



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

DATE 15 October 2026

TIME 9:00 AM - 1:00 PM

LOCATION Dolau Cothi Meeting Room, Corporate Headquarters, Picton
Terrace/Microsoft Teams Meeting

Audit and Risk Assurance Committee

15 October 2026

Agenda - 15 October 2026

1 Introductions

9:00 AM, 0 min

1.1 Apologies

9:00 AM, 0 min

Rhodri Evans (Hywel Dda UHB - Independent Member)

1.2 Declaration of Interests

9:00 AM, 0 min

All

[HDdUHB Register of Board Members Interests 2026-27](#)

2 Governance

9:00 AM, 0 min

2.1 Minutes of the Meeting held on 13 August 2026

9:00 AM, 0 min

Rhodri Evans (Hywel Dda UHB - Independent Member)

2.2 Table of Actions

9:00 AM, 5 min

Rhodri Evans (Hywel Dda UHB - Independent Member)

2.3 Matters Arising not on Agenda

9:05 AM, 0 min

Rhodri Evans (Hywel Dda UHB - Independent Member)

2.4 Escalation Status Update Report

9:05 AM, 20 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

9:25 AM, 5 min
Rhodri Evans (Hywel Dda UHB - Independent Member)

2.6 Scheme of Delegation

9:30 AM, 10 min
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

3 Audit Wales

9:40 AM, 0 min

3.1 Audit Wales Update Report

9:40 AM, 5 min
Urvisha Perez

3.2 Deep Dive Review of the Arrangements to Manage Estates

9:45 AM, 20 min
Urvisha Perez, James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning)

3.3 Review of Cancer Services

10:05 AM, 20 min
Anne Beegan, Urvisha Perez, Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care), Lisa Humphrey (Hywel Dda UHB - General Manager)

4 NWSSP – Audit and Assurance Services - Internal Audit

10:25 AM, 0 min

4.1 Internal Audit Plan Progress Report

10:25 AM, 5 min
James Johns (NWSSP - Internal Audit)

4.2 Pathways of Care Delays (Reasonable Assurance)

10:30 AM, 15 min
James Johns (NWSSP - Internal Audit), Sophie Corbett (NWSSP - Audit & Assurance Services), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Anna Chiffi (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality)

4.3 Workforce Planning (Reasonable Assurance)

10:45 AM, 15 min

James Johns (NWSSP - Internal Audit), Sophie Corbett (NWSSP - Audit & Assurance Services), Lisa Gostling (Hywel Dda UHB - Director of Workforce & OD/Deputy CEO), Tracy Walmsley (Hywel Dda UHB - Assistant Director of People Planning)

4.4 Staff Experience and Wellbeing (Reasonable Assurance)

11:00 AM, 15 min

James Johns (NWSSP - Internal Audit), Sophie Corbett (NWSSP - Audit & Assurance Services), Lisa Gostling (Hywel Dda UHB - Director of Workforce & OD/Deputy CEO), Corinna Lloyd-Jones (Hywel Dda UHB - Head of Organisation Relations)

4.5 Organisational Change Process Operational Structure

11:15 AM, 0 min

James Johns (NWSSP - Internal Audit)

- **Deferred to 10 December 2026**
-

4.6 Financial Management: Grip & Control

11:15 AM, 0 min

James Johns (NWSSP - Internal Audit)

- **Deferred to 10 December 2026**
-

4.7 Radiology Informatics System Programme (RISP)

11:15 AM, 0 min

James Johns (NWSSP - Internal Audit)

- **Deferred to 10 December 2026**
-

BREAK

11:15 AM, 10 min

5 Clinical Audit

11:25 AM, 0 min

5.1 Clinical Audit Update

11:25 AM, 15 min

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

6	Financial Focus 11:40 AM, 0 min
6.1	Financial Assurance Report 11:40 AM, 15 min <i>Huw Thomas (Hywel Dda UHB - Director of Finance)</i>
6.2	Counter Fraud Update 11:55 AM, 10 min <i>Benjamin Rees (Hywel Dda UHB - Local Counter Fraud Specialist)</i>
7	Assurance and Risk 12:05 PM, 0 min
7.1	External Recommendations and Welsh Health Circulars Assurance Report 12:05 PM, 10 min <i>Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)</i>
8	Post Payment Verification 12:15 PM, 0 min
8.1	Post Payment Verification (PPV) Mid-Year Report 12:15 PM, 15 min <i>Huw Thomas (Hywel Dda UHB - Director of Finance), Amanda Legge (NWSSP - PCS), Sue Tillman (NWSSP - PCS)</i>
9	For Information 12:30 PM, 0 min
9.1	ARAC Workplan 2026/27 12:30 PM, 0 min <i>Rhodri Evans (Hywel Dda UHB - Independent Member)</i>
10	Any Other Business 12:30 PM, 0 min

11 Review of Meeting

12:30 PM, 0 min

11.1 Matters and Risks for Escalation to the Board

12:30 PM, 0 min

12 Date and Time of Next Meeting

12:30 PM, 0 min

9.30am, 10 December 2026

In-Committee Session

In accordance with the Committee's Terms of Reference, which permit the Committee to operate an in-committee function for the consideration of sensitive and/or confidential information, the next part of the meeting will be held in private session. Attendance will be restricted to Committee Members and those individuals (or their nominated deputies) identified in the Terms of Reference.

This session will consider the following items:

1. Counter Fraud Investigations

A summary of matters considered will be reported to the next appropriate Committee meeting.

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1 - Introductions

1.1

9:00 AM, 0 Mins

1.1 - Apologies

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

| For information

1.2

9:00 AM, 0 Mins

1.2 - Declaration of Interests

All

[HDdUHB Register of Board Members Interests 2026-27](#)

| For information

2 - Governance

2.1

9:00 AM, 0 Mins

2.1 - Minutes of the Meeting held on 13 August 2026 *Rhodri Evans (Hywel Dda UHB - Independent Member)*

| For approval

Attachments

Unapproved ARAC Minutes 13 August 2026 v2.pdf

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

Date of Meeting: **09:30, Thursday 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

2.2

9:00 AM, 5 Mins

2.2 - Table of Actions

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

| For assurance

Attachments

[ARAC Table of Actions.pdf](#)

AUDIT AND RISK ASSURANCE COMMITTEE (ARAC)/ PWYLLGOR ARCHWILIO A SICRWYDD RISG
13/08/2026

TABLE OF ACTIONS/TABL GWEITHREDOEDD

Key: AC-Andrew Carruthers; HT-Huw Thomas; LD-Lee Davies; RE-Rhodri Evans; SD-Sharon Daniel

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
07/05/2026	AC(26)079	Major Infrastructure Investment Programme (Reasonable Assurance) • To work with Mr Lee Davies, Mrs Joanne Wilson and Mr Rob Elliott, in dialogue with the Procurement team, to establish how greater assurance can be provided around contract management	HT	15/10/2026	Complete The advice of the Head of Procurement has been sought and has confirmed that Capital projects have been operating compliantly within the scope of the existing frameworks. The introduction of the Procurement Act 2023 (since February 2024) will bring additional requirements when the frameworks expire and are re-procured under the new regulations. A meeting was held on 8 July. This remains in progress. Procurement is working with Estates to understand current workplans, activity volumes and resource plans. This will provide a baseline understanding of current arrangements and support the development of a clear governance framework covering the full commercial lifecycle, from route-to-market decisions and contract award through to ongoing contract management. The aim is to establish defined roles, responsibilities, oversight, and reporting arrangements to provide greater assurance and consistency across the programme. Initial engagement has commenced, and a proposed governance approach will be developed and agreed with key stakeholders before being reported through the appropriate assurance routes.

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
13/08/2026	AC(26)132	Table of Actions • AC(26)079 – to provide a further update on work in relation to contract management at the next meeting	HT	15/10/2026	Complete An update was presented to the meeting under Item AC(26)143 (Progress Update on Major Infrastructure Investment Programme Internal Audit).
13/08/2026	AC(26)134	Escalation Status Update Report • For the Executive Director of Strategy and Planning to discuss with the Chief Executive whether the stated Executive Team priorities require Board consideration and confirmation	LD	15/10/2026	Complete The three priorities were set out in the Integrated Delivery Report that was reported to Board on 24 September 2026.
13/08/2026	AC(26)138.01	Financial Assurance Report • To provide, as part of the report to the next meeting, details regarding contract management	HT	15/10/2026	Complete An update provided as part of the Financial Assurance Report at the ARAC meeting on 15 October 2026.
13/08/2026	AC(26)138.02	Financial Assurance Report • To revisit whether a report on HDdUHB patient access to treatment in other health boards should be reinstated at QSEC	SD	15/10/2026	Complete Discussed at QSEC agenda setting on 1 September 2026. Executive Director of Nursing, Quality & Patient Experience and Executive Director of Strategy & Planning to discuss including on December 2026 QSEC agenda.
13/08/2026	AC(26)138.03	Financial Assurance Report • To discuss the issue of information transfer and sharing between health boards at DDIC	HT	15/10/2026	Complete This will be incorporated into the forward plan to DDIC.
13/08/2026	AC(26)141	Correspondence Regarding Audit Participation and Implementation of Recommendations • To provide an update at the next meeting on discussions with the Chief Executive around policing the implementation of audit recommendations	RE	15/10/2026	Complete ARAC Chair and QSEC Chair met with the CEO on 27 August 2026 to discuss the concerns of the Committees (in general) regarding action AC(26)141. The CEO agreed to put actions in place and request plans from Lead Executives as to how this matter will be resolved. Follow-up meeting to be held on 22 October 2026 to discuss progress.

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
13/08/2026	AC(26)145.01	Scrutiny of Outstanding Improvement Plans - Update on Status of Risks and Audits: Community and Integrated Medicine • To agree, within a month, management responses and completion dates for those reports and recommendations without these	AC	15/10/2026	Complete Significant progress has been made in responding to the Audit and Risk Assurance Committee recommendation. A review of all outstanding improvement plans, recommendations and associated management actions within Community & Integrated Medicine has been undertaken. Work has focused on ensuring that all recommendations have clearly defined management responses, accountable leads and realistic completion dates to support effective monitoring and assurance. The majority of previously incomplete actions have now been reviewed and updated. Engagement has taken place with operational and professional leads to validate outstanding actions, confirm ownership and establish revised completion trajectories where required. A strengthened oversight process has also been implemented through routine governance reporting arrangements to improve visibility of progress and support timely escalation of risks or delays. A small number of actions remain under review where further discussion with lead officers is required to finalise management responses and completion dates. This work is progressing and is expected to be completed by the agreed deadline of 15 October 2026, at which point a fully updated position statement will be available for Committee assurance.
13/08/2026	AC(26)145.02	Scrutiny of Outstanding Improvement Plans - Update on Status of Risks and Audits: Community and Integrated Medicine • To review risks to assess duplication and potential for amalgamation	AC	15/10/2026	Complete Review of the Community & Integrated Medicine risk register has commenced to identify duplicate, overlapping or related risks that could be amalgamated. Initial work has identified opportunities to streamline the register and improve oversight. Final review and agreement of proposed changes is underway and remains on track for completion by 15 October 2026. In progress.

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
13/08/2026	AC(26)145.03	Scrutiny of Outstanding Improvement Plans - Update on Status of Risks and Audits: Community and Integrated Medicine • To provide an update to the December 2026 or February 2027 meeting	AC	15/10/2026	Complete Forward planned for the December 2026 ARAC meeting in the first instance

2.3

9:05 AM, 0 Mins

2.3 - Matters Arising not on Agenda

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

| For discussion

2.4 - Escalation Status Update Report

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

| For assurance

Attachments

[Escalation Status Update Report ARAC 15 October 2026.pdf](#)

[Appendix 2 JT to PK HDdUHB Letter Following Accountability Review Meeting.pdf](#)

[Appendix 1 CMHC Letter to Neil Wooding Chair Hywel Dda University Health Board.pdf](#)



Third Consolidated Update

ARAC Escalation Update

The NHS Wales Accountability and Support Framework: what it means for the Health Board's escalation arrangements and the risks the Health Board carries

Audit and Risk Assurance Committee | 15 October 2026

Executive Lead: Mr Lee Davies, Executive Director of Strategy and Planning

Reporting Officer: M Shaun Ayres, Director of Delivery

In Effect from 29 September 2026

One NHS Wales framework for accountability, escalation and support

Accountability Review Letter

Welsh Government's assessment of 30 September 2026, ahead of the November 2026 Escalation Board

Reset Support from 1 October 2026

NHS Wales Performance and Improvement, through October 2026 and November 2026

Our Levels are Unchanged for now

Current Levels and criteria continue until the November 2026 outcome is confirmed

What Welsh Government has told us

Following the accountability review on 16 September, Welsh Government wrote on 30 September that, despite previous assurance and the development of plans, we continue to move in the wrong direction across all domains, with concern about the Health Board’s capability and capacity to recover. It recognised a stable Board and executive team and some areas of improvement. It expects clear evidence of impact at the November escalation board; otherwise, further intervention arrangements will be considered. This is consistent with the letter from the Cabinet Secretary for Health and Care to the Chair of the Health Board on 26 August 2026, that is included as **Appendix 1**.

What has changed

On 29 September 2026, the NHS Wales Accountability and Support Framework replaced the Oversight and Escalation Framework. It joins accountability, escalation, support and de-escalation around four Pillars on a leadership (well-led) foundation.

What has not changed yet

Health Board escalation levels and every de-escalation criterion stay in place until Welsh Government confirms the outcome of the first assessment under the new framework, at the tripartite meeting in November.

The support we are receiving

From 1 October 2026, NHS Wales Performance and Improvement (NHSWPI) is working alongside us for two months on urgent care flow and discharge, financial recovery and three quality priorities. Accountability for delivery stays with Health Board Executive Directors and the Board.

What it means for this Committee

Status will normally be set for whole Pillars, and the leadership foundation draws on the governance, risk and audit evidence this committee oversees. Read against the Pillars and the letter, the risk register shows how much we carry beyond the areas under escalation.

The Health Board’s assessment. Architecture and consistency move to Advise: the committee maps may need redrawing to the Pillars, and Welsh Government challenged the Health Board’s description of the annual plan as credible. Totality remains Alert: the letter’s concern about the Health Board’s capacity to recover and the evidence of the risk register point the same way.

The Accountability Review Letter



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Welsh Government's letter of 30 September 2026 follows the accountability review on 16 September 2026. It sets out what it recognised and what it now requires in each area of the new framework. The letter is attached as **Appendix 2**.

Area	What was recognised or noted	Concerns and what is required
Leadership (well-led)	A stable Board and executive team, with some evidence of collective working. Operating model changes: a performance review group chaired by the Chief Executive, a Chief Delivery Officer being appointed and a Senior Leaders Group below the Executive Team.	Stronger oversight, clear expectations and increased accountability, holding individuals and services to account for the changes required.
Delivery and performance	Improvement in parts of the frailty pathway, some cancer tumour sites, periods of some urgent care measures and regional working in ophthalmology.	Urgent care gains have not been sustained, notably at Glangwili and Withybush Hospitals. Planned care waits are rising and rely on temporary measures and external support, and diagnostic waits over eight weeks rise each month. Operational grip and control are required, with urgent care the focus before winter.
Quality	Stronger quality governance, including a position statement and service deep dives for the clinical services plan.	A move from further governance to better outcomes. Low incident reporting alongside high harm, continuing infection outbreaks, cleanliness standards not met, and unclear risk oversight of some services, where a matrix and criteria are being developed.
Workforce	A better understanding of the workforce position, successful recruitment to hard-to-fill posts, and new development programmes for medical staff and Board members.	Evidence of impact, and a workforce plan triangulated with finance and service planning.
Finance and planning	Early development of the clinical services implementation plan, with estimated milestones. A further meeting is arranged to explore it.	The most significant issue. Welsh Government was not assured that we can deliver the £41m deficit: the risk is up to £61m, with a £19.9m savings gap, and the additional £26m could become recoverable if its conditions are not met. A deliverable plan is required, with quantified actions, named executive owners, timescales and the recurrent effect of each action.

The next Escalation Board is in November 2026. Welsh Government expects clear evidence that the Health Board's actions are making an impact, and states that otherwise further intervention arrangements will be considered. It also asked for a timeline, by 30 September, for when it will receive the actions to deliver the year-end forecast.

Five Levels and the response at each



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The numbering is familiar. What changes is the response attached to each Level and the support that comes with it. The Health Board's areas are shown at the level they hold today.

Level	Threshold	Core response	Our areas today
Level 1 Routine accountability	Broadly on plan, with effective governance; variation is managed through normal arrangements.	Routine assurance, common reporting, accountability reviews and earned autonomy.	Leadership and governance, since December 2025 Cancer, since February 2026 Child and adolescent mental health services, since July 2025
Level 2 Emerging concern: enhanced oversight and support	Emerging or sustained risk that routine arrangements are unlikely to resolve, where capacity to recover remains.	Baseline assessment, local improvement plan, enhanced monitoring and preventative support. Decided by Welsh Government officials.	None
Level 3 Significant concern: formal recovery	Significant concern in a Pillar, or Level 2 action has not secured enough improvement.	Formal recovery framework, escalation board, milestones, targeted NHSWPI support and independent review where needed.	Planned care
Level 4 Targeted intervention and support	Serious failure or risk needing commissioned intervention and substantial external capacity or turnaround support.	A formal intervention mandate, normally delivered by NHSWPI's Intensive Support, Recovery and Turnaround (ISRT) team when commissioned by Welsh Government, an integrated improvement plan and close oversight.	Finance, strategy and planning Urgent and emergency care Healthcare associated infections Fragile services, including ophthalmology
Level 5 Directed intervention and intensive support	Very serious or complex failure, where capability is insufficient to recover without intensive external intervention.	Directed intervention, intensive recovery, possible use of Ministerial powers and whole-Board accountability.	None

Level 2 is not used on the way down. A Pillar leaving Level 4 normally moves to Level 3, then to routine accountability, each step on sustained evidence. Three of the Health Board's areas have returned to routine accountability since January 2024.

Our escalation areas by Pillar

The four Pillars already structure the Health Board’s performance reviews with NHSWPI. What is new is that escalation status will follow them, normally set for a whole Pillar rather than for individual services.

Quality	Workforce	Finance and Planning	Delivery and Performance
<i>Safety, effectiveness and experience of care, including oversight of fragile and high-risk services</i>	<i>Supply, retention, wellbeing, productivity, culture and workforce planning</i>	<i>Financial sustainability, planning maturity, the integrated medium-term plan and the clinical services strategy</i>	<i>National access standards and recovery trajectories for urgent, planned, cancer and diagnostic care</i>
OUR AREAS TODAY Level 4 Healthcare associated infections Level 4 Fragile services: oversight and safety	OUR AREAS TODAY Not escalated today. Assessed under the new framework from November 2026.	OUR AREAS TODAY Level 4 Finance, strategy and planning, including the clinical services plan	OUR AREAS TODAY Level 4 Urgent and Emergency Care Level 4 Ophthalmology access, a fragile services criterion Level 3 Planned care Level 1 Cancer Level 1 Child and adolescent mental health

Leadership (well-led) foundation	Level 1 Leadership and governance, since December 2025	Assessed across all four Pillars, including digital, data and cyber resilience
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Three of the four Pillars contain an area at Level 4 today. Welsh Government will confirm the Health Board’s status under the new structure after the November 2026 assessment, and the reissued framework will follow it.

What changes in how we are assessed



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Four changes affect how the Health Board's position will be judged.

Change	What it means for us
Status is normally set for a whole Pillar	Planned care (Level 3) and Urgent and Emergency Care (Level 4) are likely to be judged within one Pillar, alongside cancer and mental health access. Improvement in one service is less likely to change the Level on its own based on the reading of the new framework. Service-specific escalation is expected to be limited to Level 2.
Leadership underpins every Pillar	Where several connected areas are under pressure, the escalation decision is more likely to centre on leadership, and where concerns span multiple Pillars, escalation of the whole organisation may be considered. The Health Board's Level 1 position for leadership and governance therefore rests on evidence across all four Pillars.
One version of the truth	A common dataset, reporting pack and evidence repository will serve every accountability, escalation and support discussion, under agreed data standards, governance and audit. The pack includes organisational risks and mitigating actions.
De-escalation rests on the Board's evidence	The Board and Chief Executive must show that outcomes are achieved and sustained, risk has reduced, evidence is reliable, plans are resourced and there is capacity to sustain improvement with less support. Automatic de-escalation remains where quantifiable criteria are met and sustained.

Assessment combines data with judgement, including the quality of Board assurance and the Health Board's capacity to recover. No single metric should normally decide status unless it shows an immediate and material risk.

What changes in support and accountability

Support is now defined alongside escalation, and the consequences of not improving are stated in advance.

Change	What it means for us
Standard intervention offer at Level 4	If a Pillar is confirmed at Level 4, the framework's standard intervention offer applies, normally delivered by NHSWPI's ISRT team under a mandate commissioned by Welsh Government. It normally works in five phases (mobilise, assess, plan, support and transition). The assessment covers all four Pillars and the leadership foundation, and the plan phase produces one integrated improvement plan that the Health Board owns.
Priorities, criteria and consequences, published	The reissued framework will set a small number of priorities and de-escalation criteria, the period to deliver and sustain them, and the consequences if improvement falls short. Welsh Government publishes it, and the Board monitors it regularly. Separately, the accountability conditions that will follow the Health Board's Annual Plan assessment are linked to the Health Board's escalation Level.
Clearer roles and one rhythm	Welsh Ministers take formal escalation decisions. NHSWPI is the single operational interface and does not decide status. Audit Wales, Healthcare Inspectorate Wales (HIW) and NHSWPI give written evidence to a tripartite meeting twice a year. Every organisation has two accountability reviews a year, one of which may be held in public.
Duties at Level 3 and above	A Senior Responsible Officer (SRO) for each escalated Pillar, Board ownership of recovery, enough resources to achieve the required outcomes, and de-escalation criteria actively monitored and reported to the Board. These largely continue the Health Board's current duties, now organised by Pillar.

The framework reflects several points the Health Board made to the national review in August 2026, including support defined at the same time as escalation, one governed evidence base with documented decisions, and automatic de-escalation once quantifiable criteria are met and sustained.

Organisational reset support: scope and leads



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From 1 October 2026, NHSWPI is working alongside the Health Board through October and November 2026, on terms developed with us from principles agreed in mid-September 2026. Its purpose is rapid recovery against current delivery concerns and the prevention of further escalation.

Pillar	Our lead	NHSWPI lead	Focus for October and November
Oversight of the support	Lee Davies Executive Director of Strategy and Planning	Adele Gittoes Director of ISRT	One triangulated monthly position from the Pillar returns, for the Health Board's Chief Executive and the NHSWPI Managing Director.
Delivery and performance	Andrew Carruthers Chief Operating Officer	Corrina Casey Director of Delivery and Performance	Urgent care: a daily operating model for flow, escalation and de-escalation; reliable discharge from the first board round, seven days a week; clear accountability from ward to executive. A recent NHSWPI desktop review, supported by the Health Board's operational teams, found a credible and strategically aligned urgent care improvement architecture, with consistent execution as the opportunity. Furthermore, Jeremy Griffiths is supporting the Health Board for several weeks from the week commencing 28 September 2026.
Finance	Huw Thomas Director of Finance	Claire Green Director of Finance	Continues the financial recovery work in place since 2023, now aligned more closely with the other Pillars. NHSWPI will also assess VAULT and monthly monitoring return intelligence for variation and opportunity, to test against the Health Board's own list of opportunities.
Quality and patient safety	Mark Henwood Executive Medical Director Sharon Daniel Executive Director of Nursing, Quality and Patient Experience	Dr Antony Gibson Medical Director Hayley Peters Nurse Director	A joint working group on healthcare associated infections (with Public Health Wales), on quality risk from overcrowding in urgent care, and on never events, through a self-assessment against the national and local safety standards for invasive procedures. Leads report back at a quality meeting in mid-November.
Workforce	<i>Not yet named</i>	<i>Not yet named</i>	The terms ask for a director lead for each Pillar and a return from all four. A workforce lead and scope are still to be agreed.

The support is intended to align with and supplement the Health Board's existing plans. For urgent care, it standardises how those plans are carried out rather than adding programmes.

Organisational reset support: governance

The support adds a monthly joint reporting line. It does not move accountability for delivery.



Authority	Status	Review
NHSWPI can advise, challenge, convene and escalate. It holds no executive decision rights over the Health Board's services. Accountability stays with the Health Board Executive Directors, clinical leaders and the Board, as the framework requires throughout escalation.	The support is co-produced with us and does not change the Health Board's escalation framework, de-escalation criteria or agreed trajectories. Pillar leads set their own meeting rhythm, aligned with existing meetings where possible; NHSWPI may add meetings where assurance or support is not being provided.	The terms are reviewed every four weeks. A light-touch review in December, led by NHSWPI with the Health Board's support, will assess the benefits and risks of the approach and inform any future support, reflecting the views of Welsh Government, NHSWPI and the health board.

We will ask the December review to consider the capability the support leaves behind and the capacity it used. For quality, delivery and performance and the leadership foundation, the framework's illustrative Level 4 de-escalation criteria include evidence that external intervention has strengthened capability.

Where assurance sits under the new framework

The Committee keeps the view of the whole; Lead Committees keep the detail of each Pillar. This map is proposed for the reissued framework, and the current mapping of all 31 criteria continues until then.

Board owns the escalation position, any integrated improvement plan and the choices they require

Audit and Risk Assurance Committee tests the whole system (architecture, consistency, totality) and gives the Board assurance on the leadership foundation

QUALITY
Quality, Safety and Experience Committee
Infections, fragile services oversight, incidents and never events, complaints and experience. The quality strand of the reset support.

WORKFORCE
People, Organisational Development and Culture Committee
Workforce plan and workstreams, variable pay, sickness absence, culture and staff voice.

FINANCE AND PLANNING
Finance and Performance Committee
Financial recovery and savings.
Strategy and Planning Committee
Annual plan, integrated medium-term plan, clinical services plan and regional planning.

DELIVERY AND PERFORMANCE
Finance and Performance Committee
Urgent and Emergency Care, planned care, cancer, diagnostics and mental health access. The urgent care strand of the reset support.

Leadership (well-led) foundation the Board, with assurance from this Committee on governance, risk and audit. Digital, data and cyber evidence comes through the Digital, Data and Innovation Committee; culture and staff voice through the People, Organisational Development and Culture Committee.

Where this Committee finds a gap, it refers it to the Lead Committee in writing and tracks the response, rather than re-examining the issue itself.

The evidence this committee oversees

The framework relies on evidence this Committee already oversees. That makes its role more important without widening its remit.

