being taken to facilitate further work with operational teams, balanced with their capacity. Feedback from teams and Executive Directors is sought and contributes to process improvements. Given earlier discussions, Mr Davies enquired regarding there is a process to review risks to identify potential duplication. Miss Wilmshurst and Mrs Wilson highlighted that the organisational structure and site-based approach determine where risks sit and are managed, and this can drive duplication. Dr Wooding enquired whether the new system mentioned earlier will address this issue, noting that certain risks would apply to all sites, for example. Also, whether consideration has been given to an AI approach to risk management. Members heard that the team is exploring AI potential. The new system will need to be as user-friendly and intuitive as possible.

Mrs Wilson emphasised that the team does provide managers with a significant amount of support; however, the risks have to be managed by the risk owners. Each area has an Assurance and Risk Business Partner allocated to them, and monthly reports are provided. They are also given suggestions of what mitigating actions can be taken. However, the team needs to move more into the sphere of providing assurance for the organisation that the controls in place are effective and reduce risk. This is what is hoped of the new system. In response to Dr Wooding's specific

query, Mr Thomas suggested that the new system will not address the fundamental issue, noting that any system will require the same level of input from users. The Assurance and Risk team has undertaken a significant amount of work on the skillset of users; it is the mindset in regard to risk management which needs to change. Miss Wilmshurst suggested that the planning process being more aligned to risks has demonstrated that this is driving decisions within the organisation, and can potentially benefit functions and services. In response to a query around whether risk management forms part of staff objectives and appraisal, Members heard that it is included in employment terms and conditions and is discussed at induction.

Decision: The Committee:

- **TOOK ASSURANCE** on the work being progressed to implement the objectives set out in our Risk Management Strategy to strengthen the effectiveness of our Risk Management Framework, and our overall risk maturity as an organisation
- **ENDORSED** the revised Risk Management Objectives for 2027.

AC(26)147

ARAC Workplan 2026/27

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

AC(26)148

Any Other Business

There was no other business reported.

AC(26)149

Matters and Risks for Escalation to the Board

As noted.

AC(26)150

Date and Time of Next Meeting

9.30am, 15 October 2026