WHAT THE FRAMEWORK DRAWS ON

The leadership foundation	Board assurance frameworks, risk registers, internal audit, Audit Wales and HIW reports, and governance reviews. The two limited assurance internal audit reports from April 2026, on operational governance and on internal escalation, are part of this evidence.
The tripartite	Written evidence from Audit Wales, given independently and within its own remit, alongside HIW and NHSWPI, twice a year.
Reliable evidence	Effective Board oversight and reliable evidence at every de-escalation and, in the illustrative Level 4 criteria, independent assurance that supports reduced intervention.
Risk	Organisational risks and mitigating actions, carried in the common reporting pack. Failure to mitigate known material risks is among the possible triggers for escalation.

WHAT IT MEANS FOR THIS COMMITTEE

Read the management responses to those reports as escalation evidence and track them accordingly.
Keep progress against audit recommendations current before each tripartite, so that the Health Board’s own account reflects the latest position.
Give weight to audit findings on data quality, such as the earlier limited assurance on the validation of emergency department waiting time data and consider internal audit assurance on de-escalation evidence.
Read the register against the Pillars and the Health Board’s criteria, so it shows the risks Welsh Government will look for. The next five slides do this.

The framework assesses the quality and credibility of Board assurance and management information. This Committee is where that quality is tested.

The letter and the risk register

The register reflects the service and financial concerns the letter names. The Health Board-Level concerns it puts first are not yet on it.

Concern named in the letter	How the register reflects it (current score out of 25)	Status
Delivering the £41m deficit	Principal and corporate risks at 25, and 17 extreme operational risks on savings, costs and income	Reflected
Urgent care at Glangwili and Withybush	Two corporate risks at 20, and extreme risks at both sites	Reflected
Planned care reliant on temporary measures	A corporate risk at 12, and 28 extreme operational risks	Reflected
Diagnostic waits over eight weeks	Radiology and ultrasound risks at 16 to 25, two of them corporate	Reflected
A workforce plan triangulated with finance	Principal and corporate workforce risks at 16	Reflected
Unclear risk oversight of some services	A principal risk on embedding the quality management system, at 12	Partly
Low incident reporting alongside high harm	One operational risk on under-reporting, at 12	Partly
Infection outbreaks continuing	Three extreme risks on facilities and stewardship; none on infection rates	Partly
Cleanliness standards not met	One organisation-wide risk at 6, within its tolerance	Partly
Capability and capacity to recover	Considered by this Committee in June 2026; not yet a distinct risk	Not yet
The escalation position and further intervention	Not recorded as a risk	Not yet

What it means for this Committee

- The register sees the parts.** It carries the service and financial risks the letter names, but not the organisation-Level concerns the letter puts first: the Health Board’s capacity to recover and the escalation position itself.
- Reporting affects the register too.** Low incident reporting alongside high harm suggests the register may also understate risk.
- Assurance needs evidence behind it.** The letter notes infection outbreaks continuing despite earlier assurance that rates would fall and challenges the Health Board’s description of the Annual Plan as credible.

The next four slides read the whole register against the framework.

The letter asks for grip, control and accountability. The read-across that follows suggests grip will hold best when it is applied to a small number of priorities, with decisions recorded on what waits. Therefore, the final two points will now be reflected in Risk 2212 namely, the risk of the Health Board not having an approvable Annual Plan/Integrated Medium Term Plan (IMTP).

Register position at 1 October 2026. Scores are current scores out of 25.

The risk register read against the framework

The 1 October 2026 register holds 674 risks, 218 of them scored 15 or above (extreme). Read against the new framework, every Pillar carries extreme risk, and 119 of the 218 sit outside the areas the Health Board’s current escalation framework covers.

Area at Level 3 or 4

Area at Level 1

Outside our current framework

Quality 78 extreme risks 6 principal or corporate	28 50 Level 4: fragile services 25, infections 3 Outside: pathology, transfusion and mortuary 16; other clinical services 11; nutrition and therapy services 11; medicines 7; community and palliative care 5
Workforce 10 extreme risks 4 principal or corporate	10 No area escalated today Outside: workforce supply, wellbeing and staff safety 10
Finance and planning 51 extreme risks 10 principal or corporate	22 29 Level 4: finance 19, strategy and planning 3 Outside: estate, infrastructure and site safety 28; climate adaptation 1
Delivery and performance 70 extreme risks 4 principal or corporate	41 8 21 Level 4: urgent and emergency care 13. Level 3: planned care 28. Level 1: cancer 8 Outside: therapy and nutrition access 7; primary and community care 6; mental health and learning disabilities 4; public health 2; other 2
Leadership foundation 9 extreme risks 1 principal or corporate	9 Level 1: leadership and governance, no extreme risks Outside: digital systems, data and information governance 9

What the read-across shows

- **Every Pillar carries extreme risk**, including workforce, where no area is escalated today. However, they naturally align to the current risk profiles.
- **Within the escalated areas**, most sits in planned care, including diagnostics and therapies (28), and fragile services (25). Infections, at Level 4, carries three.
- **Outside them**, the largest groups are estate and site safety (28), therapy and nutrition services (18) and pathology (16).
- **25 of the 218 are principal or corporate risks**. The rest are operational and reach the Board through its committees.

91

at Level 3 or 4

8

at Level 1

119

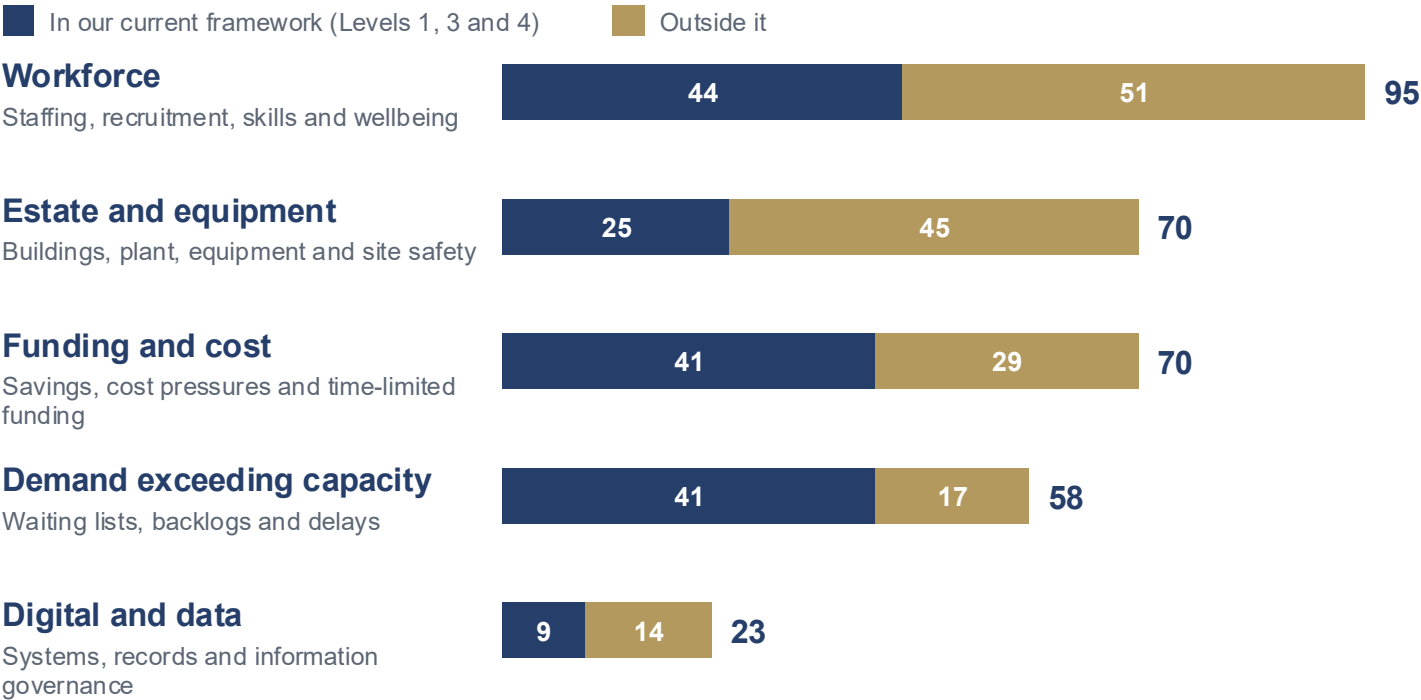
outside

Under the new framework, status is normally set for the whole Pillar, and the common reporting pack includes organisational risks. Risks outside today's criteria are therefore likely to form part of how each Pillar is judged. However, we need to be clear that this will not be linear and risks are naturally interoperable, so workforce is liable to be reflected in most of the key risks where applicable.

Indicative reading of the 1 October register, to show the whole; individual risks remain with their lead committees. Each extreme risk is counted once, in the area it most directly concerns. Pillars follow the framework's own scope, which places estates in finance and planning and digital in the leadership foundation.

Common themes across the register

Five themes recur across the extreme risks, on both sides of the line the current framework draws. 178 of the 218 carry at least one of the four enabling themes: workforce, estate and equipment, funding, and digital and data.



Number of extreme risks carrying each theme. A risk can carry more than one.

None of these themes is new to lead committees. What the register adds is their combined scale, and the fact that the same enablers sit on both sides of the line. The new framework's quality Pillar covers fragile and high-risk services generally, not only those named in an escalation framework.

Themes are read from the register's own theme tags and from risk titles..

FRAGILITY BEYOND THE NINE NAMED SERVICES

75 of 100

extreme risks the register tags as fragile services relate to services beyond the nine named in the Health Board's current framework, among them UEC, pathology and transfusion, nutrition and dietetics, therapies, cardiac diagnostics, primary care and mental health. 44 sit outside the Health Board's current framework altogether.

SHARED ENABLERS

Improvement in the escalated areas depends on the same workforce, estate and funding as the risks outside them. Action on one draws on the capacity available for the other.

Capacity, pace and persistence

The register also shows where extreme risk is concentrated, how long it persists and how quickly actions are completed. Read together, these are indicators of capacity, the concern the 30 September letter also raises.

179 of 218

Held in four directorates

Allied health professions and health sciences, community and integrated medicine, planned and specialist care, and estates and facilities hold 82 of the 91 extreme risks in the escalated areas and 91 of the 119 outside the Health Board’s current framework. This reflects where services are delivered, and it means the same teams carry both.



98

Identified more than two years ago

34 of these were identified more than five years ago. The median extreme risk was first identified about 21 months ago, with little difference between the escalated areas and the rest.



54%

Open actions past their original date

301 of the 557 open actions on extreme risks are past their original completion date. In the escalated areas the figure is 55%, and across the whole register 727 of 1,332. 14 extreme risks have no open action recorded.



None

Extreme risks recorded as tolerated

194 are recorded for treatment and 24 have no decision recorded. 211 have a target below the extreme range, 133 of them at a moderate or low score, so the register assumes almost every extreme risk will be reduced.



Taken together, the evidence suggests that the combined programme is larger than the capacity available to progress all of it at once. Some sequencing is already happening, through actions that run beyond their original dates. Making it a deliberate Board decision would give the criteria, the reset support and the register one order of priority.

Ages run from the date each risk was identified to 1 October 2026. Actions are those recorded against the register on the same date.

Aligning risk and priority

Risk and priority will not always line up, and they do not need to. What matters is that the difference is managed by decision rather than by default.

Priorities the register does not yet reflect	Extreme risk outside our current framework	Performance and risk on separate routes
• Infections, at Level 4: three extreme risks, all operational, on isolation facilities, the Glangwili Hospital environment and antimicrobial stewardship. None track the infection rates in the Health Board's criteria. • The escalation position itself, and the move to the new framework. • The Health Board's capacity to deliver the combined requirement, considered by the committee in June and raised in the 30 September 2026 letter.	• 119 extreme risks, the largest groups in estate and site safety (28), therapy and nutrition services (18) and pathology (16). • 85 of them are led by the Quality, Safety and Experience Committee, which also leads 69 in the escalated areas. • The framework lists failure to mitigate known material risks among the possible triggers for escalation.	• Performance against the urgent and planned care criteria reports to the Finance and Performance Committee. • The 41 extreme risks in those two areas are led by the Quality, Safety and Experience Committee. • A committee map drawn to the Pillars can bring the two together.

How we propose to manage it

One order of priority Set by the Board across the de-escalation criteria, the reset support and the extreme risks, and applied through the Performance Recovery Group, which brings financial and operational delivery together.	Deferral as a decision Where treatment has to wait, record a decision to tolerate for a stated period, with interim controls, a review date and approval in line with the Board's risk appetite, rather than a moved action date.	Capacity as a corporate risk Add the Health Board's capacity to deliver the combined requirement to the corporate risk register, alongside the existing risk on staff wellness and the pace of change, scored with this evidence and reviewed by the Board.	Risk read by Pillar Link each principal, corporate and extreme risk to a Pillar and its lead committee, so that performance and risk are reviewed together and feed the common reporting pack.
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The reissued framework will set a small number of priority areas. A register aligned to them, with explicit decisions on what waits, is the kind of evidence the framework assesses: early recognition of risk, credible and resourced plans, and headroom to recover.

Assessment against the committee's three tests



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Architecture and consistency move to Advise. Totality remains Alert.

Architecture

Is every requirement owned, with no gaps?

June: Advise · August: Assure
(proposed)

October: Advise (proposed)

In August we noted that a new framework could change this rating. The map of 31 criteria remains sound until the November outcome is confirmed, but it does not yet cover the workforce Pillar or the leadership foundation as a whole. The joint reports from the reset support have no agreed route to committees, the risk register does not show the escalation position, and the operating model changes recorded in the 30 September letter need a place in the map.

Returns to Assure when

the committee map is redrawn to the Pillars with the reissued framework, and the evidence in each joint highlight report reaches the lead committee for its Pillar.

Consistency

Is one account told internally and to Welsh Government?

June: Assure · August: Assure

October: Advise (proposed)

The Health Board's figures match Welsh Government's: a risk of up to £61m against the £41.0m plan, which Month 5 reporting shows as a £60.9m forecast before £19.9m of further action. But the 30 September letter challenges the Health Board's description of the Annual Plan as credible, and records that the scale and timing of the decisions coming to the Board were not clear. Savings are also reported on different bases (£33.6m identified to NHSWPI; £30.5m in Month 5 reporting).

Returns to Assure when

the Board and Welsh Government receive the same account of the decisions needed to deliver the £41m, with their scale and timing, and the Health Board's description of the plan reflects Welsh Government's assessment of it.

Totality

Is the combined programme deliverable within our capacity?

June: Alert · August: Alert

October: Alert

The 30 September letter records concern about the Health Board's capability and capacity to recover and asks us to move from plans to demonstrable improvement. The register points the same way: 218 extreme risks, 119 outside the areas the Health Board's current framework covers, drawing on the same workforce, estate and funding, with more than half of their open actions past their original dates. The reset support is a step towards the order of effort the committee sought in August.

Improves when

the Board sets one order of priority across the criteria, the reset support and the extreme risks, and records what waits as a decision.

The next ten weeks

The support period and the first assessment under the new framework run side by side. The November escalation board is where Welsh Government expects to see evidence of impact.



What we will bring to the December meeting

Item	Lead
The confirmed escalation status by Pillar and what it changes for us, if Welsh Government has confirmed it by then	Executive Director of Strategy and Planning
The outcome of the November Escalation Board, with a check that the evidence we submitted matches what the Health Board's Committees and the Board have seen	Executive Director of Strategy and Planning, with the Director of Delivery
A committee map redrawn to the four Pillars and the leadership foundation	Director of Delivery, with the Director of Corporate Governance
The December review of the reset support, with emerging findings if it is still under way: capability built, capacity used and any future support	Executive Director of Strategy and Planning
The risk register read by Pillar, with the corporate risk position on escalation, organisational capacity and infections	Director of Corporate Governance, with lead executives
A proposed order of priority across the criteria, the reset support and the extreme risks, for the Board	Executive Director of Strategy and Planning, with the Director of Delivery
A Board development session on the framework, taking up Welsh Government's offer	Director of Corporate Governance

Timings after the tripartite depend on Welsh Government confirming the outcome. We will report the position reached at the time of the December meeting.

Matters for the committee



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

The committee is asked to:

NOTE

the NHS Wales Accountability and Support Framework, in effect from 29 September 2026, and Welsh Government's letter of 30 September following the accountability review, which expects clear evidence of impact at the November escalation board. The Health Board's current escalation Levels and criteria continue until the November outcome is confirmed.

TAKE ASSURANCE

that the terms of the NHSWPI organisational reset support leave decision rights, and accountability for delivery, with Health Board Executives, clinical leaders and the Board.

AGREE

that the committee's three tests continue under the new framework, with architecture and consistency proposed at Advise and totality at Alert; that the committee gives the Board assurance on the leadership (well-led) foundation; and that a committee map redrawn to the Pillars, with the risk register read against it, comes to the December meeting.

SUPPORT

the proposed approach to aligning risk and priority: one order of priority set by the Board, deferral recorded as a decision, capacity added as a corporate risk, and the register read by Pillar.

ADVISE

the Board that the new framework changes the basis of assessment before it changes the organisation's status, and that the 30 September 2026 letter and the risk register point the same way: the combined requirement is larger than the areas under escalation, so deliverability of the whole remains a material concern. The Board may also wish to take up Welsh Government's offer of a development session.

**Cyfarwyddwr Cyffredinol Grŵp Iechyd, Gofal ac Atal / Prif
Weithredwr GIG Cymru**

**Director General Health, Health, Care and Prevention Group /
NHS Wales Chief Executive**



**Llywodraeth Cymru
Welsh Government**

Phil Kloer
Chief Executive
Hywel Dda University Health Board

Phil.kloer@wales.nhs.uk

Our Ref: JT/PK/SB

30 September 2026

Dear Phil,

Thank you for attending the Hywel Dda University Health Board accountability meeting on 16 September 2026 and the evidence submitted in advance. This letter sets out the key points of our discussion and the actions now required.

The health board recognised the scale of the challenges it's facing and acknowledged that delivery is not currently meeting expectations. You outlined work currently underway, and the immediate actions you are taking to address the concerns identified. However, despite previous assurance and the development of plans and strategies, the health board continues to move in the wrong direction across all domains with in-year deteriorations reported and concerns around the capability and capacity of the organisation to rapidly recover the position given the scale of the financial challenges as well.

Leadership (well-led)

The health board has a stable Board and executive team, with some evidence of the executive team working collectively to address the challenges the organisation faces. You shared the actions implemented throughout the health board to address leadership capability and oversight.

In particular:

- The operating model is being revised to increase grip and control, including the creation of a performance review group chaired by you.
- You are in the process of appointing a Chief Delivery Officer to strengthen executive accountability.
- A Senior Leaders Group has been implemented below the executive team to improve the connection between executive decisions and operational delivery.

Although you were able to evidence a range of actions currently underway in-year to address the challenges with leadership changes across the organisation, you must also

now strengthen the executive team's leadership approach through stronger oversight, clear expectations and increased accountability by holding individuals and services to account to deliver the changes and improvements required.

Delivery and performance

The health board evidenced some areas where delivery of services and performance has improved in-year, such as the frailty pathway in parts of the health board, cancer tumour sites, periods of some UEC metrics and regional working in ophthalmology. However, the overall performance position and sustainability of services remains an area of significant concern.

In particular:

- Improvements in urgent and emergency care performance have not been maintained , with particular challenges at Glangwili and Withybush.
- Planned care waiting times are moving in the wrong direction and remain reliant on temporary measures and external support.
- Diagnostic waits over eight weeks are too high and increasing every month which will have an impact on other services such as planned care and cancer.

The actions you are currently undertaking must improve operational grip and control of services, with a particular focus on addressing the urgent and emergency care position at the health board ahead of further winter pressures.

Quality

While elements of quality governance have been strengthened, including the development of a position statement and deep dives of services undertaken as part of the clinical services plan development. The health board must now move from implementing further governance arrangements and actions to delivery of improved outcomes to address the prominent quality and safety concerns identified.

In particular:

- Despite relatively low levels of incident reporting, there are concerns that levels of harm are high, therefore indicating a culture of inconsistent or lack of reporting.
- Infection, prevention and control outbreaks continue to be reported, despite being an area of focus and previous assurance provided that rates would reduce.
- Quality and safety risk management and oversight of specific services remain unclear, with a matrix and criteria being developed to increase oversight.

The discussion highlighted that although the health board has an understanding of the issues, overall, there remain consistent challenges which have not been addressed, such as healthcare associated infections and the failure to meet the required cleanliness standards.

Workforce

The health board evidenced an improved understanding of the overall in-year workforce position compared to previous meetings, with progress demonstrated around recruitment arrangements and changes to organisational development and management programmes.

In particular:

- Successful recruitment campaigns have been delivered for hard-to-fill posts.
- Implementation of new development programmes for medical staff and Board members.

- The executive team, senior leader's group, wider system leaders, trade union representatives and monthly all-staff meetings are being used to communicate expectations and strengthen accountability throughout the organisation.
- Leadership programmes have been reviewed and are being revised to place greater emphasis on personal accountability and responsibility.
- Digital solutions are being considered as part of future workforce planning.

As the health board moves forward with this work, it is important that you are able to evidence the impact of changes, as well as the alignment of a clear workforce plan that demonstrates effective triangulation between workforce, finance and future service planning arrangements.

Finance and planning

The health board was able to evidence some progress in-year planning achievements through the early development of the clinical services implementation plan and estimated milestones for delivery. A meeting has been arranged to explore the implementation plan and expected benefits in more detail.

On finance, the financial recovery of the health board, both delivering the current forecast and agreeing a clear recovery plan to balance, remains the most significant organisational issue with the greatest delivery challenge.

We challenged the assertion that the health board had submitted a credible annual plan, with consistent feedback that the annual plan was not supportable or acceptable, and a clear expectation of a route-map to financial balance that the health board should now be delivering.

In response to your diagnosis of the challenge to delivering the plan, you acknowledged that insufficient detailed planning and action work was undertaken during the initial planning process, with a relaxation of grip and increased autonomy to divisions which did not deliver the expected response. You described opportunities are only now being accelerated for in-year delivery, with strengthened delivery mechanisms, but there was no confidence demonstrated that this would improve the position before year end.

In particular:

- The actions to deliver a forecast £41m deficit are yet to be confirmed, despite previous requests from Welsh Government to finalise the position, with the current risk being a deficit of up to £61m.
- The current savings gap is £19.9m, which required rapid action to close the gap.
- There was lack of confidence that services will make the required cost savings, and as an executive team you must take responsibility for the required actions with strengthened delivery arrangements.
- A paper was to be shared with the Board, but you were not clear in the scale of the decisions being considered by the Board or when Welsh Government would receive a confirmation of the actions to deliver the end of year forecast.

It was disappointing that as a Board and team you were unable to provide any assurance that you have sufficient confidence or capability to deliver the £41m deficit in-year. The risk to the organisation is significant, as if the conditions attached to the additional £26m funding provided previously are not met, that funding may become recoverable, worsening the financial deficit further. The health board must now share a clear and deliverable plan to

deliver the £41m deficit, with quantified actions, named executive ownership, timescales for delivery, and a clear assessment of the recurrent impact of each action.

Required actions

Ahead of the next escalation board meeting:

- Health board to provide Welsh Government Director of Finance with a timeline to confirm when Welsh Government will receive clarity on the actions to deliver the forecast position by 30 September.

Conclusion

The health board has made little progress across the domains towards achieving de-escalation, with concerns that the organisation is now moving in the wrong direction and may not be able to recover without increased intervention arrangements. The next escalation board meeting is scheduled for November 2026, and the health board must provide clear evidence that the actions and plans put in place are making an impact, delivering improvements and better outcomes.

In summary, the current position of the health board across performance and delivery, quality and safety, and finance are unsustainable. Despite some evidence displayed at the meeting of a motivated executive team who work collectively, you must now move away from development of plans and actions and deliver demonstratable improvements in-year and mitigate the risk of further deterioration next year. To achieve this, you must strengthen your grip and control on the organisation and set clear expectations to both the executive team, and wider organisation or further intervention arrangements will have to be considered.

Yours sincerely



Jacqueline Totterdell

cc: Neil Wooding, Chair – Hywel Dda University Health Board

In attendance

Welsh Government: Jacqueline Totterdell (Chair), Jeremy Griffith, Hywel Jones, Samia Edmonds, Isabel Oliver, Helen Arthur, Rhianon Frere

Hywel Dda University Health Board: Phil Kloer, Lisa Gostling, Andrew Carruthers, Lee Davies, Sharon Daniels, James Severs, Ardiana Gjini, Huw Thomas

NHS Wales Performance and Improvement: Chris Clayton



Neil Wooding
Chair
Hywel Dda University Health Board
Second Floor
Block C
Government Buildings
Picton Terrace
Carmarthen
SA31 3BT

Neil.Wooding@wales.nhs.uk

26 August 2026

Dear Neil

Thank you for submitting your health board's annual plan for 2026/27, which I note has been approved by your Board.

However, I note that your Board has been unable to submit an integrated medium-term plan (IMTP) for 2026-29 in accordance with the NHS Wales Planning Framework. Therefore, your organisation has failed to meet its statutory duty to submit an IMTP and to have an IMTP approved by the Welsh Ministers in line with section 175(2A) of the National Health Service (Wales) Act 2006. Your Board should be clear that this is a breach of its statutory duties.

Your annual plan has been assessed and I know officials are in communication with your executive team to receive assurance on key areas of the plan. As such your organisation will be subject to a series of stringent accountability conditions. These will be agreed by Jacqueline Totterdell, Chief Executive of NHS Wales. Your accountability conditions will be linked to the escalation level that the health board finds itself in.

Officials will write to your Chief Executive setting out the accountability conditions, expectations and monitoring arrangements for the health board. You will also be aware that there are discussions ongoing to significantly improve the health board's position.

Welsh Government Offices, Cathays Park,
Cardiff. CF10 3NQ
Swyddfeydd Llywodraeth Cymru, Parc Cathays,
Caerdydd. CF10 3NQ

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
0300 0604400

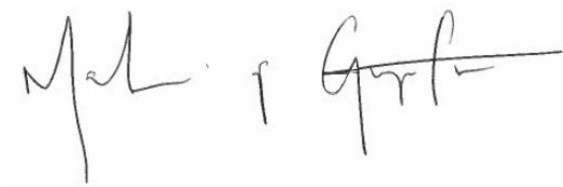
Gohebiaeth.Mabon.apGwynfor@llyw.cymru
Correspondence.Mabon.apGwynfor@gov.wales

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

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

I will be interested to discuss progress at our regular Chair discussions.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Mabon ap Gwynfor', with a long horizontal stroke extending to the right.

Mabon ap Gwynfor AS/MS

Gweinidog Cabinet dros Iechyd a Gofal
Cabinet Minister for Health and Care

2.5

9:25 AM, 5 Mins

2.5 - All Wales NHS Audit Committee Chairs'
Meeting Update

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

| For information

Attachments

[AWACC Meeting Notes 17 July 2026.pdf](#)

**ALL WALES AUDIT COMMITTEE CHAIRS (AWACC) MEETING
NOTES FROM THE MEETING HELD REMOTELY VIA
MICROSOFT TEAMS ON 17 JULY 2026 AT 11AM**

Please note, this is not intended to serve as a formal minute of the meeting. It is a Copilot-generated summary designed to support those who were unable to attend and to inform the actions and decisions log.

It was agreed at the meeting held on 30 September that formal minutes would not be taken or presented in a public format. This decision reflects the nature of the All Wales Audit Chairs Committee, which is not a decision-making forum but rather a valuable peer support group.

MEMBERS PRESENT:

Peter Curran	Chair, Welsh Ambulance Services NHS University Trust
Anne Beegan	Audit Wales (<i>Part 1 only</i>)
Simon Cookson	NWSSP Internal Audit (<i>Part 1 only</i>)
Stephen Elliot	Powys Teaching Health Board, Independent Member
Cheryl Hill	Counter Fraud Services (Wales)
Marian Jones	Digital Health Care Wales, Independent Member
Paul Lambert	Betsi Cadwaladr University Health Board Independent Member
Alun Lloyd	Health Education and Improvement Wales
Trish Mills	Director of Corporate Governance/Board Secretary, Welsh Ambulance Services NHS University Trust
Ben Rees	Head of Local Counter Fraud Services Hywell Dda UHB
Dafydd Vaughan	Aneurin Bevan University Health Board (<i>Attending in the absence of Iwan Jones</i>)

IN ATTENDANCE:

Sarah Harland	Secretariat, Welsh Ambulance Services NHS University Trust Welsh Ambulance Services NHS University Trust
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APOLOGIES RECEIVED:

Rhodri Evans	Hywel Dda University Health Board, Independent Member
Gareth Jones	Velindre NHS Trust, Independent Member
Iwan Jones	Aneurin Bevan University Health Board, Independent Member
Danielle Timmins	Betsi Cadwaladr University Health Board

PART A - EXTERNAL BRIEFINGS

Agenda Item 2 Action Log

There are currently no open actions.

Agenda Item 3 Audit Wales Update

Members received an update from Anne Beegan on recent and forthcoming work undertaken by Audit Wales. Key updates included the publication of national insight reports on planned care, urgent and emergency care, and NHS finances, together with ongoing work to broaden participation in the National Fraud Initiative. An update was also provided on lessons learned from the NHS accounts process and the progression of Audit Wales' digital transformation work.

In discussion, members received clarification on the increasing levels of limited assurance findings in workforce and financial governance, opportunities to identify common themes arising from audit work, benchmarking arrangements, and the proposed Internal Audit review of organisational grip and control arrangements. Anne confirmed that Audit Wales had adapted its Structured Assessment approach to reflect related assurance activity already taking place across NHS Wales, with a greater focus on delivery, planning and financial sustainability.

Agenda Item 4 Update from Internal Audit

Members received an update from Simon Cookson on Internal Audit activity and performance during 2025/26. The update highlighted that the majority of audit opinions remained reasonable, although workforce and financial governance continued to present the highest levels of limited assurance.

Members discussed emerging themes from audit findings, benchmarking arrangements, and the proposed approach to reviewing organisational grip and control arrangements.

The group also noted ongoing work to improve audit efficiency, the priorities within the 2026/27 audit programme, and planned national reviews relating to speaking up safely and organisational assurance.

Agenda Item 5 Counter Fraud

Members received an update from Cheryl Hill on Counter Fraud activity during Quarter 4 and across 2025/26, noting continued progress in fraud prevention, investigation and recovery, an increase in fraud referrals, and the publication of the refreshed Fraud Strategy.

Discussion focused on the benefits of fraud awareness training, the importance of strengthening preventative activity in light of new legislative requirements, and the need to improve resilience within local counter fraud services.

Members also noted developments in professional accreditation and a significant operational success involving the recovery of funds linked to a payment diversion fraud.

Agenda Item 6 Update from the Director of Corporate Governance

Members received an update from Trish Mills on matters arising from the Directors of Corporate Governance network, including developments relating to the NHS Wales Operating and Accountability Framework, the appointment of a new Welsh Government Executive Lead for Corporate Governance, and the circulation of provisional Public Accountability Meeting (PAM) dates for 2026/27.

Members discussed the forthcoming PAM process and the importance of aligning evidence requirements with existing end of year reporting arrangements to minimise duplication and maximise efficiency.

PART B - ALL WALES AUDIT COMMITTEE CHAIRS

Agenda Item 7 AWACC Chair from September 2026 – Expressions of Interest Outcome

The Chair noted that, as this was his final meeting as Chair, no expressions of interest had yet been received for the role. The Chair encouraged members to consider the opportunity, emphasising the importance of securing a successor to ensure the continuation of the Group. The Chair advised that there remained time before the next meeting in the autumn and invited members to put themselves forward over the coming weeks.

The Chair also acknowledged the significant contribution made by WAST in supporting the Group and expressed his appreciation to Trish Mills and Sarah Harland for their ongoing support in coordinating and preparing for meetings.

Agenda Item 8.1 Deep Dive – The broader role of Audit Committees in providing holistic assurance from ‘floor to board’

Members explored the wider role of Audit Committees in providing holistic assurance from “floor to board”, highlighting the importance of triangulating evidence from multiple sources to strengthen oversight, support organisational learning, and provide comprehensive assurance on governance, performance and culture across NHS Wales.

Agenda Item 8.2 Deep Dive - planning for next session (Board Assurance Framework, Counter Fraud issues, Audit Committee role in partnership working, Clinical Audits, Financial sustainability/Digital, Assurance from NWSSP Audit Committee to other Audit Committees, Digital Transformation)

Members agreed that a future deep dive on digital transformation should be deferred pending publication of the forthcoming Audit Wales report and retained as a placeholder item for the next meeting. Dafydd Vaughan suggested establishing links with the Digital Independent Member Peer Group, noting that there was likely to be overlap in themes and that closer collaboration could support shared learning and assurance.

Agenda Item 12 Any Other Business

None declared.

2.6

9:30 AM, 10 Mins

2.6 - Scheme of Delegation

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

| For approval

Attachments

[Scheme of Delegation ARAC 15 October 2026.pdf](#)

[Appendix 1 Scheme of Delegation.pdf](#)



Pwyllgor Archwilio a Sicrwydd Risg/ Audit and Risk Assurance Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	15 October 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Revised Scheme of Delegation
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Director of Corporate Governance/Board Secretary
SWYDDOG ADRODD: REPORTING OFFICER:	Charlotte Wilmshurst, Assistant Director of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/ For Decision

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

To present amendments to the Hywel Dda University Health Board's (HDdUHB's) Corporate Scheme of Delegation (SOD) to the Audit and Risk Assurance Committee for review, prior to onward submission to the Board for approval on 26 November 2026.

Cefndir / Background

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

The Health Board's current Corporate Scheme of Delegation (SOD) was approved by Board on 26 March 2026.

Asesiad / Assessment

Following completion of the Organisational Change Process for the Estates, Facilities and Capital Portfolio Review, and in accordance with the changes approved by the Remuneration and Terms of Service Committee on 2 April 2025, the new arrangements will be formally implemented with effect from the week commencing 5 October 2026.

Summary of changes which are detailed further in the table below:

- Transfer of the management of Estates from Executive Director of Allied Health Professions and Health Science to Executive Director of Strategy and Planning.
- Transfer of Fire Safety to the Health, Safety and Security function.
- Review of Job Descriptions and updated job titles of those affected by the above structure changes.
- Perinatal Stakeholder Group – representation on the newly established All Wales Group which supports the National Strategic Oversight Board.

The revised Corporate Scheme of Delegation is attached as **Appendix 1**, and for ease the changes have been extracted below:

Section	What has changed?	Rationale?
STANDING FINANCIAL INSTRUCTIONS (SFI)	CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS 15.1.1f Capital Plan 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.	Delegated responsibility changed from Executive Director of Allied Health Science to Executive Director of Strategy and Planning due to portfolio changes. Operational responsibility changed from Head of Property Performance to Director of Estates and Capital Management for consistency.
SCHEME OF DELEGATION FROM OTHER	QUALITY, SAFETY AND EXPERIENCE Management of incident reporting and investigation	Changed operational responsibility from Head of Health, Safety and Security to Deputy Director of Allied Health

	j) Reporting of incidents in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)	Professions & Health Science, Assistant Director of Facilities, Health and Safety due to portfolio changes and consistency.	
SCHEME OF DELEGATION FROM OTHER	QUALITY, SAFETY AND EXPERIENCE Management of incident reporting and investigation k) Reporting of breaches under the Ionising Radiation (Medical Exposure) Regulations to Health Inspectorate Wales (HIW)	Added Deputy Director of Allied Health Professions & Health Science, Assistant Director of Facilities, Health and Safety to operational responsibility section due to portfolio changes and consistency.	
SCHEME OF DELEGATION FROM OTHER	QUALITY, SAFETY AND EXPERIENCE Professional leadership for Therapies and Health Science a) Health and Care Professionals Council (HCPC) registration, education and standards	Operational responsibility changed from Assistant Director of Allied Health Professions/Deputy Director of Health Sciences to Deputy Director of Allied Health Professions and Health Science due to portfolio changes and consistency.	
SCHEME OF DELEGATION FROM OTHER	QUALITY, SAFETY AND EXPERIENCE Professional leadership for Therapies and Health Science b) Referral to appropriate Professional Body	Operational responsibility changed from Assistant Director of Allied Health Professions/Deputy Director of Health Sciences to Deputy Director of Allied Health Professions and Health Science due to portfolio changes and consistency.	
SCHEME OF DELEGATION FROM OTHER	OPERATIONAL Operational delivery of: g) ~~Estates and Facilities~~	Facilities has been removed from the scheme to reflect the updated organisational structure, as accountability for Facilities no longer sits within the same directorate portfolio as Estates. Delegated responsibility for Estates changed from Executive Director of Allied Health Professions and Health Science to Executive Director of Strategy and Planning due to portfolio changes.	

		Operational responsibility changed from Estates and Facilities Group Service Director to Director of Estates and Capital Management due to portfolio changes and consistency.	
SCHEME OF DELEGATION FROM OTHER	OPERATIONAL Operational delivery of: h) Facilities, Health and Safety	A dedicated delegation line for Facilities and Health & Safety has been added to reflect the revised organisational structure and associated executive accountabilities. Delegated responsibility is assigned to Executive Director of Allied Health Professions and Health Science. Operational responsibility is assigned to Deputy Director of Allied Health Professions and Health Science, Assistant Director of Facilities, Health and Safety due to portfolio changes and consistency.	
SCHEME OF DELEGATION FROM OTHER	OPERATIONAL Operational delivery of: l) Deconditioning	Operational responsibility changed from Executive Director of Allied Health Professions and Health Science to Deputy Director of Allied Health Professions and Health Science due to portfolio changes and consistency.	
SCHEME OF DELEGATION FROM OTHER	OPERATIONAL Designated Education Clinical Lead Officer (DECLO)	Added Deputy Director of Allied Health Professions and Health Science to operational responsibility section due to portfolio changes and consistency.	
SCHEME OF DELEGATION FROM OTHER	OPERATIONAL Health Safety and Security	Removed Assistant Director of EFCM (Estates, Facilities and Capital Management) and added Deputy Director	

	a) Compliance with health and safety legislation requirements including control of substances hazardous to health regulations	of Allied Health Professions and Health Science and Assistant Director of Facilities, Health and Safety to the operational responsibility section in line with new structure due to portfolio changes and consistency.	
SCHEME OF DELEGATION FROM OTHER	OPERATIONAL Health Safety and Security b) Management of security issues	Removed Assistant Director of EFCM and added Deputy Director of Allied Health Professions and Health Science and Assistant Director of Facilities, Health and Safety to the operational responsibility section in line with new structure.	
SCHEME OF DELEGATION FROM OTHER	OPERATIONAL Health Safety and Security c) Responsibility for fire safety management	Changed operational responsibility from Estates and Facilities Group Service Director to Deputy Director of Allied Health Professions and Health Science and Assistant Director of Facilities, Health and Safety in line with new structure.	
SCHEME OF DELEGATION FROM OTHER	OPERATIONAL Additional Learning Needs (ALN) arrangements	Changed operational responsibility from Executive Director of Allied Professions and Health Science to Deputy Director of Allied Health Professions and Health Science due to portfolio changes and consistency.	
SCHEME OF DELEGATION FROM OTHER	OPERATIONAL Operational quality and safety and effectiveness a) Implementing Hospital Patient Environment audits	Changed operational responsibility from Service Director, Estates and Facilities Group to Director of Estates and Capital Management and Assistant Directors of Quality, Safety and Patient Experience within each CCG in line with new structure.	

SCHEME OF DELEGATION FROM OTHER	OPERATIONAL Estates a) Develop an estates strategy and rationalisation plan	Changed operational responsibility from Programme Director Capital and Major Infrastructure to Director of Estates and Capital Management, Programme Director, Major Infrastructure Projects in line with new structure.	
SCHEME OF DELEGATION FROM OTHER	OPERATIONAL Estates b) Compliance with environmental regulations	Changed delegated responsibility from Executive Director of Allied Health Professions and Health Science to Executive Director of Strategy and Planning and changed operational responsibility from Estates and Facilities Clinical Care Group Service Director to Director of Estates and Capital Management due to portfolio changes and consistency.	
SCHEME OF DELEGATION FROM OTHER	OPERATIONAL Estates c) Management of land, buildings, including leased assets	Changed delegated responsibility from Executive Director of Allied Health Professions and Health Science to Executive Director of Strategy and Planning and changed operational responsibility from Estates and Facilities Clinical Care Group Service Director to Director of Estates and Capital Management due to portfolio changes and consistency.	
SCHEME OF DELEGATION FROM OTHER	OPERATIONAL Estates d) Authorised holder of deed and controller of property	Changed delegated responsibility from Executive Director of Allied Health Professions and Health Science to Executive Director of Strategy and Planning and changed operational responsibility from Estates and Facilities	

		Clinical Care Group Service Director to Director of Estates and Capital Management due to portfolio changes and consistency.	
SCHEME OF DELEGATION FROM OTHER	OPERATIONAL Estates e) District Valuer issues and negotiations	Changed delegated responsibility from Executive Director of Allied Health Professions and Health Science to Executive Director of Strategy and Planning and changed operational responsibility from Estates and Facilities Clinical Care Group Service Director to Director of Estates and Capital Management due to portfolio changes and consistency.	
SCHEME OF DELEGATION FROM OTHER	OPERATIONAL Estates f) Delivery of Capital Estates Projects	Removed delegated responsibility from Executive Director of Allied Health Professions and changed operational responsibility from Programme Director of Capital and Major Infrastructure and Head of Operations to Director of Estates and Capital Management due to portfolio changes and consistency.	
SCHEME OF DELEGATION FROM OTHER	OPERATIONAL Estates g) Licences and leases for property	Changed delegated responsibility from Executive Director of Allied Health Professions and Health Science to Executive Director of Strategy and Planning and changed operational responsibility from Estates and Facilities Clinical Care Group Service Director to Director of Estates and Capital Management due to portfolio changes and consistency.	

SCHEME OF DELEGATION FROM OTHER	CORPORATE N/A Perinatal Stakeholder Group	New entry for newly established group. Delegated responsibility assigned to Executive Director of Nursing, Quality and Patient Safety and operational responsibility assigned to Director of Midwifery and Professional Governance for Women and Children.	
SCHEME OF DELEGATION FROM OTHER	CORPORATE Targeted Intervention SRO	Changed operational responsibility from Director of Delivery to Executive Director of Strategy and Planning to reflect recent changes to the Director of Delivery role and associated executive accountabilities.	
LEGISLATION COMPLIANCE	ESTATES 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.	Changed delegated responsibility from Executive Director of Allied Health Professions and Health Science to Executive Director of Strategy and Planning and changed operational responsibility from Estates and Facilities Clinical Care Group Service Director to Director of Estates and Capital Management due to portfolio changes and consistency.	
LEGISLATION COMPLIANCE	ESTATES Energy Act 2008 (c.32) – Combined Heat and Power Quality Assurance (CHPQA)	Changed delegated responsibility from Executive Director of Allied Health Professions and Health Science to Executive Director of Strategy and Planning and changed operational responsibility from Estates and Facilities Clinical Care Group Service Director to Director of Estates and Capital Management due to portfolio changes and consistency.	

LEGISLATION COMPLIANCE	HEALTH AND SAFETY Health and Safety at Work Act 1974 and Secondary Legislation (Regulations)	Removed Assistant Director of EFCM from operational responsibility and added Deputy Director of Allied Health Professions and Health Science, Assistant Director of Facilities, Health and Safety due to portfolio changes and consistency.
LEGISLATION COMPLIANCE	HEALTH AND SAFETY Fire and Rescue Services Act 2005 and Regulatory Reform (Fire Safety) Order 2005	Removed Assistant Director of EFCM from operational responsibility and added Deputy Director of Allied Health Professions and Health Science, Assistant Director of Facilities, Health and Safety, due to portfolio changes and consistency.
LEGISLATION COMPLIANCE	HEALTH AND SAFETY Ionising Radiation (Medical Exposure) Regulations 1999	Changed operational responsibility from Head of Radiology to Deputy Director of Allied Health Professions and Health Science and Assistant Director of Allied Health Professions and Health Science due to portfolio changes and consistency.
LEGISLATION COMPLIANCE	PATIENT SAFETY Human Tissue Act 2004 – Corporate Licence Holder	Changed operational responsibility from Clinical Care Group Service Director - Allied Health Professions and Health Sciences, to Deputy Director of Allied Health Professions and Health Science, Assistant Director of Allied Health Professions and Health Science and designated Individual - Consultant Pathologist due to portfolio changes and consistency.
LEGISLATION COMPLIANCE	PROPERTY Residential Accommodation - Rent Smart Wales and Renting Homes (Wales) Act 2016	Changed delegated responsibility from Executive Director of Strategy and Planning to Executive Director of Allied Health Professions and Health Science.

		Changed operational responsibility from Executive Director of Allied Health Professions and Health Science to Assistant Director of Facilities, Health and Safety due to portfolio changes and consistency.	
LEGISLATION COMPLIANCE	CHILDRENS Additional Learning Needs and Education Tribunal (Wales) Act 2018	Changed operational responsibility from Executive Director of Allied Health Professions and Health Science to Deputy Director of Allied Health Professions and Health Science, Assistant Director of Allied Health Professions and Health Science and Regional DECLO with Powys and SBUHB due to portfolio changes and consistency.	
CAPITAL SCHEMES	N/A Fire Enforcement Work WGH	Changed operational responsibility from Project Director of Capital and Major Infrastructure to Director of Estates and Capital Management due to portfolio changes and consistency.	
CAPITAL SCHEMES	N/A Fire Enforcement Work GGH	Changed operational responsibility from Project Director of Capital and Major Infrastructure to Director of Estates and Capital Management due to portfolio changes and consistency.	
CAPITAL SCHEMES	N/A Business Continuity Programme Business Case	Operational responsibility changed from Programme Director of Capital and Major Infrastructure to Director of Estates and Capital Management due to portfolio changes and consistency.	

CAPITAL SCHEMES	N/A Technical Estates Fund (TEF)	Delegated responsibility changed from Executive Director of Allied Health Professions and Health Science to Executive Director of Strategy and Planning. Operational responsibility changed from Project Director, Head of Operations to Director of Estates and Capital Management and Head of Operational Estates due to portfolio changes and consistency.
CAPITAL SCHEMES	N/A Picton Terrace	Line removed as project now completed.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to **REVIEW** and **RECOMMEND** the revised version of Hywel Dda University Health Board's Scheme of Delegation for onward approval to the Board on 26 November 2026.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	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, Teitl a Sgôr Risg 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
Nodau Cynllunio 2026/27 Planning Goals 2026/27	Not Applicable
Hypergyswilt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	10. Not Applicable

Model Cymdeithasol ar gyfer lechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (complete for strategic change and/or significant service changes)	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	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 cyfarfod hwn: Parties / Committees consulted prior to this meeting:	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.
Tegwch lechyd: Health Equity:	Not Applicable
Risg: Risk:	A sound system of internal control ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed.

Cyfreithiol: Legal:	Model SOs are issued by Welsh Ministers to Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Health Boards in Wales must agree SOs for the regulation of their proceedings and business. SOs are designed to translate the statutory requirements set out in the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779 (W.67)) into day to day operating practice, and, together with the adoption of a Scheme of Decisions reserved to the Board; a Scheme of Delegations to officers and others; and SFIs, they provide the regulatory framework for the business conduct of the Health Board.
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	No Direct Impacts
Cydraddoldeb: Equality:	The Model SOs and SFIs have been subject to an Equality Impact Assessment as part of the NHS Reform Programme, and the revised SOs were subject to an in-house 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 September 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.

CORPORATE SCHEME OF DELEGATION

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 Executive 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	All Executive Leads
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	9.2.2	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	Finance and Performance 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	Executive Director of Finance	Executive 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)	Executive Director of Finance	Executive 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	Executive Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	2.2.1	RESPONSIBILITIES AND DELEGATION	The Board	Accountability for overall Financial Control	Chief Executive and Executive Director of Finance	Executive 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	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	Executive 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;	Executive 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	Executive Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	2.3.1	RESPONSIBILITIES AND DELEGATION	The Board	d) The provision of financial advice to other Board members and LHB officers, and LHB committees and Advisory Groups	Executive 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,	Executive 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	Executive 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	Executive 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 Internal Audit function	Chief Executive	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	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	Executive Director of Finance and Director of Corporate Governance/Board Secretary
STANDING FINANCIAL INSTRUCTIONS (SFI)	3.4.-24	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)	3.4.43	AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT	External Audit	Formally consider and review the External Audit risk based annual audit plan, designed to deliver the Auditor General's objectives	Audit and Risk Assurance Committee	Executive Director of Finance and Director of Corporate Governance/Board Secretary
STANDING FINANCIAL INSTRUCTIONS (SFI)	3.4.53	AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT	External Audit	Keep under 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	Executive 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 Executive 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	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 Executive Director of Finance and Audit Committee, at least annually, on counter fraud work within the LHB	Local Counter Fraud Specialist	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.	Executive 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	Executive 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	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	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;	Executive Director of Finance	Executive 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;	Executive Director of Finance	Executive 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;	Executive Director of Finance	Executive 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	Executive Director of Finance	Executive 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	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	Executive Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	5.2.1	FINANCIAL MANAGEMENT AND BUDGETARY CONTROL	Budgetary Delegation	Delegate, via the Executive 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	Chief Executive	Executive Director of Finance

STANDING FINANCIAL INSTRUCTIONS (SFI)	5.2.1	FINANCIAL MANAGEMENT AND BUDGETARY CONTROL	Budgetary Delegation	Accountability letters setting out: a) The amount of the budget; b) The purpose(s) of each budget heading; c) Individual or committee responsibilities; d) Arrangements during periods of absence; e) Authority to exercise virement; f) Achievement of planned levels of service; and g) The provision of regular reports must be signed by the delegated budget holder.	Chief Executive	Budget Holders
STANDING FINANCIAL INSTRUCTIONS (SFI)	5.2.2	FINANCIAL MANAGEMENT AND BUDGETARY CONTROL	Budgetary Delegation	The budgetary total or virement limit set by the Board must not be exceeded.	Chief Executive, Executive Director of Finance, Budget Holders	Chief Executive, 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	Executive 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 used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Executive 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 Executive 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	Executive 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.	Executive Director of Finance	Executive 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 including a) regular financial reports, for revenue and capital to the Board, for the Board to understand the current and forecast financial position, evaluate risks and opportunities and make informed decisions b) regular reports to budget holders, covering the areas for which they are responsible c) an accountability and escalation framework d) investigation and reporting of variances from financial, activity and workforce budgets e) monitoring of management action to correct variances; f) arrangements for the authorisation of budget transfers and virements.	Executive Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	5.3.3	FINANCIAL MANAGEMENT AND BUDGETARY CONTROL	Financial Management and Budgetary Control	- Accountable for managing services within the delegated budget - investigate causes of expenditure and budget variances using information from activity, workforce and other relevant sources - develop plans to address adverse budget variances	All budget holders	All budget holders
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	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 Executive Director of Finance

STANDING FINANCIAL INSTRUCTIONS (SFI)	6.2a	ANNUAL ACCOUNTS AND REPORTS	Annual Accounts and Reports	Signing of the: Performance Report, Accountability Report, Statement of Financial Position and the 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 (FRM) and International Financial Reporting Standards	Executive Director of Finance	Executive Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	6.5	ANNUAL ACCOUNTS AND REPORTS	Annual Accounts and Reports	Preparation of the Annual Report in line with the Welsh Government's Manual for Accounts	Chief Executive	Director of Corporate Governance/Board Secretary / Executive Director of Finance / Communications and Engagement Director
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	Executive Director of Finance	Executive 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	Executive 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	Executive 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.	Executive 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	Executive 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;	Executive 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	Executive 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	Executive 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	Executive 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	Executive 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.	Executive Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	8.2	CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS	Petty Cash	Responsible for issuing instructions restricting the use of petty cash.	Executive 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	Executive 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.	Executive 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	Executive Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	9.3.2	INCOME, FEES AND CHARGES	Fees and Charges	Inform the Executive 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)	9.4.1	INCOME, FEES AND CHARGES	Income Due and Debt Recovery	Inform the Executive Director of Finance of any income due that arises from any contracts, service level agreements, leases, activities such as private patients or other transactions.	Budget holders and managers	Budget holders and managers

STANDING FINANCIAL INSTRUCTIONS (SFI)	9.4.2	INCOME, FEES AND CHARGES	Income Due and Debt Recovery	Inform the Executive Director of Finance when overpayment of salary or expenses have been made, in order that recovery can be made	Budget holders and managers	Budget holders and managers
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.	Executive 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 Executive Director of Finance	Chief Executive and Executive Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.1.42	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	Executive Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.1.2-3	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	Executive Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.2.1a	NON-PAY EXPENDITURE	The Executive 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;	Executive Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.2.1b	NON-PAY EXPENDITURE	The Executive Director of Finance's responsibilities	b) Prepare procedural instructions or guidance within the Scheme of Delegation on non-pay expenditure	Executive Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.2.1c	NON-PAY EXPENDITURE	The Executive Director of Finance's responsibilities	c) Ensure systems are in place for the authorisation of all accounts and claims;	Executive Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.2.1d	NON-PAY EXPENDITURE	The Executive Director of Finance's responsibilities	d) Ensure Directors and officers strictly follow NHS Wales-system and procudeures of verification, recording and payment of all amounts payable.	Executive Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.2.1e	NON-PAY EXPENDITURE	The Executive Director of Finance's responsibilities	e) Maintain a list of Executive Directors and officers (including specimens of their signatures) authorised to certify invoices.	Executive Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.2.1f	NON-PAY EXPENDITURE	The Executive 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	Executive Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.2.1g	NON-PAY EXPENDITURE	The Executive Director of Finance's responsibilities	g) Ensure that where consultancy advice is being obtained, the procurement of such advice must be in accordance with applicable procurement legislation, guidance issued by the Welsh Ministers and SFIs;	Executive Director of Finance	Executive Directors
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.3	NON-PAY EXPENDITURE	Duties of Budget Holders and Managers	Full compliance with the Scheme of Delegation, guidance and limits specified by the Chief Executive and Executive Director of Finance and details in section 10.3.1	All Budget Holders	All Budget Holders
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.6.1	NON-PAY EXPENDITURE	Prepayments	Approval of proposed prepayment arrangements if specified conditions set out in 10.6.1 are satisfied	Executive 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)	11.1	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Services	Responsibility for procurement services delivered by NHS Wales Shared Services Partnership Procurement Services	Chief Executive	Executive Director of Finance/NWSSP Director of Procurement
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.2	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Services	Responsible for ensuring that the LHB's Executive Directors, Independent Members and officers strictly follow procurement, tendering and contracting procedures	Chief Executive	Executive Directors, Independent Members and officers
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.7.1	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Sustainable Procurement	Support social, environmental, economic and cultural goals in Wales, by being mindful to structure requirements ensuring Welsh companies have the opportunity to transparently and fairly compete to deliver services regionally or across Wales where possible within the legislative framework. The principles of Well-being of Future Generations (Wales) Act 2015 (the WBFG Act 2015) should be adopted at the earliest stage of planning	Executive Director of Finance	Executive Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.7.6	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)	Executive Director of Finance	Executive 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	Executive Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	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).	Executive 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 all staff with delegated budgetary responsibility or who are part of the procurement process for goods, services and works are aware of the legislative and policy frameworks and requirements governing public procurement. Section 11.11,11.12	Executive Director of Finance	Executive 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	Executive Director of Finance	Budget holder/NWSSP
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.10.1	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Process	Source goods from the Health Board's approved catalogue. If the item is not included in the catalogue seek advice from Procurement Services on opportunities to source goods through public sector contract frameworks.	All budget holders	All budget holders
STANDING FINANCIAL INSTRUCTIONS (SFI)	10.2	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	'Goods and Non-Health Services Only' - In the absence of an existing suitable procurement framework to source the required item, a competition must be run in accordance with the 2023 Act and the limits below. The limits apply to the Whole Life Cost Contract Value (excluding VAT). The LHB must ensure the value of their requirement considers cumulative spend across the LHB for like requirements and opportunity for collaboration with other NHS Wales Organisations.	Executive Director of Finance	All Budget Holders
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.10.2.a	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	Below £5,000 Evidence of value for money has been achieved Purchase Order	Executive Director of Finance	All Budget Holders/NWSSP
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.10.2.b	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	£5,000 - £24,999 Evidence of 3 written quotations Simple form of Contract/Purchase Order	Executive Director of Finance	All Budget Holders/NWSSP
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.10.2.c	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	£25,000 plus to the prevailing Procurement Act 2023 threshold Advertised open call for competition. Minimum of 4 tenders received if available Formal Contract and Purchase Order	Executive Director of Finance	All Budget Holders/NWSSP
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.10.2.d	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	Over the prevailing Procurement Act 2023 threshold Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route Formal Contract and Purchase Order	Executive Director of Finance	All Budget Holders/NWSSP
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.10.2.e	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	Contracts above £1 million Welsh Government approval required Formal Contract and Purchase Order See Schedule 1	Executive Director of Finance	All Budget Holders/NWSSP
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.10.3	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	In Scope Health Services Only' - in the absence of an existing suitable procurement framework, follow the most appropriate and proportionate procurement process as set out under the PSR Wales Regulations. There is no minimum financial threshold for application of the PSR Wales Regulations.	Executive Director of Finance	All Budget Holders/NWSSP
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.12	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Designing Competitions	Nominate officer who shall oversee and manage each contract on behalf of the LHB and engage with Procurement team so as to ensure that obligations in SFIs are met	Chief Executive	Budget holder/manager
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.13	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	Approve Single Tender Actions (that meet with requirements set out in Section 11.13) up to £25,000 & report to Audit and Risk Assurance Committee	Executive Director of Finance	Executive Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.13	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Procurement Thresholds	Approve Single Tender Actions (that meet with requirements set out in Section 11.13) exceeding £25,000 & report to Audit and Risk Assurance Committee	Chief Executive and Executive Director of Finance	Chief Executive and Executive Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.15	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Evaluation, Approval and Award	The evaluation of procurement competitions must be undertaken by a minimum of 2 evaluators from within the operational service of the Health Board. Evaluation Teams for competitions of greater complexity and value must be multi-disciplinary and reach a consensus recommendation for internal approval. Approval must follow Scheme of Delegation. All communication must be managed by Procurement Services; and permitting stage payments as part of a formally agreed implementation/delivery plan which must be supported by written evidence issued by the budget holder	Executive Director of Finance	NWSSP Procurement Service and Budget holder/manager
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.16	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Contract Management	The relevant budget holder shall oversee and manage each contract on behalf of the LHB so as to ensure that these implicit obligations are met. This contract management will include: - retaining accurate records - monitoring contract performance measures - engaging suppliers to ensure performance delivery - implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement	Executive Director of Finance	NWSSP Procurement Service and Budget holder/manager
STANDING FINANCIAL INSTRUCTIONS (SFI)	11.17.1	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Extending and Varying Contracts	Goods and Non-Health Services Only' - extending or varying the contract is possible if the provision to do so was included in the original contract award. If there is no such provision, the 2023 Act define such limitations. (Section 74-77 of the Act)	Executive Director of Finance	NWSSP/Budget holder

STANDING FINANCIAL INSTRUCTIONS (SFI)	11.17.2	PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES	Extending and Varying Contracts	In Scope Health Services Only - modification is possible if the provision to do so was included in the original contract award or framework agreement or the contract was awarded under Direct Award Process 1 and the modification does not render the contract 'materially different' in character. If these provisions are not met the PSR Wales Regulations define limitations concerning modifications of contract. Further approvals will also be required if no extension was provided for in the original contract.	Executive Director of Finance	NWSSP Head of Procurement/Budget holder
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	All officers
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	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 (IPCA), where appropriate) for its provision of health care services	Chief Executive	Executive Director of Strategy and Planning (Executive 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	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	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	Executive 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	Executive Director of Workforce & OD
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.2.2	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)	Executive 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).	Executive Director of Workforce & OD	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	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) Executive 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	Line 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	Executive 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	Executive Director of Workforce & OD	Executive 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	Executive 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	Executive Director of Workforce & OD (as per Relocation Expenses Policy)	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	Executive Director of Workforce & OD (as per Relocation Expenses Policy)	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	Budget Holders	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	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.	Executive 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	Executive 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	Executive 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 agreements	Executive 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	Executive 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); Executive Director of Workforce & OD Head of Information Governance	Executive 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	Executive 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	Executive 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	Executive Director of Workforce & OD	NWSSP
STANDING FINANCIAL INSTRUCTIONS (SFI)	14.5.2i	PAY EXPENDITURE	Payroll	Responsible for: i) Security and confidentiality of payroll information	Executive 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	Executive 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	Executive 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	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	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	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	Executive 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	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	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	Executive Director of Strategy and Planning	Executive 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	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	~~Executive Director of Allied Health-Professions & Health Science~~ Executive Director of Strategy and Planning	~~Head of Property Performance~~ Director of Estates and Capital Management
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	Executive 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	Executive 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	Executive 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	Executive 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	Executive 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	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.	Executive Director of Finance	Executive Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	15.4.8	CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS	Capital Procedures and Responsibilities	Ensure for each capital project over £2m that the Welsh Government Project Bank Accounts policy is applied unless there are compelling reasons not to do so.	Executive Director of Finance	Executive 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 Executive Director of Strategy and Planning and Executive Director of Finance)	Chief Executive	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	Executive Director of Finance	Executive 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	Executive Director of Finance	Executive 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	Executive Director of Finance	Executive 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 Executive Director of Finance	Executive 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 Executive Director of Finance). Further delegation for the day-to-day responsibility subject to delegation being entered in a record available to the Executive 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	Executive Director of Finance	Executive 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	Executive Medical Director	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
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/Executive Medical Director	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	Executive 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	Executive 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	Executive 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	Executive 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 Executive 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	Executive 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 Executive 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	Executive 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 Executive 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	Executive 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	Executive 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 Executive 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	Executive 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	Executive 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	Executive 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)	Executive 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	Executive 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	Executive 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	Executive 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	Executive 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	Executive 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	Executive 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);	Executive 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;	Executive 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.	Executive 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.	Executive 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.	Executive Director of Finance	Digital Director
STANDING FINANCIAL INSTRUCTIONS (SFI)	18.3.1	DIGITAL, DATA and TECHNOLOGY	Responsibilities and duties of the Executive 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.	Executive 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.	Executive 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	Executive 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.	Executive 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 Executive Director of Finance	Deputy Director of Finance
STANDING FINANCIAL INSTRUCTIONS (SFI)	19.3.1	PATIENTS' PROPERTY	Responsibilities of the Executive 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	Executive 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	Executive 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.	Executive Director of Nursing, Quality & Patient Experience and Executive Director of Finance	Head of Hywel Dda Health Charities and Head of Accounting and Statutory Reporting
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 Executive 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 Executive 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	Executive Medical Director	Executive Medical Director
SCHEME OF DELEGATION FROM OTHER	N/A	CLINICAL LEADERSHIP	Nursing	b) Maintain a refreshed clinical leadership model	Executive Director of Nursing, Quality and Patient Experience	Executive 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	Executive Medical Director	Associate Executive Medical Director – Medical Education
SCHEME OF DELEGATION FROM OTHER	N/A	CLINICAL LEADERSHIP	Research & Governance	a) Authorisation of Research projects	Executive Medical Director	Director of Research, Innovation and Value
SCHEME OF DELEGATION FROM OTHER	N/A	CLINICAL LEADERSHIP	Research & Governance	b) Authorisation of sponsorship deals in relation to research projects	Executive Medical Director	Director of Research, Innovation and Value
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	Executive Medical Director	Director of Research, Innovation and Value
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;	Executive Director of Nursing, Quality & Patient Experience	Assistant Director (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	Executive Director of Nursing, Quality & Patient Experience	Assistant Director (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	Executive Director of Nursing, Quality & Patient Experience	Assistant Director (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	Executive 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	Executive Director of Nursing, Quality & Patient Experience	Grade 1-3 - Complaint Investigation Team with Service Manager Grade 4/5 – Complaint Investigation Team with Service Director/General Manager
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	Executive 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	Executive 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)	Executive 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)
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	Executive Director of Nursing Quality & Patient Experience	Assistant Director (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	Executive 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	Executive Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing, Assurance & Safeguarding
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 incidents meeting criteria for nationally reporting to NHS Executive	Executive Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing, Assurance & Safeguarding
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	Executive 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 incidents (severe, catastrophic, or those that meet criteria to report nationally)	Executive 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)	Executive 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)	Executive Director of Nursing, Quality & Patient Experience (Grade 5's only) Chief Operating Officer (other)	Assistant Director of 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)	Executive Director of Allied Health Professions and Health Science	~~Head of Health, Safety & Security~~ Deputy Director of Allied Health Professions & Health Science, Assistant Director of Facilities, Health and Safety
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)	Executive Director of Allied Health Professions and Health Science	Deputy Director of Allied Health Professions & Health Science, Assistant Director of Facilities, Health and Safety, 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)	Executive 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)	Executive 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	Executive Director of Nursing, Quality & Patient Experience	Assistant Director (Legal and Patient Support)
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Clinical Governance	Joint responsibility for Clinical Governance (Clinical Directors)	Executive Director of Nursing, Quality & Patient Experience/Executive Medical Director/Executive Director of Allied Health Professions and Health Science	Executive Director of Nursing, Quality & Patient Experience /Executive Medical Director/Executive 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	Executive Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing Assurance & Safeguarding (Grade 5 only) Operation Team (other)
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	Executive Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing Assurance & Safeguarding (Grade 5 only) Operation Team (other)
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	Executive Medical Director	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	Executive Medical Director	Committee
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Ethics & Clinical Trials	b) Authorisation of clinical trials	Executive Medical Director	Director of Research, Innovation and Value
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	Executive 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	Executive Medical Director	Assistant Director - Executive Medical Directorate/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	Executive 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	Executive 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	Executive 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/Assistant Director of Nursing MHLD
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Safeguarding of Adults and Children	b) Investigation in accordance with POVA requirements	Executive 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	Executive Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing Assurance & Safeguarding (Grade 5 only) Operation Team (other)
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Safeguarding – Deprivation of Liberties	a) Supervising Authority	Chief Operating Officer	Community and Integrated Medicine Clinical Care Group Service Director / 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
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	N/A	Management of Infections, Diseases & Notifiable Outbreaks	Executive Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing Assurance & Safeguarding (Grade 5 only) Operation Team (other)
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
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Coordination of Welsh Risk Pool Assessments	b) Claims & Complaints	Executive Director of Nursing, Quality & Patient Experience	Assistant Director (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
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
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
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	Executive 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)	Executive 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)	Executive 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	Executive Medical Director	Executive Medical Director
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Management of Nurse Development, Revalidation and Practice Standards	a) NMC revalidation process	Executive 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)	Executive 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)	Executive 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	Executive Director of Allied Health Professions and Health Science	~~Assistant Director of Allied Health Professions/Deputy Director of Health Sciences~~ Deputy Director of Allied Health Professions & Health Science
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	Professional leadership for Therapies and Health Science	b) Referral to appropriate Professional Body	Executive Director of Allied Health Professions and Health Science	~~Assistant Director of Allied Health Professions/Deputy Director of Health Sciences~~ Deputy Director of Allied Health Professions & Health Science
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	Executive Director of Public Health	Executive Director of Public Health
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	N/A	Accountable Officer for Controlled Drugs	Executive Medical Director	Head of Medicines Management
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	N/A	Value Based Healthcare	Executive Medical Director/Executive Director of Finance	Director of Research, Innovation and Value
SCHEME OF DELEGATION FROM OTHER	N/A	QUALITY, SAFETY AND EXPERIENCE	N/A	Community Health Pathways Platform	Executive Medical Director	Executive Medical Director
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	N/A	Development of a Community by Design Strategic Plan	Executive Director of Strategy and Planning	Executive Director of Strategy and Planning
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	Executive Director of Strategy and Planning and Chief Operating Officer	Executive Director of Strategy and Planning and 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	Executive Medical Director	Head of Medicines Management
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	c) Maintaining a register of commissioning contracts	Executive Director of Strategy and Planning/Executive Director of Finance/Chief Operating Officer	Executive Director of Strategy and Planning/Executive Director of Finance/Chief Operating Officer
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	Executive Director of Strategy and Planning/Executive Director of Finance/Chief Operating Officer	Executive Director of Strategy and Planning/Executive Director of Finance/Chief Operating Officer
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	Executive Director of Strategy and Planning/Executive Director of Finance/Chief Operating Officer	Executive Director of Strategy and Planning/Executive Director of Finance/Chief Operating Officer
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	f) Agreement of contract variations	Executive Director of Strategy and Planning/Executive Director of Finance/Chief Operating Officer	Executive Director of Strategy and Planning/Executive Director of Finance/Chief Operating Officer
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	<u>As per Scheme of Delegation and Authorised Limits</u>	N/A
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	h) Signing contracts of value < £125,000 and contract variations > £50,000	<u>As per Scheme of Delegation and Authorised Limits</u>	N/A
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	i) Signing contracts of value < £500,000 and contract variations > £125,000	<u>As per Scheme of Delegation and Authorised Limits</u>	N/A

SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	j) Signing of contracts of value >£1,000,000	<u>As per Scheme of Delegation and Authorised Limits</u>	N/A
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	k) 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)	l) 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	Executive Director of Strategy and Planning/Executive Director of Finance	Executive Director of Strategy and Planning/Executive Director of Finance
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	m) 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	Executive Director of Strategy and Planning and Chief Operating Officer	Executive Director of Strategy and Planning and Chief Operating Officer
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	n) 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	Executive Director of Strategy and Planning and Chief Operating Officer	Executive Director of Strategy and Planning and Chief Operating Officer
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	o) 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	Executive Director of Strategy and Planning and Chief Operating Officer	Executive Director of Strategy and Planning and Chief Operating Officer
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	p) 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	Executive Director of Strategy and Planning and Chief Operating Officer	Executive Director of Strategy and Planning and Chief Operating Officer
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	q) Authorisation of invoices against contracts (within budget) excluding NHS Long Term Agreements (LTAs)	Executive Director of Strategy and Planning and Chief Operating Officer	<u>As per Scheme of Delegation and Authorised Limits</u>
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning (including Primary Care Services)	r) Authorisation of invoices against NHS LTAs	Executive Director of Finance	<u>As per Scheme of Delegation and Authorised Limits</u>
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	Chief Operating Officer	Head of Long Term Care / Service Director for Community & Integrated Medicine
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	Chief Operating Officer	Head of Long Term Care / Service Director for Community & Integrated Medicine
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	Chief Operating Officer	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	Chief Operating Officer	Service Director for Community & Integrated Medicine
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	Chief Operating Officer
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	Commissioning of Continuing Healthcare and Funded Nursing Care	f) Direct payments for continuing healthcare	Chief Operating Officer	Clinical Care Group Service Director – Community and Integrated Medicine /Head of 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	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	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	Executive Director of Strategy and 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	Executive Director of Strategy and Planning	Executive Director of Strategy and 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	Executive 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	Executive 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	Executive 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	Executive 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	Executive Medical Director	IPFR Manager/Team
SCHEME OF DELEGATION FROM OTHER	N/A	COMMISSIONING	N/A	Provision of Low Vision Service for HDdUHB population.	Chief Operating Officer	Chief Operating Officer
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
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
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
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	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
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	f) Primary Care	Chief Operating Officer	Assistant Director of Primary Care
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	g) Estates & Facilities	~~Executive Director of Allied Health Professions and Health Science~~ Executive Director of Strategy and Planning	~~Estates & Facilities Group Service Director~~ Director of Estates and Capital Management
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	h) Facilities, Health and Safety	Executive Director of Allied Health Professions and Health Science	Deputy Director of Allied Health Professions and Health Science, Assistant Director of Facilities, Health and Safety
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	i) 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:	j) Organ Donation	Chief Operating Officer	Chief Operating Officer

SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	k) Falls	Executive Director of Nursing, Quality & Patient Experience	Executive Director of Nursing, Quality & Patient Experience
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	l) Deconditioning	Executive Director of Allied Health Professions and Health Science	Executive Director of Allied Health Professions and Health Science ~~Deputy Director of Allied Health Professions and Health Science~~ , Assistant Director of Allied Health Professions and Health Science
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	m) WGH Creche	Chief Operating Officer	Women & Family Health Clinical Service Group General Manager
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	n) Out of Hours Service	Chief Operating Officer	Assistant Director of Primary Care
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	o) 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:	p) Establish revised children's partnership arrangements	Executive Director of Public Health	Executive Director of Public Health
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	q) Providing assurance on screening services	Executive Director of Public Health	Consultant in Public Health
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	r) Management of Substance Misuse Service	Chief Operating Officer	Commissioning Manager – Substance Misuse
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Delivery of:	s) Hospital Helicopter Landing Sites (HHLS) - Accountable Manager	Chief Operating Officer	Service Director for Community & Integrated Medicine
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	N/A	Designated Education Clinical Lead Officer (DECLO)	Executive Director of Allied Health Professions and Health Science	~~Deputy 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	Executive 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	Executive 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	Executive 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)	Executive Director of Public Health	Executive Director of Allied Health Professions and Health Science, Executive Director of Nursing, Quality and Patient Experience and the Executive 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	Executive 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~~ , ~~Deputy Director of Allied Health Professions and Health Science~~ , Assistant Director of Facilities, Health and Safety, Digital Director, Deputy Chief Operating Officer
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Health and Safety, Security	b) Management of security issues	Executive 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~~ , ~~Deputy Director of Allied Health Professions and Health Science~~ , Assistant Director of Facilities, Health and Safety, Digital Director, Deputy Chief Operating Officer
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Health and Safety, Security	c) Responsibility for fire safety management	Executive Director of Allied Health Professions and Health Science	~~Estates & Facilities Group Service Director~~ ~~Deputy Director of Allied Health Professions and Health Science~~ , Assistant Director of Facilities, Health and Safety
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Health and Safety, Security	Responsibility for Annual Health and Safety Report	Executive Director of Allied Health Professions and Health Science	Executive Director of Allied Health Professions and Health Science
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Additional Learning Needs	Additional Learning Needs (ALN) arrangements	Executive Director of Allied Health Professions and Health Science	Executive Director of Allied Health Professions & Health Science ~~Deputy Director of Allied Health Professions and Health Science~~ , Regional DECLO with Powys & SBUHB
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Medical Records	Responsibility for Medical Records Directorate	Executive Director of Finance	Executive Director of Finance

SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	a) Physiotherapy Records	Executive Director of Finance	Allied Health & Health Sciences Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	b) Occupational Therapy Records	Executive Director of Finance	Allied Health & Health Sciences Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	c) Speech and Language Therapy Records	Executive Director of Finance	Allied Health & Health Sciences Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	d) Dietetics Records	Executive Director of Finance	Allied Health & Health Sciences Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	e) Podiatry Records	Executive Director of Finance	Allied Health & Health Sciences Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	f) Orthoptic Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	g) Audiology Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	h) Cardio Physiologist Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	i) Neurophysiology Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	j) OOH Clinical Service Records	Executive Director of Finance	Assistant Director of Primary Care
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	k) Acute Medical Records	Executive Director of Finance	Health Records Manager
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	l) Primary Care	Executive Director of Finance	Assistant Director of Primary Care
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	m) District Nursing	Executive Director of Finance	Clinical Care Group Service Director – Community and Integrated Medicine
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	n) Community	Executive Director of Finance	Clinical Care Group Service Director – Community and Integrated Medicine
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	o) Outpatient service records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	p) Palliative Care Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	q) Nursing Records	Executive Director of Finance	Assistant Director (Operations, Quality and Nursing)
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	r) Mental Capacity Records	Executive Director of Finance	Assistant Director (Operations, Quality and Nursing)
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	s) Specialist Nurse (tissue viability records)	Executive Director of Finance	Assistant Director (Operations, Quality and Nursing)
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	t) Cancer Services Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	u) Community Paediatric Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	v) Acute Paediatric and Neonates Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	w) Community Children's Service Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director

SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	x) Midwifery and Women's Health Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	y) Obstetrics and Gynaecology Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	z) Pathology Records	Executive Director of Finance	Allied Health & Health Sciences Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	aa) Radiology Records	Executive Director of Finance	Allied Health & Health Sciences Clinical Care Group Service Director Radiology Services Manager
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ab) Cardiology Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ac) Renal Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ad) General Medicine Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ae) Gastroenterology Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	af) Neurology Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ag) Stroke Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ah) Care of The Elderly	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ai) General surgery, vascular, breast care records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	aj) Ophthalmology Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ak) Ear, Nose and Throat Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	al) Trauma and Orthopaedics Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	am) Plaster Services Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	an) Dermatology Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ao) Rheumatology Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ap) Theatres Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	aq) Day Surgery Unit Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ar) Pre-assessment Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	as) Endoscopy Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	at) Anaesthetics Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	au) Urology Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director

SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	av) Critical Care Records	Executive Director of Finance	Planned & Specialist Care Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	aw) Mental Health and Learning Disability Records	Executive Director of Finance	Mental Health & Learning Disabilities Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ax) Psychology Records	Executive Director of Finance	Allied Health & Health Sciences Clinical Care Group Service Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	ay) Mental Health Subject Access Requests	Executive Director of Finance	Mental Health Act Administrator
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	az) Acute Subject Access Requests	Executive Director of Finance	Acute Records Manager
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	aaa) Managed Practices records	Executive Director of Finance	Assistant Director of Primary Care
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	aab) Low Vision records	Executive Director of Finance	Head of Dental and Optometry
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Operational Health Records Management	aac) Dental services records for specific services and not independent Dental Practices	Executive Director of Finance	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	~~Service Director, Estates & Facilities Group~~ Director of Estates and Capital Management, Assistant Directors of Quality, Safety and Patient Experience within each CCG
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	Chief Operating Officer	Assistant Director of Primary Care
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Managed Practices	Management and service delivery of Health Board Managed Practices (including premises contracts)	Chief Operating Officer	Assistant Director of Primary Care
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	N/A	Medicines and Healthcare products Regulatory Agency (MHRA) (linking in with the Executive Medical Director for issues relating to medicines/blood as necessary)	Executive Director of Allied Health Professions & Health Science	Executive Director of Allied Health Professions & Health Science/Executive 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	Executive Medical Director	Head of Medicines Management
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	N/A	Development of a medicines optimisation strategy (primary & secondary care)	Executive Medical Director	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	Chief Operating Officer	Assistant Director of Primary Care
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	N/A	Performance issues (Medical, dental, pharmacy, optometry) management of performance panels and matters arising from managed practices.	Executive Medical Director	Assistant Director of Primary Care
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Estates	a) Develop an estates strategy and rationalisation plan	Executive Director of Strategy and Planning	~~Programme Director Capital and Major Infrastructure~~ Director of Estates and Capital Management, Programme Director, Major Infrastructure Projects
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Estates	b) Compliance with environmental regulations	~~Executive Director of Allied Health Professions and Health Science~~ Executive Director of Strategy and Planning	~~Estates & Facilities Clinical Care Group Service Director~~ Director of Estates and Capital Management
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Estates	c) Management of land, buildings, included leased assets	~~Executive Director of Allied Health Professions and Health Science~~ Executive Director of Strategy and Planning	~~Estates & Facilities Clinical Care Group Service Director~~ Director of Estates and Capital Management

SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Estates	d) Authorised holder of deed and controller of property	~~Executive Director of Allied Health Professions and Health Science~~ Executive Director of Strategy and Planning	~~Estates & Facilities Clinical Care Group Service Director~~ Director of Estates and Capital Management
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Estates	e) District Valuer issues and negotiations	~~Executive Director of Allied Health Professions and Health Science~~ Executive Director of Strategy and Planning	~~Estates & Facilities Clinical Care Group Service Director~~ Director of Estates and Capital Management
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Estates	f) Delivery of Capital Estates Projects	Executive Director of Strategy and Planning and Director of Allied Health Professions & Health Science	Programme Director Capital and Major Infrastructure and Head of Operations ~~Director of Estates and Capital Management~~
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Estates	g) Licences and leases for property	~~Executive Director of Allied Health Professions and Health Science~~ Executive Director of Strategy and Planning	~~Estates & Facilities Clinical Care Group Service Director~~ Director of Estates and Capital Management
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)	Executive 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	Executive 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)	Executive Director of Finance	Digital Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Information Management & Technology Strategy	d) Caldicott Standards and Action Plan	Executive 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	Executive Director of Finance	Head of Information Governance
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Information Management & Technology Strategy	f) IG Training Programme	Executive Director of Finance	Head of Counter Fraud
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Information Management & Technology Strategy	g) Data Quality	Executive 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	Executive Director of Finance	Digital Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Information Management & Technology Strategy	i) Purchases/installation of IT software & hardware	Executive Director of Finance	Digital Director
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Information Management & Technology Strategy	j) Delivery of specific IT projects	Executive 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	Executive 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 Strategy and Planning Committee	Executive Director of Finance	Head of Performance
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	Performance Management & Business Intelligence	c) Establish Performance Management Office	Executive 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	Executive 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	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	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	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	Executive Director of Public Health	Executive 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	Executive Director of Public Health	Executive Director of Public Health
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	N/A	Responsibility for Biodiversity	Executive Director of Public Health	Executive Director of Public Health
SCHEME OF DELEGATION FROM OTHER	N/A	OPERATIONAL	N/A	Compliance with Climate Change regulations	Executive Director of Public Health	Executive 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	Executive Director of Public Health	Executive 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	Executive Director of Public Health	Executive 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 / Executive 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 / Executive 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	Executive Director of Strategy and Planning
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Partnership Working	Health Board link with Llais	Executive Director of Strategy and Planning	Executive Director of Strategy and Planning / Communications and Engagement Director
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)	Executive Director of Nursing, Quality & Patient Experience	Assistant Director-(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.	Executive Medical Director	Director for Research, Innovation and Value
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	Executive Director of Nursing, Quality & Patient Experience	Executive 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 (excluding armed forces)	c) Engaging with armed forces, carers, staff, refugees, asylum seekers and those with sensory impairment	Executive 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	Head of Communications
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Communications	b) Internal communications with staff (Corporate Information)	Communications and Engagement Director	Head of Communications
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	Head of Communications
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	Head of Communications
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 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	Head of Communications
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Advertising	a) Relating to recruitment	Executive Director of Workforce & OD	Assistant Director of People Management
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Advertising	b) Other	Communications and Engagement Director	Head of Communications

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	Executive 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	Executive Director of Public Health / Chief Executive Officer	Assistant Director of Workforce & OD, Business Support, Strategic Partnerships, Diversity & Inclusion and Executive Director of Strategy and Planning
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Partnership Governance	Regional Partnership Board Governance	Chief Executive Officer	Assistant Director of Primary Care
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Partnership Governance	Public Services Board Governance	Executive Director of Public Health	Executive Director of Public Health
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	N/A	International Health Partnerships (Working Overseas)	Executive Director of Public Health	Executive Director of Public Health
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	N/A	International Health Partnerships (Volunteering)	Executive Director of Public Health	Executive Director of Public Health
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Equality, Diversity and Human Rights	Public Sector Equality Duty (2016)	Executive Director of Public Health	Assistant Director of Business, Partnerships and Inclusion / Consultant in Public Health
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	Executive Director of Workforce & OD	Executive Director of Workforce & OD
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Committee Lead	d) Quality, Safety and Experience Committee	Executive Director of Nursing, Quality & Patient Experience	Executive Director of Nursing, Quality & Patient Experience
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Committee Lead	e) Charitable Funds Committee	Executive Director of Nursing, Quality & Patient Experience	Executive 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 Committee	Executive Director of Finance	Executive Director of Finance
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Committee Lead	h) Health and Safety Committee	Executive Director of Allied Health Professions and Health Science	Executive 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 Committee	Executive Director of Strategy and Planning	Executive Director of Strategy and Planning
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Committee Lead	k) Digital, Data and Innovation Committee	Executive Director of Finance	Executive Director of Finance
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	Committee Lead	l) Healthcare Professionals Forum	Executive Director of Allied Health Professions and Health Science	Executive 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	Executive Director of Workforce & OD	Executive Director of Workforce & OD
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	N/A	Perinatal Stakeholder Group	Executive Director of Nursing, Quality & Patient Experience	Director of Midwifery and Professional Governance for Women and Children
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	N/A	Targeted Intervention SRO	Executive Director of Strategy and Planning	Director of Delivery Executive Director of Strategy and Planning
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	N/A	Medical Examiners Service	Executive Medical Director	Executive Medical Director
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	N/A	Engagement with Education Providers	Executive 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	Executive 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	Executive Director of Workforce & OD	Assistant Director of OD
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	Staff Engagement and Support	c) Staff communication (corporate)	Executive 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	Executive Director of Workforce & OD	Communications and Engagement Director
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	Staff Engagement and Support	e) Speak Up Safely	Executive 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	Executive Director of Workforce & OD	Assistant Director of People Planning

SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	Workforce Planning, recruitment and	b) Establish & implement workforce plans to address key performance measures in sickness reduction, appraisal rates, mandatory training, job planning and employee relations, support & investigation	Executive Director of Workforce & OD	Assistant Director of People Planning
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	N/A	Organisational Development Strategy	Executive Director of Workforce & OD	Assistant Director of OD
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	N/A	Staff Side and Employee Relations	Executive Director of Workforce & OD	Assistant Director of People Management
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	N/A	Workforce Equality and Diversity	Executive Director of Workforce & OD	Assistant Executive 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	Executive Medical Director	Assistant Director (Executive Medical Directorate)
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	Medical Staffing	b) Job Planning	Executive Medical Director	Assistant Director (Executive Medical Directorate)
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	Medical Staffing	c) Monitoring and quality assurance of job plans	Executive Medical Director	Assistant Director (Executive 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) Executive 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	Executive Medical Director	Executive Medical Director
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	N/A	Workforce policies and procedures	Executive Director of Workforce & OD	Assistant Director of People Management
SCHEME OF DELEGATION FROM OTHER	N/A	WORKFORCE	N/A	Finance Professional Leadership	Executive Director of Finance	Assistant Directors of Finance and Head of Service Modernisation
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	N/A	Responsibility for Quality Impact Assessment	Executive Director of Nursing, Quality & Patient Experience	Executive Director of Nursing, Quality & Patient Experience
SCHEME OF DELEGATION FROM OTHER	N/A	CORPORATE	N/A	Responsibility for Integrated Impact Assessment	Executive Director of Nursing, Quality & Patient Experience	Executive Director of Nursing, Quality & Patient Experience
LEGISLATION COMPLIANCE	N/A	Concerns	N/A	NHS Redress (Wales) Measure 2008 (2008 nawm1) - Measures of the Welsh Executive 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	Executive Director of Nursing, Quality & Patient Experience	Assistant Director (Legal and Patient Support)
LEGISLATION COMPLIANCE	N/A	Concerns	N/A	National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023	Executive Director of Nursing, Quality & Patient Experience	Assistant Director (Legal and Patient Support)
LEGISLATION COMPLIANCE	N/A	Corporate	N/A	The Well-being of Future Generations (Wales) Act 2015	Executive Director of Public Health	Executive Director of Public Health
LEGISLATION COMPLIANCE	N/A	Corporate	N/A	Social Services and Well-being (Wales) Act 2014	Chief Operating Officer	Chief Operating Officer
LEGISLATION COMPLIANCE	N/A	Corporate	N/A	The Partnership Arrangements (Wales) Regulations 2015	Chief Operating Officer	Assistant Director of Primary Care
LEGISLATION COMPLIANCE	N/A	Corporate	N/A	Charities Act 2011	Executive Director of Nursing, Quality & Patient Experience	Head of Hywel Dda Health Charities
LEGISLATION COMPLIANCE	N/A	Corporate	N/A	Charities Act 2022	Executive 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 (Wales) Act 2025	Chief Operating Officer	Chief Operating Officer
LEGISLATION COMPLIANCE	N/A	Corporate	N/A	The Health and Social Care (Quality and Engagement) (Wales) Act 2020	Executive 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 as amended	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	Executive 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	Executive 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	~~Executive Director of Allied Health Professions and Health Science~~ Executive Director of Strategy and Planning	~~Estates & Facilities Clinical Care Group Service Director~~ Director of Estates and Capital Management
LEGISLATION COMPLIANCE	N/A	Estates	N/A	Energy Act 2008 (c.32) - Combined Heat and Power Quality Assurance (CHPQA)	~~Executive Director of Allied Health Professions and Health Science~~ Executive Director of Strategy and Planning	~~Estates & Facilities Clinical Care Group Service Director~~ Director of Estates and Capital Management
LEGISLATION COMPLIANCE	N/A	Health & Safety	N/A	Health and Safety at Work Act 1974 & Secondary Legislation (Regulations)	Executive 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,~~ Deputy Director of Allied Health Professions and Health Science, Assistant Director of Facilities, Health and Safety, 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	Executive 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,~~ Deputy Director of Allied Health Professions and Health Science, Assistant Director of Facilities, Health and Safety, Digital Director, Deputy Chief Operating Officer
LEGISLATION COMPLIANCE	N/A	Health & Safety	N/A	Ionising Radiation (Medical Exposure) Regulations 1999	Executive Director of Allied Health Professions and Health Science	~~Head of Radiology,~~ Deputy Director of Allied Health Professions and Health Science, Assistant Director of Allied Health Professions and Health Science.
LEGISLATION COMPLIANCE	N/A	Information Governance	N/A	General Data Protection Regulations 2018 - Protection of personal information	Executive 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	Executive 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	Executive 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	Executive 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)	Executive 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)	Executive 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	Executive Medical Director	Pharmaceutical & Prescribing Manager, Head of Medicines Management
LEGISLATION COMPLIANCE	N/A	Mental Health	N/A	Mental Health Act 1983	Chief Operating Officer	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	Mental Health & Learning Disabilities Clinical Care Group Service Director

LEGISLATION COMPLIANCE	N/A	Patient Safety	N/A	Human Tissue Act 2004 – Corporate Licence Holder	Executive Director of Allied Health Professions and Health Science	Clinical Care Group Service Director – Allied Health Professions and Health Sciences – Designated Individual - Consultant Pathologist, Deputy Director of Allied Health Professions and Health Science, Assistant Director of Allied Health Professions and Health Science
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	Executive Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing, Assurance and Safeguarding (Grade 5 only) Operation Team (other)
LEGISLATION COMPLIANCE	N/A	Patient Safety	N/A	Nurse Staffing Levels (Wales) Act 2016	Executive 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	Executive Director of Nursing, Quality & Patient Experience	Deputy Director Nursing, Quality & Patient Experience/Assistant Director of Nursing Assurance & Safeguarding (Grade 5 only)
LEGISLATION COMPLIANCE	N/A	Patient Safety	N/A	Health and Social Care (Quality and Engagement) (Wales) Act 2020 - The Duty of Candour	Executive Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing Assurance & Safeguarding
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	Executive Director of Public Health	Head of Health Emergency Planning
LEGISLATION COMPLIANCE	N/A	Public Health	N/A	Smoke-Free Premises (Wales) Regulations 2007	Executive 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	Executive 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	Executive 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	Executive Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing Assurance & Safeguarding
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	Chief Operating Officer	Head of Long Term Care / Clinical Care Group Service Director - Community & Integrated
LEGISLATION COMPLIANCE	N/A	Safeguarding	N/A	Protecting Vulnerable Groups Act 2006 - Provides the legislative framework for the new Vetting and Barring scheme	Executive Director of Nursing, Quality & Patient Experience	Assistant Director of Nursing Assurance & Safeguarding
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	Local Health Boards (Directed Functions) (Wales) (Amendment) Regulations 2026	Chief Operating Officer	Clinical Care Group Service Director – Community and Integrated Medicine /Head of Long Term Care
LEGISLATION COMPLIANCE	N/A	Finance	N/A	Health Service Procurement (Wales) Act 2024	Executive Director of Finance	Executive Director of Finance
LEGISLATION COMPLIANCE	N/A	Finance	N/A	The Social Partnership and Public Procurement (Wales) Act 2023 (effective from 1 April 2024).	Executive Director of Finance	Executive Director of Finance
LEGISLATION COMPLIANCE	N/A	Partnerships	N/A	The Social Partnership and Public Procurement (Wales) Act 2023 (effective from 1 April 2024).	Executive Director of Public Health	Executive Director of Public Health
LEGISLATION COMPLIANCE	N/A	Property	N/A	Residential Accommodation - Rent Smart Wales and Renting Homes (Wales) Act 2016	Executive Director of Strategy and Planning Executive Director of Allied Health Professions and Health Science	Executive Director of Allied Health Professions and Health Science Assistant Director of Facilities, Health and Safety
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	Executive Director of Allied Health Professions and Health Science	Executive Director of Allied Health Professions and Health Science, Deputy Director of Allied Health Professions and Health Science, Assistant Director of Allied Health Professions and Health Science, Regional DECLO with Powys & SBUHB
CAPITAL SCHEMES	N/A	N/A	N/A	Women & Children's Phase 2. GGH	Director of Acute Services (SRO)	Project Director - General Manager, Children, Women and Family Health Clinical Service Group
CAPITAL SCHEMES	N/A	N/A	N/A	Fire Enforcement Work WGH	Executive Director of Strategy and Planning (SRO)	Project Director of Capital and Major Infrastructure Director of Estates and Capital Management
CAPITAL SCHEMES	N/A	N/A	N/A	Fire Enforcement Work GGH	Executive Director of Strategy and Planning (SRO)	Project Director of Capital and Major Infrastructure Director of Estates and Capital Management
CAPITAL SCHEMES	N/A	N/A	N/A	Diagnostic Imaging – All Schemes	Chief Operating Officer (SRO)	Project Director - Clinical Care Director for Radiology
CAPITAL SCHEMES	N/A	N/A	N/A	Carmarthen Hwb	Executive Director of Strategy and Planning (SRO)	Project Director - Senior Delivery Manager for System Flow & Urgent Care
CAPITAL SCHEMES	N/A	N/A	N/A	Cross Hands Health & Wellbeing Centre, Cross Hands, Carmarthenshire	Chief Operating Officer	Project Director - General Manager, Carmarthenshire Integrated System Service Group
CAPITAL SCHEMES	N/A	N/A	N/A	Aseptic Unit, Witherbush General Hospital	Executive Medical Director	Project Director - Clinical Director, Pharmacy & Medicines Management

CAPITAL SCHEMES	N/A	N/A	N/A	Business Continuity Programme Business Case	Executive Director of Strategy and Planning (SRO)	Programme Director of Capital and Major Infrastructure ~~Director of Estates and Capital Management~~
CAPITAL SCHEMES	N/A	N/A	N/A	Cylch Caron, Tregaron	Chief Operating Officer	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	Chief Operating Officer	Project Director - General Manager, Pembrokeshire Integrated System Service Group
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
CAPITAL SCHEMES	N/A	N/A	N/A	Sexual Assault Referral Centre (SARC)	Executive Director of Strategy and Planning (SRO)	Project Director - General Manager, Children, Women and Family Health Clinical Service Group

3 - Audit Wales

3.1

9:40 AM, 5 Mins

3.1 - Audit Wales Update Report

Urvisha Perez

| For assurance

Attachments

[Audit Wales Update Report ARAC 15 October 2026.pdf](#)

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

Date issued: October 2026



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Introduction

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

We also provide additional information on:

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

Accounts audit update

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

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

Performance audit update

Review of cancer services

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

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

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

Structured Assessment 2026

- **Executive Lead:** Director of Strategy and Planning
- **Focus of the work:** Our 2026 structured assessment approach has been revised to place greater emphasis on effectiveness and impact. Our work, therefore, will focus on the Health Board's 2025- 26 Annual Plan, considering both what has been planned and delivered, and the impact these actions are having on organisational finances, performance and outcomes. As part of our fieldwork, we will also gather high-level intelligence on hosted bodies and joint committees to inform our broader understanding of these arrangements.
- **Status:** Fieldwork underway
- **Expected committee date:** December 2026

Review of eye care services

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

Review of the management and prevention of diabetes

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

Other relevant publications

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

NHS digital: delivery not matching ambition

September 2026

Since the last committee update, Audit Wales has not published any corporate documents and there are no relevant consultations currently underway.

Further information

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

Visit our [website](#) to find:



Our [publications](#) which cover our audit work at public bodies.



Information on our upcoming work and forward work programme for [performance audit](#).



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



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We welcome correspondence and telephone calls in Welsh and English.

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



3.2 - Deep Dive Review of the Arrangements to Manage Estates

*Urvisha Perez,
James Severs (Hywel
Dda UHB - Executive
Director of Allied
Health Professions
and Health Science),
Lee Davies (Hywel
Dda UHB - Executive
Director of Strategy
and Planning)*

| For assurance

Attachments

[Audit Wales Review of Estates Management.pdf](#)

Are NHS estates fit for purpose?

Hywel Dda University Health Board

August 2026

We have prepared and published this report under section 61(3)(b) of the Public Audit Wales Act 2004.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Audit Wales follows the international performance audit standards issued by the International Organisation of Supreme Audit Institutions (INTOSAI).

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Audit snapshot

What we looked at

- 1 Our review looked at how well Hywel Dda University Health Board (the Health Board) manages its estate.

Why this is important

- 2 The NHS Estate in Wales provides the essential infrastructure to deliver healthcare services. It plays a key role in delivering safe, high-quality care and improving the patient experience. However, the NHS estate varies widely in age, condition, and location across Wales. A poorly maintained estate creates health and safety risks, including fire safety issues and potential harm to patients. An outdated estate can also affect service performance, be less energy efficient and be a barrier to providing modern healthcare.
- 3 The NHS in Wales needs to modernise its estate, deliver environmental improvements, improve access, and adapt to meet the needs of modern healthcare. There are several NHS strategies and plans which are dependent on estate improvements. These range from immediate strategic priorities relating to infrastructure and capital investment, to the requirements to reduce carbon emissions and improve energy efficiency.
- 4 Welsh Government's 2018 long-term plan for health and social care – [A Healthier Wales](#) – highlighted the importance of the NHS estate as a key enabler for transforming health and social care. Including the need for modern facilities, supporting digital integration, and a focus on energy efficiency and environmentally friendly practices. This is all against a backdrop of significant financial pressures across the NHS in Wales.

What we have found

- 5 The Health Board has a strong strategic approach to managing its estate, supported by clear governance, effective capital planning, and good use of management information. Its estate strategic plan aligns well with organisational and national priorities, and capital investment is targeted through robust prioritisation processes.
- 6 However, the estate faces significant challenges. Buildings are relatively old, backlog maintenance costs are among the highest in Wales, and available funding is far below the level needed to address estates risks and improve asset condition. Significant fire and water safety risks remain, alongside weaknesses in estate data, asset management, and information on safety impacts. While the estates workforce is well resourced and supported by workforce plans, leadership changes, training gaps, and ongoing compliance pressures reduce assurance.

What we recommend

- 7 We have made five recommendations to the Health Board. These focus on:
 - strengthening the estates strategic plan;
 - establishing an estates strategic outcome measure;
 - strengthening asset registers;
 - improving information on the impact of estate condition; and
 - developing a plan to address fire and water safety risks.

Key facts and figures

197

Number of buildings managed by the Health Board in 2024-25. ¹

**£24.3
million**

Capital monies used to improve estates in 2025-26 (excluding year-end funding).

**£221
million**

Cost to eradicate risk-adjusted backlog in 2024-25, an increase of 86% since 2022-23. High-risk backlog accounts for £35.9 million.

10.4%

Percentage of the 3,701 issues addressed following fire safety assessments in 2024-25 at the end of September 2025.

70%

Percentage of the 792 issues addressed following water safety assessments in 2024-25 at the end of September 2025.

6.8%

Vacancy rate in estates at the end of March 2025, compared to an all-Wales position of 11.6%.

¹ The number of buildings is based on the 2024-25 EFPMS submission, the Health Board have reported that the number is now 84 (leasehold and freehold)

Our findings

Strategic approach to estates

Overall, the Health Board has a strong and well-aligned estate strategic plan

- 8 The Health Board has a clear vision for its estate.
- 9 The Health Board has a Property Asset Strategic Plan for 2023 to 2026, approved by the Board in May 2023. The plan provides a clear approach to managing, improving, and reducing the size of its estate where appropriate.
- 10 The Health Board is developing a new Estates Strategy and plans to update the Property Asset Strategic Plan for 2027 to 2030. This will ensure that both documents reflect the Health Board's refreshed strategic direction and support its short, medium, and long-term priorities.
- 11 The Estates and Facilities Department developed the plan and updates it when estate plans change. Several programmes support the strategic plan, including the Strategic Property and Environment Programme, Corporate Landlord Model, Decarbonisation Programme, Space Utilisation Framework, and Infrastructure Investment Plan.
- 12 Positively, the strategic plan:
 - draws on a range of data available at the time of its development;
 - covers acute and community hospitals, mental health facilities, health centres, administrative accommodation, and leasehold properties;
 - supports the Health Board's long-term strategy 'A Healthier Mid and West Wales' and its service transformation ambitions, including the programme business case;

- aligns with key enabling plans including clinical services, digital technology, accommodation, and decarbonisation;
- supports national priorities such as decarbonisation, wellbeing, and public sector collaboration;
- reflects commitments to sustainability, energy efficiency, renewable energy, waste reduction and biodiversity;
- identifies opportunities to work with partners through community hubs and integrated care centres; and
- sets out opportunities to improve and reduce the estate through property disposals, lease reductions, and new accommodation solutions.

13 However, the strategic plan does not:

- include clear milestones, measures, or targets, although some projects have delivery timescales;
- set out a fully funded and affordable financial plan to meet all estate needs; and
- clearly explain how the Health Board's equality and socio-economic duties affect estate planning decision.

14 The Health Board undertook substantial engagement with staff, patients, and wider stakeholders in developing its long-term strategy, A Healthier Mid and West Wales, and its service transformation ambitions. This informed the development of the Property Asset Strategic Plan .

Governance arrangements for managing estates

The Health Board has strong estate governance and risk oversight, but leadership gaps, and long-standing risks reduce assurance

Lines of accountability

- 15 The Health Board is changing who is responsible for estates. During our audit, responsibility for operational estates sat with the Executive Director of Allied Health Professions and Health Science. Property and discretionary capital projects sat under the Executive Director of Strategy and Planning. Before this, the Chief Operating Officer held each of these functions until 2025.
- 16 Responsibility for property and discretionary capital projects initially moved with operational estates to the Executive Director of Allied Health Professions and Health Science, before transferring to the Executive Director of Strategy and Planning in September 2025. Operational estates remains the responsibility of the Executive Director of Allied Health Professions and Health Science. However, the Health Board has started an organisational change process to move the estates team under the Executive Director of Strategy and Planning. The change is due to take effect by September 2026.

Corporate oversight

- 17 There is clear oversight of estates at Board and committee level.
- 18 The Board receives regular assurance on estates matters through its committee structure. The Board receives reports on significant estates risks and developments. For example, in May 2026, it received an update on plans for a second generator at Prince Philip Hospital. It also receives exception reports from the Strategy and Planning Committee that highlight significant issues.

- 19 The Strategy and Planning Committee (SPC) oversees estate performance, investment, and strategic development. It also monitors the principal risk linked to modernising the estate and equipment. The committee reviews this risk regularly and considers the quality of the assurance provided by the Estates team.
- 20 The SPC reviews estates strategies, investment plans, capital programmes, major business cases, and infrastructure projects before referring them to the Board, where needed. It also monitors progress against estate plans and capital projects, receives updates from the Capital Sub-Committee, and reviews estates-related risks.
- 21 During the past six months, the SPC has reviewed capital programme updates, estates condition and performance reports, Targeted Estates Fund projects, and specific issues such as leases, infrastructure pressures, and major developments. Committee reports also highlighted the Health Board's backlog maintenance costs and explained the risks these pose to service continuity, statutory compliance, patient safety, operational resilience, and financial sustainability.

Operational management

- 22 The Health Board has operated without a substantive Director of Estates and Facilities since 2024. This followed a change to the previous post holder's role as Director of Estates, Facilities and Capital Management. Since August 2024, the previous Director moved to a new post within the Major Capital Team.
- 23 The Health Board advertised the Director of Estates and Facilities role in October 2025 but was unable to appoint to the post. The role has since been revised to include responsibility for capital. As a result, the Health Board has had limited senior leadership for estates while managing significant estate risks, investment pressures, and major service changes.

- 24 Day to day estates services have been led by the Head of Estates and Facilities Operational Services. In the absence of a substantive Director of Estates and Facilities, the post holder has reported to the Executive Director of Allied Health Professionals and Health Science. This role is supported by senior managers responsible for maintenance and engineering, estates risk and compliance, property services, facilities services, and health and safety.
- 25 The Health Board is reviewing its estates management arrangements through an organisational change process. The proposed structure will separate estates and capital from facilities and corporate health and safety services. Facilities and corporate health and safety will remain under the Executive Director of Allied Health Professions and Health Science. The changes should improve accountability and align responsibilities more closely with strategic priorities. At the time of our work, the organisational change process was still underway.
- 26 The Estates and Facilities Integrated Governance Group (E&FIGG) is the Health Board's main operational oversight group for estates and facilities. It meets monthly and brings together representatives from estates, facilities, finance, workforce, and health and safety. The group reviews performance, quality and safety, workforce matters, finance, risk, and statutory compliance. It also oversees actions arising from audits, inspections, incidents, and risk assessment. The group reports key issues through the Health Board's governance structure, including the Health and Safety Committee and Strategy and Planning Committee.
- 27 Several operational groups support the E&FIGG. These cover estates operations, maintenance and engineering, facilities management, health and safety, and estates risk and compliance. The groups meet monthly and operate under agreed terms of reference. They review service performance, operational risks, statutory compliance, workforce matters, and progress against improvement plans. Issues that require wider oversight are escalated to the E&FIGG.

- 28 Minutes from these groups show regular scrutiny of performance, quality and safety, workforce, finance, risk, and compliance matters. Action logs and risk registers support this oversight. However, some weaknesses remain, including gaps in estate condition data and ongoing organisational change.
- 29 At the time of our work, the Health Board was considering a Corporate Landlord Model to strengthen estate governance. The model would bring responsibility for estate planning, investment, and maintenance into a single framework. This should support a more coordinated approach to managing estate assets, the capital planning process and addressing estate risks across the organisation. If implemented effectively, it could improve oversight and help align estate decisions with service priorities.

Managing estate risks

- 30 The Health Board has clear processes for identifying and managing estate risks. However, these processes have not yet reduced the overall level of risk.
- 31 The condition and long-term sustainability of the estate is a key strategic risk for the Health Board. The risk is included in the Board Assurance Framework (BAF) and supports Planning Goal 8, under the Strategic Objective 4, Positive Futures.
- 32 The BAF recognises that ageing buildings, growing maintenance backlogs, and reliance on capital funding could affect future service delivery. The risk remains one of the Health Board's highest-rated strategic risks, highlighting the needs to invest in and modernise the estate.
- 33 However, the Board does not have a strategic outcome measure to show whether estate performance is improving over time.

- 34 The Board and its committees, including the Audit and Risk Assurance Committee, regularly review the Corporate Risk Register. Key estate risks include ageing buildings and infrastructure, fire safety compliance, and mortuary capacity. The register highlights the risk that deteriorating buildings and infrastructure could affect the safe delivery of services. The Audit and Risk Assurance Committee also receives regular reports on risk management.
- 35 In July 2026, Estates and Facilities had 136 open risks, more than any other service area. The Health Board reported that 76% of these risks require capital funding to address.
- 36 Operational risk registers provide detailed information on estate risks. These include backlog maintenance, statutory compliance, fire safety, workforce capacity, and major projects.
- 37 Estates and Facilities achieved the highest assurance rating within the Health Board's internal escalation framework. This suggests the service has effective arrangements for identifying, monitoring and managing risk. However, despite strong oversight and governance, there is little evidence that risk scores have reduced over a sustained period. This is largely due to the lack of available capital funding.

Using financial resources to improve estates

The Health Board manages its capital funding well, but the estate needs more investment than the funding available

Funding prioritisation process

- 38 The Health Board has a robust approach to how it prioritises the capital funds available to improve its estate.
- 39 In 2025-26, the Health Board had £7.4 million of discretionary funding and dedicated funds to invest in its estate. This investment has increased compared with the previous two financial years (**Exhibit 1**).

Exhibit 1: use of discretionary and dedicated funds for estates for 2023-24, 2024-25 and 2025-26 (£ million)

Fund	2023-24	2024-25	2025-26
Discretionary capital allocation	1.5	1.9	1.7
Estates and Facilities Advisory Board (EFAB) funding	4.2	3.7	0.1
Targeted Estates Fund (TEF) ²	-	-	5.6
TOTAL	5.7	5.6	7.4

Source: Audit Wales analysis of financial monthly monitoring returns

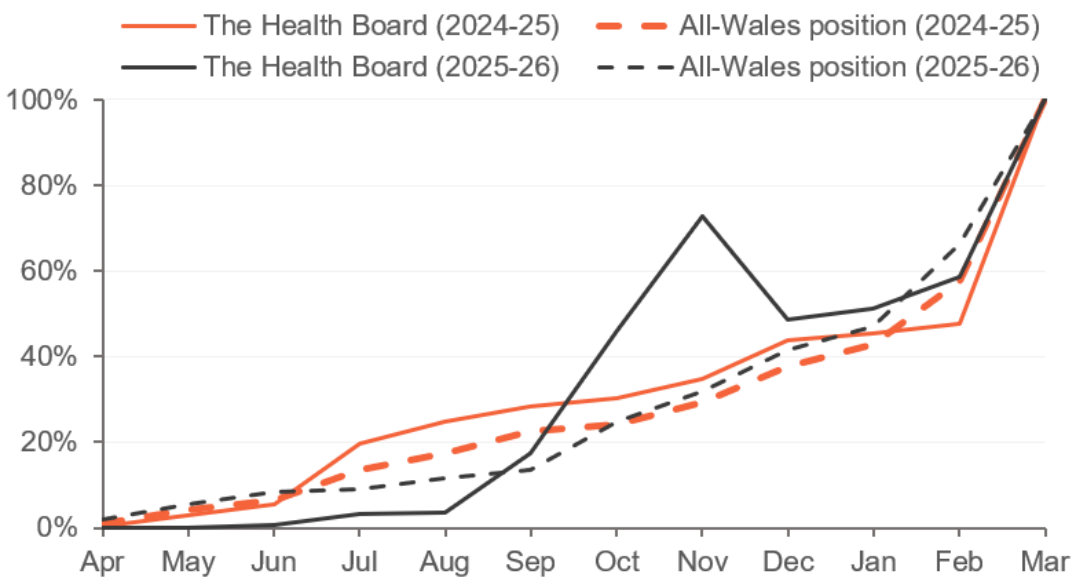
² A Welsh Government capital funding programme designed to address specific high-priority risks and deficiencies within the NHS Wales estate, particularly those affecting patient safety, statutory compliance, and service resilience. The Targeted Estates Fund (TEF) replaced the Estates and Facilities Advisory Board (EFAB) funding in 2025-26.

- 40 In 2025-26, the Health Board also received £16.9 million of all-Wales capital funds, on top of its TEF allocation. This funding supported infrastructure upgrades, backlog maintenance, fire safety work, and improvements to healthcare facilities across the estate.
- 41 In total, the Health Board received £24.3 million for estate investment. However, this is much lower than the estimated £221 million needed to address the risk-adjusted backlog and £159 million needed to bring the estate up to physical condition B, based on 2024-25 estimate.
- 42 The Health Board has also secured funding through programmes such as Invest to Save and the Health and Care Energy Scheme to support energy efficiency and decarbonisation projects.
- 43 The Health Board has clear arrangements for allocating capital funding. Services identify and prioritise schemes before submitting bids. The estates, digital and equipment teams then review and rank these before the Capital Planning Group considers them.
- 44 The Capital Planning Group reviews and prioritises schemes before they enter the capital programme. The Capital Sub-Committee and Strategy and Planning Committee provide further challenge and oversight. Together, these arrangements provide a clear process for making investment decisions and support accountability for programme delivery.
- 45 In May 2025, we reviewed the Health Board's arrangements for capital investment prioritisation. We found a structured approach to assessing and prioritising schemes. The Health Board uses risk registers, backlog maintenance data, condition surveys, and service needs to target investment towards statutory compliance, health and safety, and business continuity risks.
- 46 Practical challenges can affect delivery, including service disruption, links between projects, and programme sequencing. To manage these risks, the Health Board keeps a reserve list of schemes. This allows funding to be redirected when project timelines change or additional funding becomes available.

Monitoring and managing capital funds

- 47 The Health Board has a strong approach for monitoring and managing its capital spending.
- 48 The Health Board has clear arrangements for overseeing capital investment. The Strategy and Planning Committee oversees the capital programme and reviews the Infrastructure Investment Plan. It receives regular progress reports. The Capital Sub-Committee and Capital Planning Group support this work. Together, these groups oversee the delivery of capital schemes.
- 49 The Health Board regularly reviews capital spending and project performance. Governance groups monitor budgets, progress against plans, key milestones, and emerging risks. Project teams use highlight reports and dashboards to track delivery. This helps managers and committees identify problems early and take action when needed.
- 50 We reviewed the spend profile for the Health Board's discretionary allocation for 2024-25 and 2025-26. Our analysis shows that the Health Board used its discretionary allocation in full. Although we found that most spending takes place towards the end of the financial year (**Exhibit 2**).

Exhibit 2: monthly running total discretionary estate spend, compared with the all-Wales position, for 2024-25 and 2025-26 (percentage of total spend)



Source: Audit Wales analysis of financial monthly monitoring returns

- 51 In 2025-26, the Health Board received an extra £3.3 million of year-end funding from Welsh Government, which could be used for estate projects. The Health Board was able to spend the funding effectively. However, because the funding was received late in the financial year, it created an uneven spending pattern. It also limited the range of projects that could be delivered within the available timeframe.
- 52 The Health Board has clear arrangements for managing major projects. The Energy Performance Contract programme is a good example. The programme uses formal reporting, financial monitoring, risk management, and escalation processes. Governance groups review progress and risks through the Estate Performance and Improvement Group and wider estates governance arrangements. Board committees provide further oversight, and financial performance is monitored throughout the programme.

- 53 The Health Board works with local authorities and Welsh Government to deliver major estates developments, including Cylch Caron, Pentre Awel and the Carmarthen Hwb development. Progress, funding, and delivery risks for these schemes are monitored through the Capital Sub Committee and reported to the Strategy and Planning Committee.

Ensuring an efficient and productive estate

The Health Board manages its estate well but faces significant condition risks, investment pressures and data weaknesses that limit long-term planning and assurance

Condition of the estate

- 54 The Health Board’s estate is comparatively older, has a higher backlog risk and requires higher investment to improve the physical condition.
- 55 Compared with the all-Wales position, the Health Board has a high proportion of the estate built before 1995, with the proportion the third highest in Wales. The cost to remove high-risk backlog per square metre is also the third highest in Wales, although the cost to remove high and significant risk backlog is the highest in Wales. Although the proportion of the estate meeting the required physical condition standard is above the all-Wales average, the cost to achieve physical condition B is the second highest in Wales (Exhibit 3).

Exhibit 3: age and condition of the estate, compared to the all-Wales position, 2024-25

Measure	The Health Board	All-Wales position ³
% of estate built before 1948	7.1	13.5
% of estate built before 1995	76.1	63.9

³ Also includes Public Health Wales NHS Trust, Health Education and Improvement Wales, and NHS Wales Shared Services Partnership which were outside the scope of the audit.

Measure	The Health Board	All-Wales position ³
Cost to remove high-risk backlog per m ² occupied floor area (£)	188.25	164.60
Cost to remove high and significant-risk backlog per m ² occupied floor area (£)	1,145.22	458.43
% of estate meeting physical condition standard	86	83
Cost to achieve physical condition B per m ² occupied floor area (£)	833.30	538.54

Source: Estates and Facilities Performance Management System (EFPMS)

- 56 Across the Health Board's sites, the cost to remove high-risk backlog is highest at Withybush General Hospital, at £570.26 per m² occupied floor area. The cost to reach physical condition B is highest at Amman Valley Hospital at £3,128.86 per m² occupied floor area.
- 57 The Health Board has not used external surveys to support its backlog figures. Of the 22 Health Board sites entered in the EFPMS, 19 rely on internal surveys completed in 2022. Two entries have not been reviewed, and one is recorded as 'other'. Relying mainly on internal surveys reduces independent assurance and may affect the consistency and reliability of the data used to assess risk and prioritise capital investment.
- 58 Surveys also have a limited lifespan because they reflect estate conditions at a single point in time. As buildings age and circumstances changes, the value of the data declines. The Health Board last reviewed all sites in 2022. Since then, its estate has changed due to ageing assets, new compliance requirements, and changing service needs. Continued reliance on these surveys increases the risk that decisions are based on outdated information that no longer reflects the current condition of the estate.

- 59 RAAC (Reinforced Aerated Autoclave Concrete) is present at two of the Health Board's acute hospital sites: Bronglais Hospital and Withybush General Hospital. The Health Board has recorded this issue on its corporate risk register.
- 60 The Health Board last assessed the condition of the RAAC panels in 2024 at Bronglais and in 2025 at Withybush General Hospital. It has received capital funding to carry out mitigation work. While this work helps reduce immediate risks, it does not remove the need for long-term solutions.
- 61 The Health Board did not provide a planned budget split between planned preventative maintenance (PPM) and reactive maintenance. Instead, it provided actual spend only. This limits transparency and makes it harder to assess whether resources are being used efficiently. Without a planned budget breakdown, the Health Board cannot clearly show whether it is prioritising preventative maintenance or responding to issues as they arise.

Robust management information

- 62 The Health Board makes good use of management information to manage its estate.
- 63 It uses a broad range of information to monitor estate condition, performance, utilisation, and future estate requirements. This includes asset condition reports, risk registers, internal surveys, and backlog data.
- 64 The Health Board uses the EFPMS to benchmark performance. It uses the system to compare sites within the organisation and to compare performance with other Welsh health boards. However, the Health Board has recognised the need to use this information more systematically in future to report on estate performance, building efficiency and the impact of acquisition and rationalisation plans.
- 65 The Health Board has a CAFM (computer aided facilities management) system. Evidence shows that improvements to CAFM reporting have helped support planned maintenance and key performance indicator (KPI) monitoring.

- 66 However, the Health Board does not have a single asset management system or a fully reliable asset register. Information is spread across several systems, making it harder to link asset condition, costs, and performance. This reduces confidence in the data and limits the Health Board’s ability to produce reliable maintenance schedules. It also makes it harder to show that assets receive the checks needed to maintain compliance.
- 67 There is also scope to further develop routine performance reporting, benchmarking, and utilisation data. This would support more comprehensive monitoring of estate performance and help the Health Board show the benefits delivered through estate change.

Maximising productivity and efficiency

- 68 The Health Board performs well in functional suitability and space utilisation. However, its energy consumption is the highest in Wales. Performance across these measures has largely stayed unchanged over the past three years (Exhibit 4).

Exhibit 4: productivity and efficiency performance of the estate, compared to the all-Wales position, 2024-25

Measure	The Health Board	All-Wales position ⁴
% of estate functionally suitable	90	84
% of space utilisation	99	92
energy performance (kilowatts (kw))	474	367

Source: Estates and Facilities Performance Management System

⁴ Also includes Public Health Wales NHS Trust, Health Education and Improvement Wales, and NHS Wales Shared Services Partnership which were outside the scope of the audit.

- 69 Across the Health Board's sites, Tregaron Hospital has the lowest functional suitability (38%). It also has the lowest space utilisation at 40%.
- 70 The Health Board has strengthened its approach to space utilisation by introducing a monthly accommodation group and a supporting Space Utilisation Principles and Framework. These arrangements provide oversight of accommodation decisions and help make better use of available estate space. A case study at the Sealyham Building, Withybush General Hospital, showed how Occupeye sensor data can highlight underused areas and support capacity planning.
- 71 The Health Board does not have a standalone estate disposal strategy. It includes proposed disposals as part of its Property Asset Strategic Plan. The Health Board has disposed of six properties since 2022, generating capital receipts of £112,115. It has confirmed that no sites are subject to restrictions on sale or alteration.
- 72 The Health Board is making greater use of technology to improve estate efficiency and support decarbonisation. Through its Energy Performance Contract and wider decarbonisation programme, it is investing in LED (light emitting diode) lighting, solar photovoltaic (PV) systems, low-carbon heating, heating optimisation, building management systems, battery storage, and insulation improvements.
- 73 Despite this investment, the Health Board has the lowest proportion of internal floor space covered by LED lighting. LED lighting covers 6.4% of its internal floor space, compared with an all-Wales average of 45.4%.

Supporting the quality of care

Significant fire and water safety risks, weak information and resource pressures reduce assurance over patient and staff safety

Minimising harm to patients and staff

- 74 The Health Board has weaknesses in how it manages and reduces safety risks linked to the condition of its estate. These risks can affect both patients and staff.
- 75 The Health Board identifies estate-related issues and risks through several sources. These include risk registers, condition surveys, backlog maintenance assessments, statutory compliance checks, incident reporting systems, and operational governance arrangements.
- 76 The Health Board has a range of mechanisms for capturing staff and service user concerns through existing governance, incident reporting, and operational processes. This includes capturing staff concerns through its DATIX system and through monthly site safety walkabouts. In July 2026, the Health Board had four open incidents relating to estates.
- 77 The Health Board recognises opportunities to strengthen the systematic collection and reporting of estate-specific experience and satisfaction information.

Ensuring compliance

- 78 The Health Board has reasonable processes in place to ensure its estate meets legal requirements, although there are significant gaps in compliance.

79 Compared with the all-Wales position, the Health Board performs slightly better overall in meeting statutory health and safety requirements. However, its compliance with fire safety requirements is the lowest in Wales. Performance in both areas has stayed unchanged over the past three years (Exhibit 5).

Exhibit 5: occupied floor area meeting statutory and safety requirements, compared to the all-Wales position, 2024-25 (percentage)

Measure	The Health Board	All-Wales position ⁵
% of occupied floor area meeting statutory health and safety requirements	88	87
% of occupied floor area meeting statutory fire safety requirements	67	84

Source: Estates and Facilities Performance Management System

- 80 Across the Health Board’s sites, Tregaron Hospital has the lowest compliance with statutory health and safety requirements, with only 48% of occupied floor area meeting the required standard. Glangwili General Hospital has the second lowest level of compliance at 75%.
- 81 Hafan Derwen, on the St David’s Hospital site, has the lowest compliance with statutory fire safety requirements, with only 40% of occupied floor area meeting the required standard. All four acute hospital sites have less than 70% of occupied floor area compliant with fire safety requirements. Prince Philip Hospital has the lowest level of compliance at 55%, making it the lowest-performing acute hospital site in Wales for fire safety compliance.

⁵ Also includes Public Health Wales NHS Trust, Health Education and Improvement Wales, and NHS Wales Shared Services Partnership which were outside the scope of the audit.

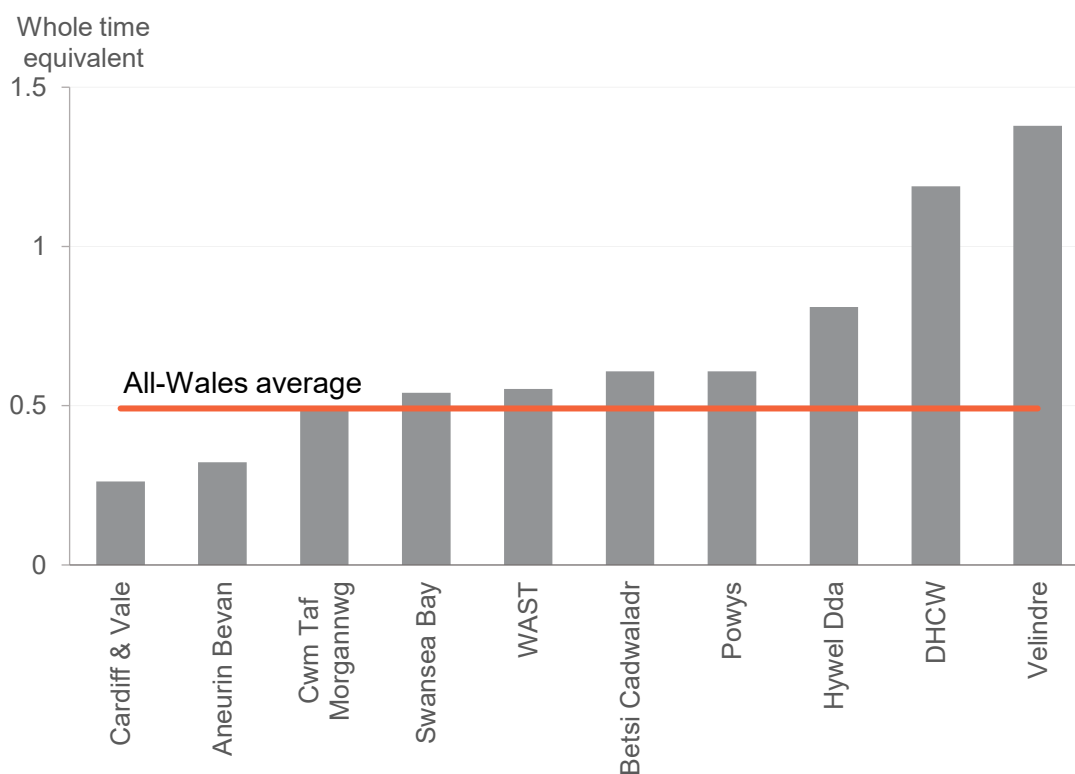
- 82 In 2024-25, the Health Board completed all required fire risk assessments. These assessments found 3,701 issues. By September 2025, the Health Board had resolved only 10.4% of them. The Health Board said it does not have enough resources to address the volume of work needed. It uses a prioritisation process to help manage the backlog.
- 83 The Health Board has three formal fire enforcement notices and 54 informal notices. This shows ongoing fire safety concerns across the estate. Formal notices indicate breaches of legal requirements, while informal notices highlight areas that need improvement. The Health Board is working hard to address the issues raised through the notices, with a long term phased delivery programme in place.
- 84 At the time of our work the Health Board had received one notice of intended prosecution from the Health and Safety Executive.
- 85 The Health Board has a water safety policy and carries out regular risk assessments. However, only eight of the 12 required assessments had been completed at the time of our work. These assessments found 792 issues, of which the Health Board has resolved 70%.
- 86 The Health Board reported that it does not have enough trained Responsible Persons (RPs) and Deputy Responsible Persons (DRPs). Staff shortages and workload pressures limit the team's ability to meet water safety requirements. New monitoring technology has also found significant issues with water systems that require action.
- 87 The Health Board has arrangements in place to monitor statutory and safety compliance. These include through operational governance groups, compliance and risk functions, risk registers and regular reporting to the Estates and Facilities Integrated Governance Group, Health and Safety Committee, and Strategy and Planning Committee.
- 88 The Health Board uses maintenance policies, asset registers, and maintenance systems to monitor compliance across its estate and equipment. It also uses operational and corporate risk registers to record and escalate areas of non-compliance and related risks.

Managing the estate workforce

The Health Board has a well-staffed estates team and clear workforce plans, but training gaps, leadership changes and limited workforce data reduce assurance

89 The Health Board has a larger than average sized estates team. At the end of March 2025, it had 0.81 whole time equivalent staff in post per 1,000 m² occupied floor area, compared with the all-Wales position of 0.49 whole time equivalent (**Exhibit 6**).

Exhibit 6: size of the estates function per 1,000 m² occupied floor area, by NHS body on 31 March 2025 (whole time equivalent)



Source: Audit Wales analysis of NHS data

- 90 The Health Board has carried out targeted reviews of staffing needs in key operational areas. One review of planned preventative maintenance found workforce and skills gaps were affecting compliance with Health Technical Memorandum requirements.
- 91 In response, the Health Board approved and recruited an additional 10.4 whole-time equivalent posts. It has already reported early improvements in maintenance performance indicators. The higher staffing levels shown in Exhibit 6 are likely to reflect the recruitment of these additional staff.
- 92 The Health Board did not provide data on its use of external contractors. As a result, we could not assess how far contractors are used to supplement the in-house estates workforce.
- 93 The Health Board reports a low vacancy rate within its estates team. At the end of March 2025, the vacancy rate was 6.8% compared with the all-Wales average of 11.6%. The vacancy rate had improved to 1.6% by September 2025.
- 94 At the end of March 2025, the Health Board also reported a low sickness absence rate of 4.8% in its estates team. This is below the all-Wales average of 6.6%.
- 95 In 2024-25, the Health Board did not use agency staff to support its estates team. The Welsh Government required NHS bodies to stop using agency staff in estates by 30 September 2025, and the Health Board met this requirement.
- 96 The Health Board has recognised the need to modernise and strengthen its estates workforce. Its Estates Operational Workforce Plan, agreed in 2026, focuses on succession planning, training, and improving planned preventative maintenance compliance. The plan identifies several workforce risks, including an ageing workforce and potential retirements over the next few years. Fourteen per cent of the Health Board's estates staff are aged over 60, compared with the all-Wales average of 25.4%.

- 97 The plan highlights that temporary arrangements for the Head of Estates and Facilities Operational Services have been a challenge over the last 12 months, following the absence of a Director of Estates and Facilities. The Health Board has reviewed the skills and capacity needed to meet key challenges over the next five years. It aims to align the workforce with its short, medium, and long-term priorities. Proposed changes to roles and responsibilities will be implemented through the organisational change process, following consultation with staff and stakeholders.
- 98 Despite delays caused by COVID-19, the Health Board is still committed to its apprenticeship programme. It plans to recruit eight apprentices across its four acute hospital sites by 2028. The programme is supported by funded workforce plans, partnerships with local colleges, mentoring arrangements, and succession planning to help address future retirements and skills shortages.
- 99 Completion of performance development reviews in the estates department was below the target of 85%. In March 2025, the completion rate was 82.9%. This has subsequently improved to 88% in July 2026.
- 100 The estates team has identified its training needs and monitors completion rates. However, gaps were identified in key areas, including violence against women, domestic abuse and sexual violence, infection prevention and control, information governance, and moving and handling. Compliance with core skills training has since improved to 93%.
- 101 We found limited evidence on how the Health Board trains estates staff to use digital estate management systems and other digital tools. Although the workforce plan identifies training needs and refers to improvements linked to a new CAFM reporting system, the evidence provided did not show the level of training completed, the costs involved, or staff competence in using these systems.

Recommendations

102 We have made five recommendations because of our work.

R1 The Health Board should ensure its new Estates Strategy and updated Property Asset Strategic Plan (2027-2030) set out clear priorities, milestones, targets, timescales, and accountability arrangements. The strategy should also show how equality considerations, socio-economic factors and stakeholder engagement inform estates planning and decision-making **(paragraphs 10 and 13)**.

R2 The Health Board should establish a strategic outcome measure for its estate, supported by clear targets and regular Board reporting. This would help demonstrate whether estate performance is improving over time **(paragraph 33)**.

R3 The Health Board should strengthen its asset management arrangements by developing a complete and reliable asset register and improving links between its systems. This would support more effective maintenance planning, compliance monitoring, and asset performance reporting **(paragraph 66)**.

R4 The Health Board should improve how it collects, records and reports information on the impact of estate condition on patient safety, staff experience, and service delivery. This should include information on estate-related incidents, as well as feedback from staff and patients **(paragraph 77)**.

R5 The Health Board should develop and implement a clear plan to improve statutory compliance. The plan should address outstanding fire and water safety risks and provide regular reports on progress, key risks, and planned actions **(paragraph 82 and 85)**.

Appendices

1 About our work

Scope of the audit

We looked at the following areas, as they relate to estates, during the period March to May 2026:

- strategic planning;
- governance arrangements;
- utilisation of financial resources;
- estate productivity and efficiency;
- implications on quality and safety; and
- workforce management.

We did not look at:

- major estates projects funded (or potentially funded) through the All-Wales Capital Health Programme;
- operational management of estates, including the management of leased estate;
- 'soft facilities management' services such as cleaning or security services, which are also key to supporting fit-for-purpose estate; and
- primary care estates.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the NHS body have a clear planning approach for its estate in the medium to longer term?

- Does the NHS body have effective governance arrangements for estates management?
- Is the NHS body using its financial resources available for estates appropriately?
- Does the NHS body have an efficient and productive estate?
- Does the NHS estate support the quality of care and experience of patients and staff?
- Does the NHS body have effective arrangements for managing its estate workforce?

Criteria

We assessed the Health Board's approach against audit criteria shaped by:

- NHS Wales planning frameworks, and other relevant NHS Wales planning documents, including the NHS Wales Decarbonisation Strategic Delivery Plan 2021-30;
- Legislation, including the Wellbeing of Future Generations Act (2015), the Equality Act 2010 and the Public Sector Equality Duty (PSED);
- Relevant guidance from NHS Shared Services Partnership;
- Previous audit work on the management of NHS estates.

Methods

We reviewed a range of documents, including:

- Board and committee papers and minutes.
- Key governance documents, including Integrated Quality, Finance and Performance Delivery Group, and Estates and Facilities Integrated Governance Group.
- Key strategies and plans, including the Annual Plan, the Property Asset Strategic Plan, and the Capital Plan.

- Key risk management documents including the Board Assurance Framework and the Corporate Risk Register.

We interviewed the following key stakeholders:

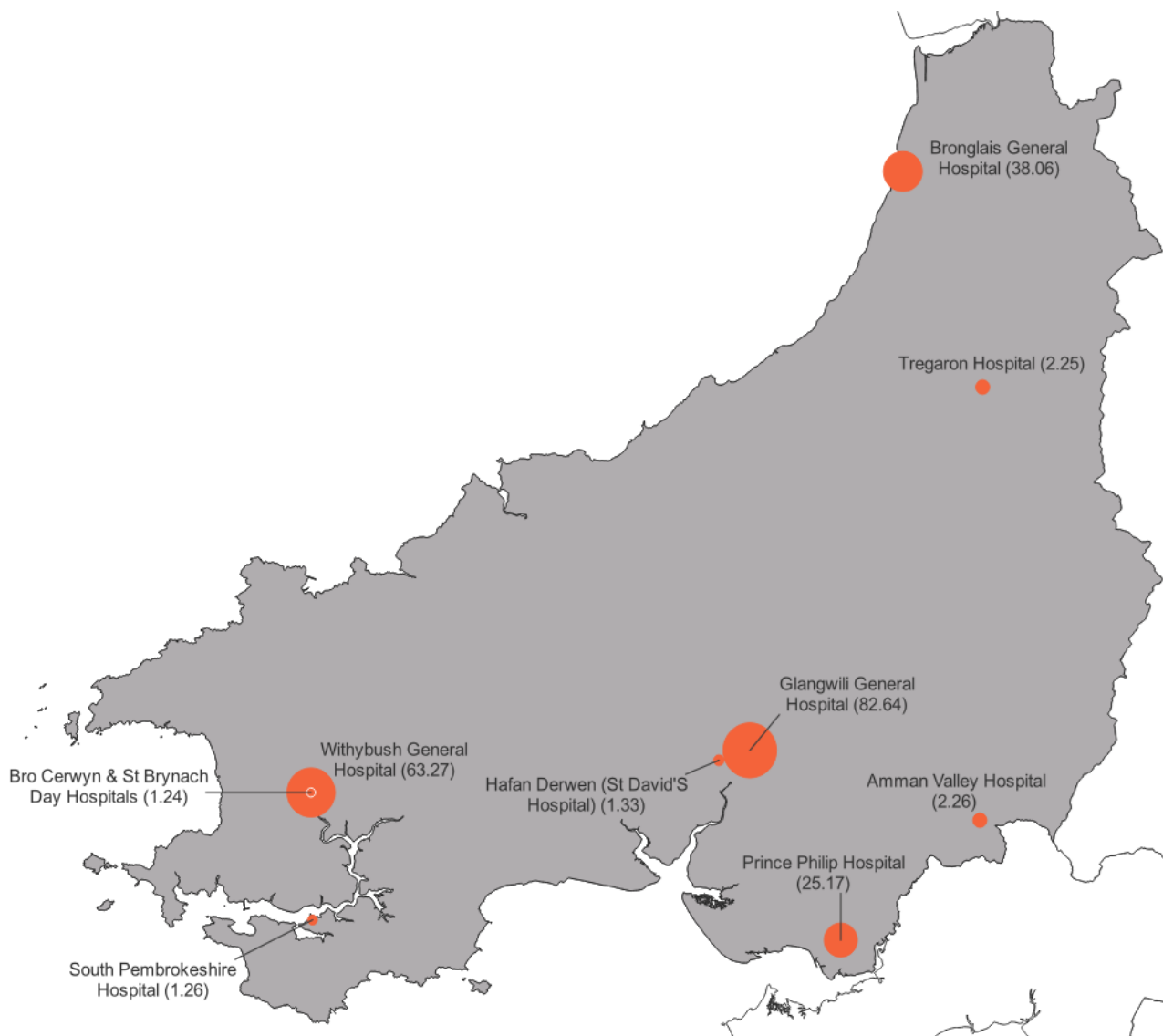
- Executive Director of Strategy and Planning
- Executive Director of Allied Health Professions and Health Science
- Head of Operational Estates and Facilities
- Head of Property Performance
- Health and Safety Manager, and Head of Estates, Risk, Compliance, Policy, and Systems.

We reviewed national data available from the Estates and Facilities Performance Management System (EFPMS), monthly financial monitoring returns submitted to the Welsh Government, and local data provided to us by the Health Board. We have not audited the data from these sources.

2 Size and location of the Health Board's backlog maintenance

The map below shows the size and location of the Health Board's risk adjusted backlog in 2024-25. It excludes sites with a backlog of £1 million or less.

Exhibit 7: size and location of the Health Board's risk adjusted backlog, 2024-25 (£ million)



3 Key terms in this report

Term	Description
<u>2018 Estatecode Wales</u>	Gives detailed advice on how to manage land and buildings used for healthcare services.
A Healthier Mid and West Wales	Hywel Dda University Health Board's long-term strategy to improve health services by shifting more care closer to home, improving prevention and wellbeing, and developing sustainable hospital services and estate infrastructure.
Backlog maintenance	A measure of the investment needed to restore a building to a set standard, based on assessed risk.
Computer Aided Facilities Management (CAFM)	A system used to manage estates and facilities work, including asset records, planned and reactive maintenance, compliance checks, and reporting.
Corporate Landlord Model	An approach to estate management where responsibility for planning, investment, maintenance, and use of estate assets is coordinated through a central estates function, helping to support consistent decision-making and strategic use of resources.
DATIX	An electronic system used across NHS Wales to record, manage and analyse patient safety incidents, concerns, complaints, and risks.
Discretionary capital	Funds that an organisation can allocate at its own discretion.

Term	Description
Estates and Facilities Advisory Board (EFAB)	A Welsh Government capital funding programme that supported targeted estates improvements across NHS Wales, including infrastructure, decarbonisation, and fire safety. It was replaced by the Targeted Estate Fund (TEF) in 2025-26.
Estates and Facilities Performance Management System (EFPMS)	An all-Wales system used to collect and report data on NHS estates and facilities. It supports monitoring, benchmarking, and improving performance, and informs planning and decision-making.
Functionally suitable	The percentage of occupied floor area that meets the <u>2018 Estatecode Wales</u> Condition B standard.
Health Technical Memorandum (HTM)	NHS technical guidance that sets standards for engineering, safety, and operations in healthcare estates to ensure safe and compliant environments.
High-risk backlog	Issues that need urgent action to prevent serious failure, major service disruption, or safety risks that could cause harm or legal action.
Occupied floor area	The total floor area of buildings in use to deliver NHS services, including spaces owned, leased, or used under agreements.
Occupeye	A sensor-based occupancy monitoring system that provides data on how workspaces are used, helping organisations improve space utilisation and estate planning.
Organisational change process	A structured way to plan and manage change. It helps organisations improve how they work and make changes in a clear, fair, and organised way, while keeping staff informed and services running effectively.

Term	Description
Physical condition B	Defined by the <u>2018 Estatecode Wales</u> as below an acceptable standard, or unacceptable in its current condition, and often requiring full replacement.
Responsible Person	A senior manager with overall responsibility for ensuring that an estate or engineering system is safe, compliant with legal and HTM requirements, and managed by competent staff.
Risk-adjusted backlog	The estimated cost to fix maintenance issues, weighted by how serious the risk is to safety, services, or compliance.
Significant-risk backlog	Repairs or replacements that need urgent action to avoid compliance concerns or risks to safe healthcare delivery.
Space utilisation	The percentage of occupied floor area that is fully used as defined in the <u>2018 Estatecode Wales</u> .
Targeted Estates Fund	A Welsh Government capital fund that targets high priority estate risks in the NHS, including safety, compliance, and resilience. It provides £80 million (2025–27), with NHS bodies contributing 30%.

4 Management Response Form

Recommendation	Commentary on planned actions	Completion date	Responsible officer
R1 The Health Board should ensure its new Estates Strategy and updated Property Asset Strategic Plan (2027-2030) set out clear priorities, milestones, targets, timescales, and accountability arrangements. The strategy should also show how equality considerations, socio-economic factors and stakeholder engagement inform estates planning and decision-making (paragraphs 10 and 13).	The Health Board once the longer-term strategic plans linked to the AHMWW programmes are agreed with Welsh Government will develop a new Estates Strategy to support the delivery. In advance of this delivered an accelerated rationalisation programme and refresh the Property Asset Strategic Plan (2027-30). In parallel, the Corporate Landlord Model being established will aim to strengthen governance arrangements, delegated decision-making processes, asset-based planning and enhanced accountability mechanisms which directly support delivery of this recommendation.		

Recommendation	Commentary on planned actions	Completion date	Responsible officer
	The Health Board can explore a strategic estates performance framework through the new Estates Strategy. The Corporate Landlord Business Case already proposes a comprehensive KPI framework including utilisation, maintenance, cost, project delivery and customer performance measures which will support strategic outcome reporting and monitoring. Actions: • Health Board to revise and endorse new Property Asset Strategic Plan – 2027/2028 • Health Board to revise and endorse new Estates Strategy to include framework and key metrics - 2028	June 2027 June 2028	Head of Property Head of Estates Operations

Recommendation	Commentary on planned actions	Completion date	Responsible officer
R2 The Health Board should establish a strategic outcome measure for its estate, supported by clear targets and regular Board reporting. This would help demonstrate whether estate performance is improving over time (paragraph 33).	This is being reviewed and will be in place with approval shortly.	March 2027 overall	Head of Estates Operations
	Actions: • Liaise with NWSSP for consultation on appropriate measure. Meeting agreed and in schedule.	November 2026	Head of Estates Operations
	• Implementation and roll out monthly reporting for measure including in Estates CCG and inclusion within Performance Team reporting.	November 2026	Head of Estates Operations
	• Seek Committee and/or Board approval for strategic outcome measure	March 2027	Head of Estates Operations

Recommendation	Commentary on planned actions	Completion date	Responsible officer
R3 The Health Board should strengthen its asset management arrangements by developing a complete and reliable asset register and improving links between its systems. This would support more effective maintenance planning, compliance monitoring, and asset performance reporting (paragraph 66).	The Corporate Landlord Model provides a significant delivery mechanism for this recommendation through improvements to asset information, system integration, planned maintenance planning, asset-level reporting, and asset challenge processes.	March 2028	Head of Property
	Actions:		
	- This will include delivery of new Estate code Facet estate surveys across the retained estate. The Health Board is exploring funding options in this respect. - Develop a risk-based asset management strategy setting out our vision and goals for the Health Board.	June 2027	Head of Property
		Linked to recommendation 1	

Recommendation	Commentary on planned actions	Completion date	Responsible officer
	- Develop a system for the identification of estates Priority 1 assets (Phase 1). To support: - Statutory compliance management - Planned preventative maintenance (PPM) - Lifecycle replacement analysis & planning - Critical infrastructure resilience - EFPMS/estate reporting	August 2027	Head of Estates Risk & Compliance
R4 The Health Board should improve how it collects, records and reports information on the impact of estate condition on patient safety, staff experience,	Existing incident reporting and governance arrangements will be reviewed to strengthen the collection and reporting of estate-related safety, service and user experience information.		

Recommendation	Commentary on planned actions	Completion date	Responsible officer
and service delivery. This should include information on estate-related incidents, as well as feedback from staff and patients (paragraph 77).	Actions: • All Estates staff to be trained in use of Civica, agreed with Head of Patient Experience. Training to be scheduled. • All Wales Peoples Experience Framework. Head of Patient Experience to send link to estates for review and training. • Routine and consistent of PI claims in partnership with Legal & Risk to review lessons learnt across the Estate.	December 2026 December 2026 August 2026 – Completed and ongoing	Head of estates Operations Head of estates Operations Head of estates Operations
R5 The Health Board should develop and implement a clear plan to improve statutory compliance. The plan should address outstanding fire and	The Health Board will continue to strengthen fire and water safety improvement arrangements through existing programmes and governance structures.		

Recommendation	Commentary on planned actions	Completion date	Responsible officer
water safety risks and provide regular reports on progress, key risks, and planned actions (paragraph 82 and 85).	Actions: • Demonstrate good governance around meeting attendance and monitoring of performance for Fire Safety Group and Water Safety Group. Inclusive of minutes, actions, Terms of Reference, Risk escalation and reporting. Critical to show upward flow of risks to Health & Safety Compliance Group and Health and Safety Committee • Provide report and evidence on Training Needs Analysis and implementation against these risks. • Provide evidence on HB WHTM Approach and implementation of approved Water Safety and Fire Safety policies	December 2026	Head of Maintenance & Engineering
		December 2026	Head of Maintenance & Engineering
		December 2026	Head of Estates Operations

Recommendation	Commentary on planned actions	Completion date	Responsible officer
	- Document all audits against Fire and water from NWSSP within AMaT system and demonstrate completion of actions within assigned timeframes up to this agreed date. - Demonstrate completion of major fire project works phase 2 at WGH and GGH to include reduction in risk score against Risk Reference 813.	July 2027 December 2029	Head of Estates Operations Head of Estates Operations

About us

The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

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

3.3 - Review of Cancer Services

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| For assurance

Attachments

[Audit Wales Review of Cancer Services ARAC 15 October 2026.pdf](#)

[Review of Cancer Services HDdUHB Management Response.pdf](#)

Are cancer services improving?

Hywel Dda University Health Board

September 2026

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Audit snapshot

What we looked at

- 1 We looked at Hywel Dda University Health Board (the Health Board)'s approach to managing cancer services. This includes how it plans services, prevents cancer, supports early detection, and leads and oversees service performance.
- 2 We also reviewed trends in cancer service performance. Our 2025 [national report on cancer services](#) highlighted data quality concerns and recommended improvements at a national level. We have not reviewed data quality as part of this review.

Why this is important

- 3 Demand for cancer services is increasing, driven by factors such as:
 - an ageing population;
 - rising levels of obesity and alcohol use;
 - better survival rates, meaning patients need ongoing follow-up and monitoring; and
 - the ongoing introduction of new tests and treatments.
- 4 Cancer outcomes are worse when patients wait too long for treatment. Long waits can shorten life expectancy and reduce quality of life after treatment. This increases pressure on health boards to deliver timely care.
- 5 Cancer services account for a growing share of NHS spending. This is driven by increasing demand and the costs of new tests and treatments.

What we have found

- 6 The Health Board has worked well to manage increasing service demand. Performance against cancer waiting time targets has improved but is still below the 75% target. In March 2026, performance was around 62%. There is wide variation in timeliness performance between tumour pathways, and some patients wait longer than others.
- 7 The Health Board is taking steps to manage rising demand and pressure. Actions include redesigning care pathways, increasing diagnostic capacity, and improving staffing. However, many actions are reactive, not well tracked, and not fully evaluated. As a result, they have not yet delivered sustainable performance improvements.
- 8 Leadership and governance provide clear oversight and escalation routes, but their impact is limited. There are gaps in coordination, inconsistent reporting, and limited use of data to support decision-making and Board scrutiny. This weakens accountability and reduces confidence that changes are improving patient outcomes.
- 9 The Health Board understands the challenges it faces. However, it does not have a single clear, long-term, joined-up strategy or costed improvement plan for cancer services. Financial pressures, workforce and capacity gaps, and limited use of outcomes and equity data reduce confidence in its ability to deliver timely, fair, and sustainable improvements.

What we recommend

10 We have made six recommendations to the Health Board in the following areas:

- creating a costed improvement plan to deliver the strategy;
- improving how cancer improvement actions are tracked;
- ensuring consistent reporting of improvement activity;
- including a wider range of data in monitoring reports;
- working with partners to improve access to cancer screening data; and
- using cancer outcomes data to support planning.

Key facts and figures



The number of new suspected cancer referrals rose by 24% between 2022–23 and 2025–26.



Spending on cancer services rose from £70 million to £109 million between 2019–20 and 2023–24. This is £17 million more than if spending had kept pace with inflation over the same period.



In March 2026, most referrals were for suspected skin (511), urological (372), and lower gastrointestinal (313) cancers.



In March 2026, 60.2% of patients started treatment within 62 days, compared with the 75% target.



In March 2026, there was wide variation in treatment waiting times. Performance ranged from 96% for skin cancer to just 18% for urological cancer, against a 75% target.



Between 2002 and 2024, one-year cancer mortality rates have fallen by 18.5%.

Our findings

Cancer service improvement planning

No clear long-term improvement plan, weak co-ordination, and rising demand limit confidence that cancer services will sustainably improve waiting time performance

Cancer improvement plans

- 11 The Health Board does not have a single, overarching cancer strategy or forum to oversee it. Instead, it relies on annual plans and other documents. While these refer to national standards and priorities, they are fragmented and do not set out a clear long-term approach to cancer services. This reduces clarity on future direction and limits confidence in the Health Board's ability to deliver the improvements needed for timely and sustainable cancer care.
- 12 The Annual Plan 2026–27 sets out relevant priorities, including improving pathway timeliness, increasing diagnostic capacity, and meeting the Suspected Cancer Pathway (SCP) target. These priorities broadly align with national expectations and show a good understanding of key challenges. However, the plan is high-level. It does not clearly set out the workforce, financial, digital or estate requirements needed to meet demand in the short- or longer-term.

- 13 There is no single, integrated cancer improvement plan to deliver the Health Board's ambitions. Although many improvement activities are underway, they are not brought together into a clear programme. This makes it hard to show how they support priorities or drive progress. Many initiatives are poorly defined, lack evaluation, and are often reactive rather than focused on underlying system issues. Actions also lack clear ownership, timescales, measures of success, and links to performance recovery. As a result, the Health Board continues to rely on short-term measures, such as overtime and backlog initiatives, to manage pressures.
- 14 Planning assumptions are cautious about performance improvement. Current trajectories suggest the Health Board does not expect to meet the national target within existing resources. There is no clear plan for how it will achieve the target or reduce variation and inequities in access and outcomes. While equity is recognised at a strategic level, it is not well embedded in cancer planning. There is also limited evidence of targeted actions to reduce inequalities.
- 15 The Health Board does not expect to achieve the 75% target in 2026–27. Performance is forecast to level off at 66% by Quarter 2. Given the gap between planned performance and national expectations, and the lack of a clear, integrated delivery approach, there is limited confidence that current plans will lead to sustained improvement.

Cancer intelligence and data

- 16 The Health Board has well-established processes to monitor cancer demand and performance. Regular reporting and governance give a clear view of performance trends, pathway pressures and variation across tumour types. This helps identify areas under pressure and supports operational responses and targeted reviews.

- 17 However, the Health Board needs to improve how it uses data to support planning. Operational data is used routinely to manage demand in the short-term, but this approach is mostly reactive. It is not clearly linked to medium- and long-term planning. Although demand and capacity modelling is developing, there is limited evidence that it is used consistently to align workforce capacity or support sustainable services.
- 18 The Health Board collects detailed data across the cancer pathway, including performance against key targets, diagnostic pressures, backlogs, and reasons for delays. This is used well at an operational level to manage services and respond to immediate pressures. However, it is not always reported in enough detail to the Board and its committees. This limits oversight of where pressures are greatest and reduces its value for longer-term planning.
- 19 The Health Board is not making full use of outcomes data to inform decisions. While there is some awareness of measures such as stage at diagnosis, mortality and patient experience, this data is not used routinely in planning, management or Board reporting. As a result, the focus remains on process targets rather than patient outcomes, limiting the ability to prioritise actions and plans based on impact.

Supporting fragile services

- 20 Delays in cancer treatment vary across tumour pathways. The greatest pressures are in urology and lower gastrointestinal services. These pathways have the largest backlogs and the lowest performance. They also account for a high number of patients waiting longer than 62 days.
- 21 The causes of pressure on services are well understood and regularly monitored. Key constraints include limited diagnostic capacity, workforce shortages, and reliance on tertiary providers for some treatments, which can delay patient pathways. The Health Board has strong operational oversight, including tumour-specific reviews and targeted interventions. This shows a good understanding of risks and a clear commitment to improving performance.

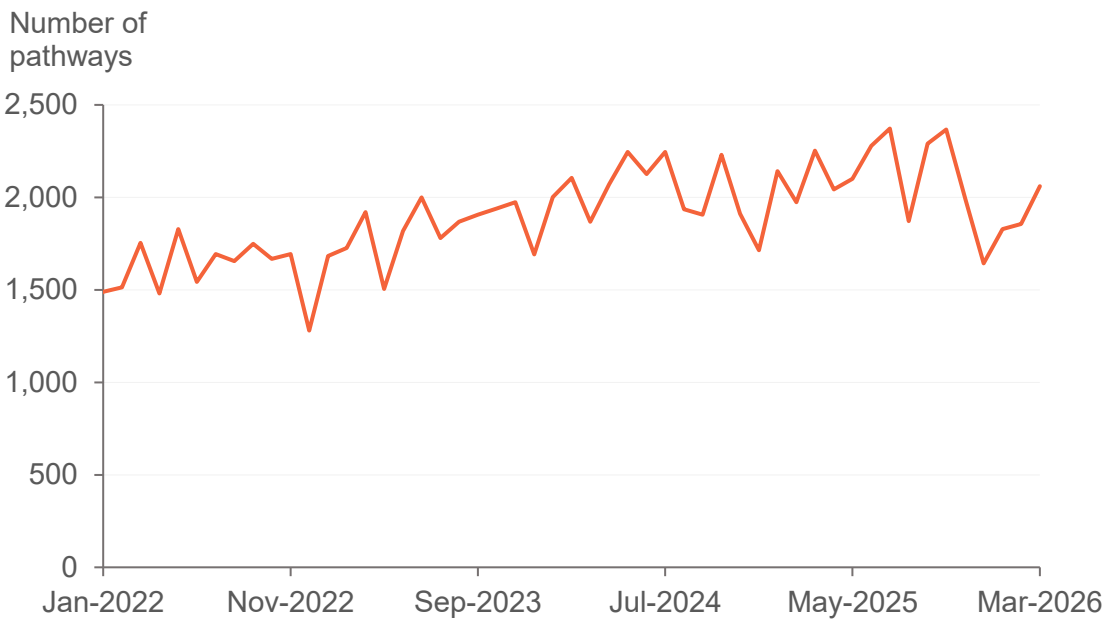
Financial and resource planning

The absence of comprehensive financial and resource plans for cancer services, limit assurance that resources can meet rising demand and national targets

Funding plans

- 22 The Health Board does not have a full picture of the total investment needed to improve cancer services. Financial planning is fragmented, although some areas have been costed in detail. Investment decisions are made through separate initiatives, often focused on high-pressure areas such as diagnostics. This limits visibility of overall resource needs across the full cancer pathway.
- 23 Wider financial pressures mean that current funding is not enough to meet national targets. Improvement plans rely on additional funding that is uncertain and may not be sustainable.
- 24 The following exhibits show the trend in cancer service demand and funding. **Exhibit 1** shows the number of new suspected cancer pathways opened each month. It highlights a continued rise in demand. There has been a marked increase in referrals between 2022–23 and 2025–26, particularly in skin (+100%), urological (+25%) and head and neck (+21%) tumour sites.

Exhibit 1: newly opened suspected cancer pathways Hywel Dda University Health Board, January 2022 to March 2026 (number)



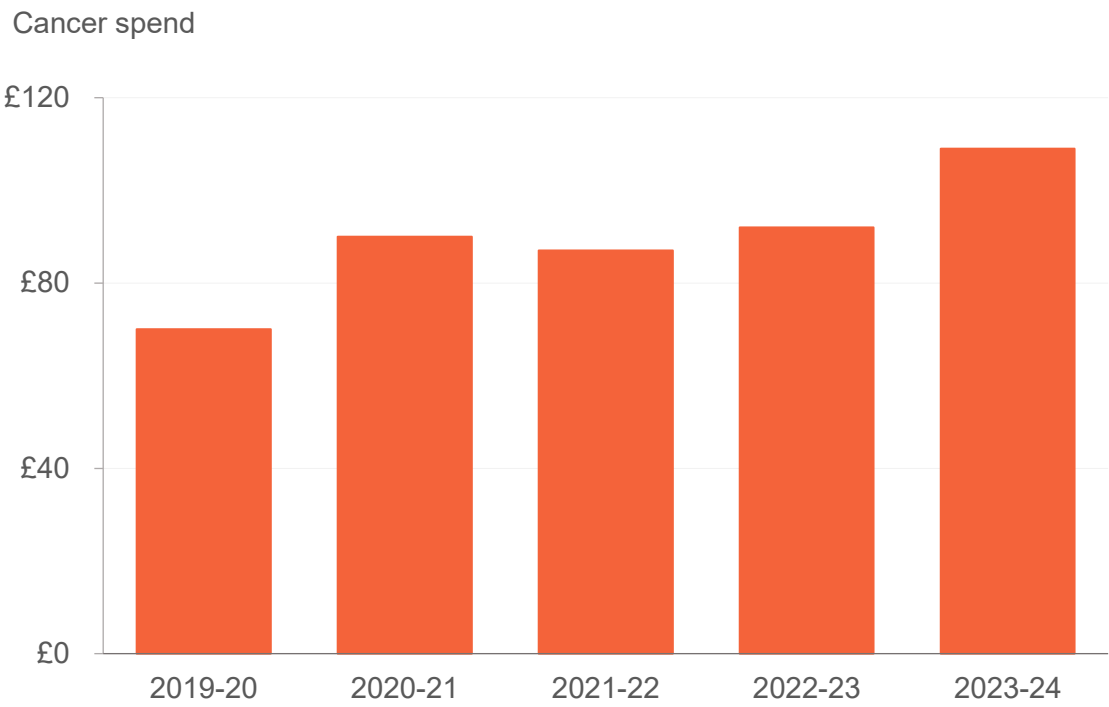
Source: Audit Wales analysis of Digital Health and Care Wales data

Note: Under the suspected cancer pathway (SCP), a pathway starts at the point of suspicion, for example when a GP makes a referral. Pathways are closed, and waiting times end, when patients start their first definitive treatment, are downgraded (told they do not have cancer), choose not to have treatment or if the patient died. Note that patients can be on more than one pathway.

25 Demand is rising, and costs have increased faster than inflation. **Exhibit 2** shows spending on cancer services between 2019–20 and 2023–24. Over this period, the Health Board’s cancer spending rose by around 31% above inflation¹. Spending on hospital cancer medicines has also increased. Between 2019–20 and 2024–25, it rose from £15.7 million to around £25.4 million^{2,3}. This is about £6 million more than if costs had increased in line with inflation (in 2024-25 prices).

¹ Inflation is calculated using 2023–24 as a baseline and HM Treasury inflation data.
² Some specialist medicine costs cover both cancer and other treatments but are included in the total. This is unlikely to have a significant impact on the overall figures.
³ Medicine figures cover hospital spending by the Health Board only and exclude costs for patients treated elsewhere.

Exhibit 2: actual cancer services spend, Hywel Dda University Health Board, 2019–20 to 2023–24 (£ million)



Source: Audit Wales analysis of the Health Board’s data, sourced from the Welsh Government

26 Cancer service costs are not clearly set out, and there is no single view of total planned spending, despite rising demand and costs. Detailed costing and demand modelling exist for some parts of the cancer pathway, but this information is not brought together into one integrated financial plan. As a result, there is limited visibility of overall investment needs. This reduces assurance that funding is aligned, affordable, and enough to meet future demand and cost pressures across cancer services.

Wider resourcing requirements

- 27 The Health Board understands the workforce pressures affecting cancer services. These include staff shortages, hard-to-fill vacancies, and reliance on a small number of specialist staff, especially in diagnostics and oncology. It has completed a workforce review and introduced role redesign and changes to skill mix to address some of these issues. However, without a single, integrated cancer workforce plan, it is unclear how well this information informs longer-term decisions. This creates a risk that workforce actions are not well coordinated or sufficient to support future service capacity.
- 28 The Health Board has considered estates needs at a strategic level. It recognises that ageing buildings and facilities are a barrier to modern cancer care. While some service areas show forward planning, estate development is limited by capital funding. This restricts the pace and scale of improvement.
- 29 The Health Board does not have a clear, costed plan for cancer-specific equipment. Some planning exists at service level and links to demand and capacity modelling. However, the overall approach is gradual and shaped by funding limits rather than a proactive, system-wide strategy. This limits assurance that equipment will meet future demand or respond quickly to failures.
- 30 The Health Board recognises the value of digital technology and has made progress in using it to support cancer services. This includes real-time dashboards, digital radiology⁴, and innovative approaches such as virtual clinics and AI-supported tools.

⁴ The Health Board now uses the Welsh Radiology Information System. This system supports functions such as patient scheduling and clinical reporting of medical images.

Cancer prevention and population screening

The Health Board is taking targeted actions to improve prevention and screening uptake, but gaps in capacity, data and coordination limit the impact

31 The All-Wales Cancer Improvement Plan estimates that 38% of cancers each year are preventable. For context, if the Health Board prevented 20% of cancers, it could have saved £2.1 million in bed day costs in 2024-25, based on the most recent financial data. **Exhibit 3** shows the potential gains if the Health Board successfully implemented a cancer prevention strategy.

Exhibit 3: potential capacity gains from cancer prevention, Hywel Dda University Health Board, based on 2024–25 activity

		2024-25 actual	-10% reduction	-20% reduction	-38% reduction
	Finished consultant episodes	12,572	11,315 (1,257 reduction)	10,058 (2,514 reduction)	7,795 (4,777 reduction)
	Admission episodes	11,742	10,568 (1,174 reduction)	9,394 (2,348 reduction)	7,280 (4,462 reduction)
	Bed days	21,074	18,967 (2,107 reduction)	16,859 (4,215 reduction)	13,066 (8,008 reduction)
	Bed day cost savings		(£1.1 million)	(£2.1 million)	(£4.0 million)

Source: Audit Wales analysis and modelling of Digital Health and Care Wales data from the Patient Episode Database for Wales, Headline Figures and Primary Diagnosis Datasets for Welsh providers.

Notes:

- 1) The analysis outlines the broad impact of a 10%, 20% and 38% reduction in cancer cases, based on 2024–25 activity levels.
- 2) Savings calculation based on £500 per day cost of an NHS bed in Wales used in our [2025 National Cancer Services Report](#).

Public health risk assessment

- 32 The Health Board understands the main factors that increase cancer risk. It uses population needs assessments and national data to identify risks such as smoking, poor diet, low physical activity and alcohol use. Its '20Four7' prevention model aims to address deep-rooted health inequalities. It focuses on the most deprived communities and supports people to stay well. The model aims to reduce inequalities through cancer prevention, earlier diagnosis and more accessible, joined-up services.
- 33 However, population health information is fragmented. The use of data to target action is limited by data quality, data sharing and analytical capacity. The Health Board is committed to improving lifestyles and has introduced initiatives to reduce cancer risk and tackle inequality. However, prevention is not consistently part of day-to-day practice and is not well coordinated across services. Past underinvestment and workforce pressures have led to a reliance on national programmes, with limited targeted local action. As a result, there is no clear, joined-up approach to cancer prevention that is likely to deliver lasting improvements in outcomes.

Approaches to improving population lifestyles

- 34 The Health Board is delivering a range of programmes to reduce cancer risk and improve population health. Prevention is a strategic priority. There has been recent investment in health and well-being coaching, immunisation outreach, smoking cessation services, and support for screening programmes, including preparation for lung cancer screening.
- 35 For 2026–27, the Health Board have increased their investment in prevention by introducing a four-tier health coaching service. This targets GP practices in its most deprived communities, and offers digital, group and one-to-one support to help people change behaviours. This shows a renewed focus on prevention after a period of underinvestment.
- 36 However, funding remains relatively modest, and there are risks to the long-term sustainability of some programmes. Workforce pressures also limit delivery and the Health Board's ability to expand prevention across services. While there is a clear strategic intent and some positive initiatives, the overall approach is not yet well coordinated or well resourced. As a result, there is limited confidence that it will deliver lasting improvements in cancer outcomes or reduce health inequalities.

Targeted prevention and population screening

- 37 There are clear referral routes for patients whose cancer is detected through national screening programmes. The Health Board works closely with Public Health Wales NHS Trust through joint governance, data sharing, and screening improvement work. However, delays in access to screening data and capacity issues in colonoscopy, radiology, pathology and endoscopy mean that screening does not always lead to timely diagnosis and treatment.
- 38 The Health Board is building an understanding of the factors that affect screening uptake. It recognises the impact of deprivation, awareness, and access and social barriers. It has set up a dedicated screening forum to improve uptake among underserved groups. However, screening data is often out of date, and local analytical capacity is limited. This makes it harder to identify and respond to inequalities in participation.

- 39 The Health Board has introduced targeted human papillomavirus vaccination (HPV) campaigns through school and community outreach. Despite this, uptake remains below the national target, at around 77% compared with 90%. This suggests current actions have not yet achieved the coverage needed to maximise the prevention of this cause of cancer.

Cancer leadership and oversight

Limited strategic oversight and outcomes-focused scrutiny reduce accountability and make sustained improvement in cancer services harder to achieve

Managerial leadership

- 40 There are clear leadership arrangements for cancer services. The Chief Operating Officer (the COO) has overall responsibility. They are supported by a General Manager for cancer performance, and a Cancer Services Delivery Manager who oversees performance tracking and reporting. A new Clinical Lead for Planned Care and Cancer has strengthened clinical leadership, although the role is still developing and its impact is not yet fully realised. However, the absence of a dedicated Cancer Board creates a gap in strategic oversight and coordination.
- 41 Senior managers can make decisions and escalate issues through established governance processes. Weekly performance and executive panel meetings support timely decisions and risk management, using cancer performance reports. The recent de-escalation by the Welsh Government suggests these arrangements are helping to improve and oversee performance⁵.
- 42 Managers, clinicians and support staff work well together, supported by regular meetings and shared oversight of performance. The Health Board also works with partners such as Public Health Wales NHS Trust, NHS Wales Performance and Improvement, and the voluntary sector. However, the lack of a Cancer Board limits opportunities to bring together clinical, operational, and patient views in one place and weakens accountability for long-term improvement.

⁵ In February 2026, the Health Board moved from Level 3 (targeted intervention) to Level 1 (routine monitoring) for cancer performance. This followed three consecutive months with performance of at least 63% against the 62-day target, meeting Welsh Government criteria for automatic de-escalation.

- 43 Regional working is essential to cancer services, with some patients treated by other health bodies, including the South-West Wales Cancer Centre at Swansea Bay University Health Board. The Health Board works closely with these partners. However, delays in patient transfers, fragmented digital systems, funding approval processes, and unclear referral routes can reduce coordination and delay access to treatment across organisational boundaries.

Oversight and scrutiny

- 44 The Board and Finance and Performance Committee receive regular reports on cancer performance. These include SCP performance, backlogs, trajectories, risks and improvement actions. The reports give a good overview and support scrutiny. However, they lack detail on tumour-specific performance, pathway stages, and outcomes such as stage at diagnosis and mortality. This limits the Board's ability to understand variation, identify the greatest pressures, and assess whether services are improving patient outcomes.
- 45 The Board and its committees are aware of cancer performance challenges and receive regular updates on improvement work. However, actions are reported through both the Integrated Performance Assurance Report and Planning Objective updates. Differences in how actions are presented create a risk of confusion, reduce transparency, and make it harder to track progress and accountability consistently.
- 46 Although scrutiny is in place, it focuses mainly on targets rather than outcomes. There is also limited evidence of routine follow-up of improvement actions. As a result, governance provides oversight of performance but gives less assurance that decisions are leading to sustained improvement.

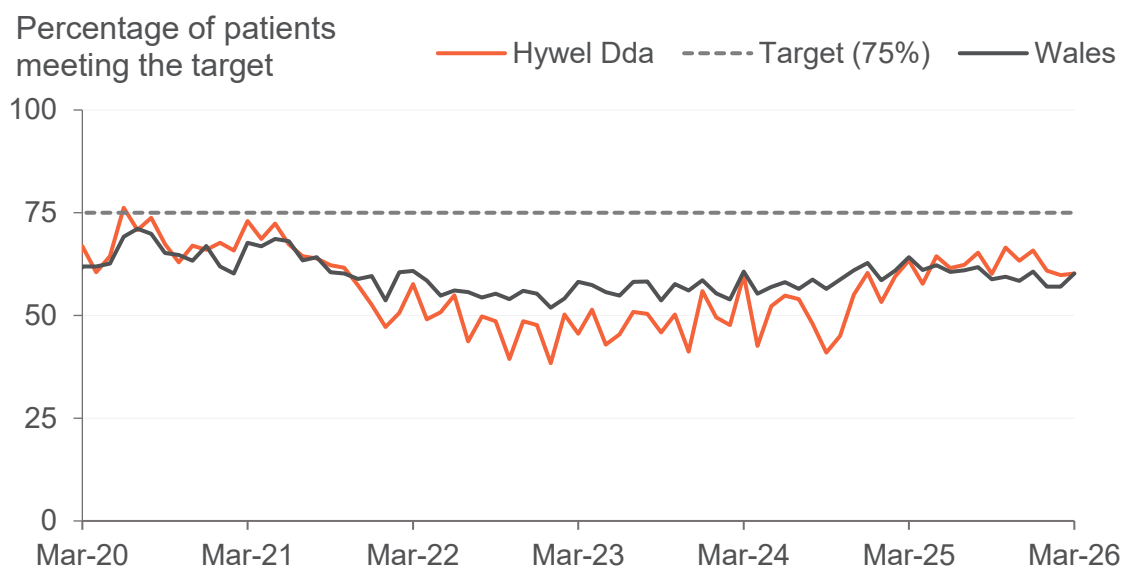
Cancer performance

Although improvement actions are underway, limited evaluation and reactive approaches are hindering sustained progress to meet the 62-day target

62-day cancer performance

- 47 The Welsh Government target is for 75% of patients to start their first treatment within 62 days of suspected cancer. Early diagnosis and prompt treatment improve outcomes. They increase survival rates and enhance quality of life. Long waits can lead to more advanced cancer. This may reduce life expectancy, limit treatment options and affect physical health after treatment.
- 48 **Exhibit 1**, outlined earlier in the report, shows that the number of new suspected cancer pathways opened each month has grown. Despite this, the Health Board has done well to ensure performance has not deteriorated. The Health Board's performance is in line with the Wales average but remains well below the national target (**Exhibit 4**). In March 2026, 60.2% of patients started treatment within 62 days. It is widely accepted that the number of cancer cases will continue to increase in Wales and service pressures are expected to grow.

Exhibit 4: patients meeting the 62-day cancer treatment target, Hywel Dda University Health Board, March 2020 to March 2026 (percentage)

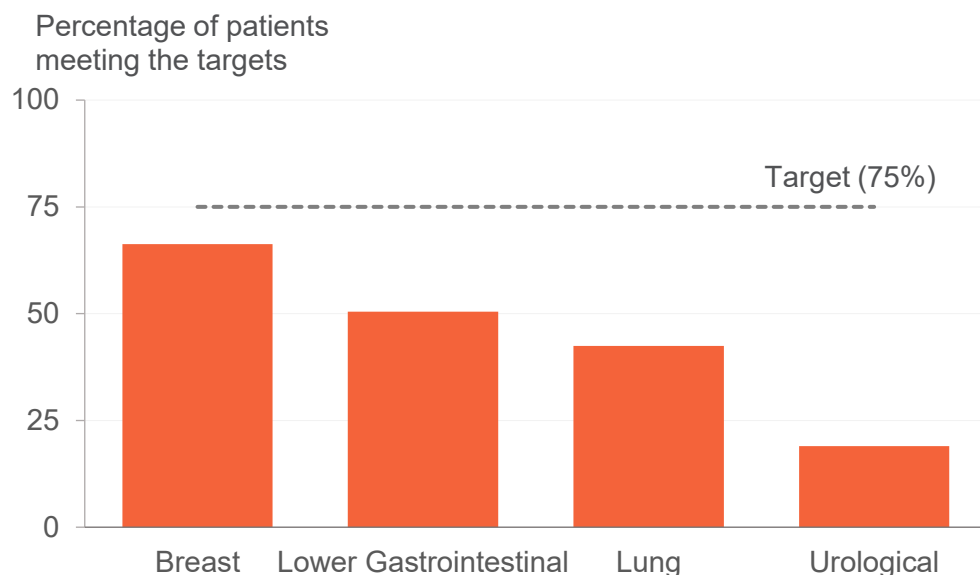


Source: Audit Wales analysis of Digital Health and Care Wales data

Note: The data includes patients who started treatment and those waiting for confirmation that they do not have cancer.

- 49 Overall performance also hides large differences between sex and tumour types. For example, for every month during 2025-26, performance against the 62-day target for men was worse than for women. The most significant difference recently was in December 2025, where around 75% women started treatment within 62 days, but only around 58% for men did. This is a gender gap of nearly 17%. It presents a picture of services that aren't adapting to changing demand.
- 50 Timeliness of access is related to the type of tumour. Some areas, such as skin cancer, are performing better. In March 2026, skin cancer pathways met the target, with 96% of patients starting their treatment within 62 days. **Exhibit 5** shows performance for four common cancers. It highlights concerning delays in urological, lung and lower gastrointestinal pathways.

Exhibit 5: patients meeting the 62-day cancer treatment target, Hywel Dda University Health Board by tumour site, 12-month average during 2025-26 (percentage)



Source: Audit Wales analysis of Digital Health and Care Wales data

Notes:

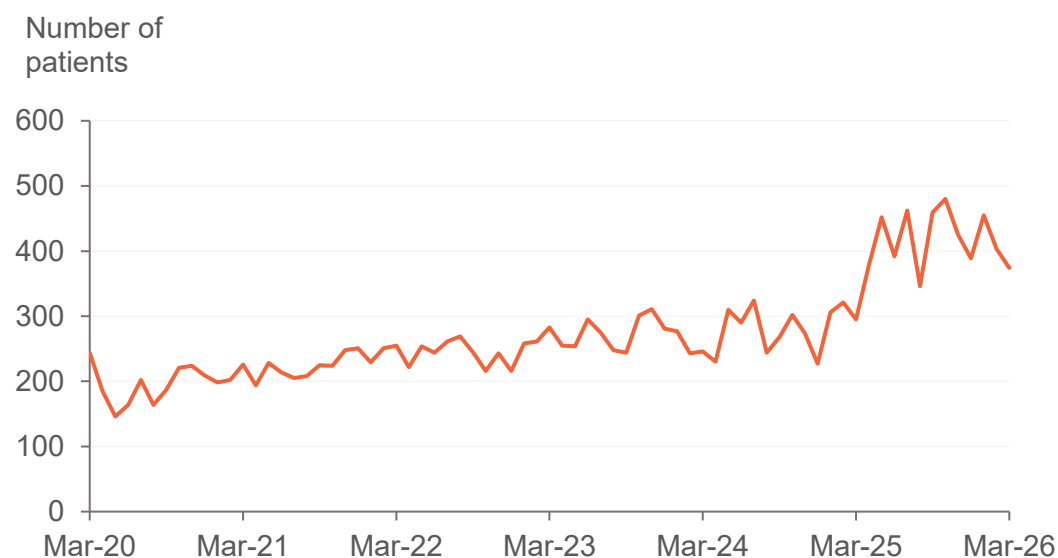
1. The data show average 62-day performance over the most recent 12 month period (March 2025 to March 2026).
2. The data includes patients who started treatment and those waiting for confirmation that they do not have cancer.

Impact of action to improve cancer services

- 51 The Health Board is taking a range of actions to improve cancer services. These include redesigning pathways, expanding diagnostic capacity, developing the workforce, and introducing new technologies. These actions show a clear understanding of the challenges and a commitment to improvement. However, they have not yet led to sustained improvements across all pathways, and performance remains below national targets.

- 52 The Health Board has made workforce and service changes to manage immediate pressures. These include expanding clinical roles, developing new clinics, and increasing diagnostic capacity. While these steps have helped in some areas, they are often focus on short-term issues and do not always address the root causes of limited capacity.
- 53 The Health Board continues to invest in improvement initiatives such as outsourcing diagnostics, using teledermatology, redesigning pathways, and increasing diagnostic activity. Planned actions aim to build on this work and respond to ongoing demand and capacity pressures. This shows an active approach to tackling barriers to better performance.
- 54 Performance against the 62-day target suggests these actions have not yet had enough impact. However, the number of patients starting treatment each month has positively increased since March 2025 (**Exhibit 6**).

Exhibit 6: cancer patients starting treatment each month Hywel Dda University Health Board, March 2020 to March 2026 (number)



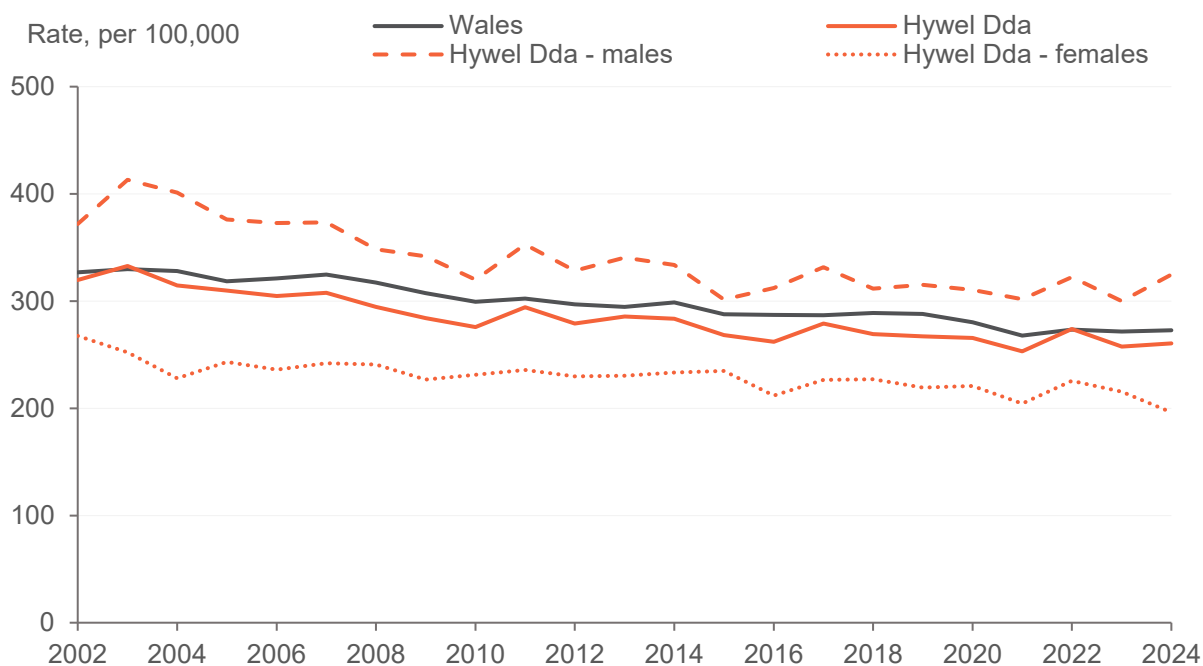
Source: Audit Wales analysis of Digital Health and Care Wales

- 55 The Health Board needs to improve how it plans, manages and evaluates improvement work. Actions are reported through several routes but are not always clearly defined, consistently owned or linked to measurable outcomes. There is limited evidence of regular evaluation, making it hard to assess whether actions are effective or to apply learning across cancer services.

Improving cancer outcomes

- 56 The Health Board has some awareness of key cancer outcome measures, such as stage at diagnosis, mortality and patient experience. However, it does not routinely use this data in day-to-day management or service improvement. As a result, outcomes data is reported but does not drive decision-making.
- 57 Cancer performance reporting focuses mainly on activity and waiting times, such as the SCP. Outcome measures, including mortality and stage at diagnosis, are not routinely reported to the Board or its committees. This limits oversight of the quality and effectiveness of care.
- 58 Limited use of outcomes data reduces the Health Board's ability to understand variation, assess whether changes are improving care, and prioritise actions based on impact. As a result, improvement work often focuses on processes rather than patient outcomes.
- 59 The Health Board needs to make better use of outcome data to support planning, prioritisation, and service improvement. A stronger focus on outcomes would provide greater assurance that performance gains lead to real benefits for patients.
- 60 Analysis of one-year mortality data from 2002 and 2024 shows a steady decline in cancer mortality rates (**Exhibit 7**). The Health Board's mortality rate is also lower (better) than the Wales average. However, outcomes remain worse for males than for females.

Exhibit 7: one-year cancer mortality Hywel Dda University Health Board, 2002 – 2024 (rate per 100,000 population)



Source: Audit Wales analysis of Public Health Wales NHS Trust data

Note: Deaths where cancer is the primary cause, using the European Age Standardised Rate to enable fair comparisons over time and place.

61 While long-term trends are improving, our [national report](#) found that cancer outcomes in Wales remain poor compared to other countries. The Health Board needs to focus more on outcomes to develop targeted and prioritised improvement actions.

Recommendations

Cancer services planning

- R1** The Health Board should develop a fully costed, organisation-wide strategic cancer improvement plan to support sustainable delivery of the cancer strategy as demand increases. This should be aligned to the National Cancer Strategy which is due to be published in February 2027 (**paragraph 11- 13**).
- R2** The Health Board should improve how it tracks cancer improvement actions by ensuring each action has a clear owner, timeline, and expected outcomes. This will support better monitoring and strengthen accountability (**paragraph 13**).
- R3** The Health Board should work with Public Health Wales NHS Trust to agree, as soon as possible, a full set of data on screening services. This should include:
- Timeliness at each stage of all current cancer screening pathways, and lung screening once fully rolled out.
 - Date on screening uptake, with analysis by population groups (including age, location, sex (where relevant), and ethnicity (**paragraph 37**)).

Cancer reporting

R4 The Health Board should strengthen reporting of cancer improvement activity by adopting a single, consistent approach to reporting all improvement actions (**paragraph 44**).

R5 The Health Board should improve cancer reporting to the Board and its committees by including average waiting times, tumour-specific performance, and outcomes data. This will support stronger scrutiny and more targeted assurance (**paragraph 45**).

R6 The Health Board should make greater routine use of cancer outcomes data, such as stage at diagnosis, mortality, quality of life and patient experience, to inform decision-making, governance and improvement priorities (**paragraph 58**).

Appendices

1 About our work

Scope of the audit

We looked at the following areas:

- How well the Health Board plans its cancer services and whether they align with the National Cancer Plan, Quality Statement and Cancer Recovery Programme.
- How the Health Board seeks to reduce cancer prevalence by targeting preventative actions and supports screening programmes to detect cancer sooner.
- How cancer services are led and managed to drive improvements.
- How services are performing and the actions that the Health Board is taking to drive service improvement and achieve better patient outcomes.

We did not consider service quality, clinical governance or patient experience.

We have also not completed an audit of the data used in this review, but we have looked at the all-Wales data validation process.

Audit questions and criteria

Questions

We used the following questions to focus our fieldwork:

- Has the Health Board clearly set out how it will achieve timely and equitable access to cancer diagnosis and treatment?
- Has the Health Board set out a coherent approach to cancer prevention?
- Is the Health Board providing strong leadership and governance for timely and equitable access to cancer diagnosis and treatment?

- Is the Health Board making progress to deliver timely and equitable access to cancer diagnosis and treatment?

Criteria

We assessed the Health Board's arrangements against the following criteria:

- The Health Board has clear funded plans based on sound business intelligence which sets out cancer services priorities and objectives, and the approach it is taking to achieve them.
- The Health Board has a clear approach to target population health improvements as means to reduce cancer prevalence in the longer-term.
- The Health Board's leadership for cancer services work collaboratively and are empowered to drive cancer service improvements in the short and longer-term.
- The Health Board is making continuous improvement on 62-day cancer performance, successfully addressing underperforming services and driving improvements to achieve better outcomes for patients.

Methods

Our audit methods included document review, data analysis, and interviews. We interviewed the following:

- Chief Operating Officer;
- Clinical lead for Cancer;
- Director of Public Health; and
- General Manager for Planned Care and Cancer.

We also held a focus group with the operational specialty management leads.

2 Key terms in this report

Term	Description
62-day Suspected Cancer Pathway (SCP)	The all-Wales performance standard that 75% of patients should start their first definitive treatment within 62 days from the point of suspicion.
Admission episodes	The first period of care under a consultant with a health provider's episode of care.
Bed days	A day during which a patient occupies a hospital bed and stays overnight in the hospital.
Bed days cost savings	The financial benefits gained from reducing the number of hospital bed days.
Cancer Quality Statement	National statement outlining quality expectations for cancer care and outcomes across NHS Wales.
Cancer Recovery Programme	Programme of actions intended to restore/improve cancer services post-disruption (e.g., COVID-19), focusing on waits, pathways and outcomes.
Cellular pathology	Laboratory analysis of tissue/cell samples (histology/cytology) critical for diagnosis and treatment decisions.
Colonoscopy	Endoscopic examination of the large bowel to diagnose/biopsy lower GI cancers.
European Age-Standardised Rate (EASR)	A rate adjusted to a standard European population age-structure to enable fair comparisons over time/places.

Term	Description
Finished consultant episodes	Refer to the periods of patient care under a consultant's supervision that have concluded due to discharge, transfer, or death.
Genomic cancer therapies / genetic testing	Testing and treatments guided by tumour or inherited genetic information to better target care and risk reduction.
National Cancer Improvement Plan	National plan setting priorities and actions for improving cancer services across Wales, aligning health boards to common standards and trajectories.
Patient-Reported Experience Measures (PREMs)	Validated questionnaires used in healthcare to evaluate quality from the patient's perspective. PREMs focus on the experience of care (how it was received).
Patient-Reported Outcome Measures (PROMs)	Validated questionnaires used in healthcare to evaluate quality from the patient's perspective. PROMs measure the effectiveness of treatment on health status
Population health risks	Modifiable risk factors (e.g. smoking, obesity, alcohol) associated with cancer incidence in local populations.
Real terms spend	Expenditure adjusted for inflation to reflect true purchasing power over time.
Stage at diagnosis	The extent of cancer spread at the time of diagnosis, strongly linked to outcomes and treatment options.
Systemic Anti-Cancer Therapy (SACT)	Drug treatments circulating via the bloodstream (e.g., chemotherapy, targeted and immunotherapies) to treat cancer

Term	Description
Screening	A preventive medical test designed to detect cancer early, often before symptoms appear, improving the chances of successful treatment
Teledermatology	The remote assessment of skin conditions using digital images or video, so a specialist can diagnose or triage patients without seeing them in person
Tumour site	The anatomical location/type of cancer (e.g. lower gastrointestinal, lung, breast, urological, skin).

3 Management response form

To be completed after receipt by Audit Committee

Recommendation	Commentary on planned actions	Completion date	Responsible officer

About us

The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

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Audit Wales is the umbrella term used for both the Auditor General for Wales and the Wales Audit Office. These are separate legal entities with the distinct roles outlined above. Audit Wales itself is not a legal entity.



Audit Wales

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We welcome correspondence and
telephone calls in Welsh and English.

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

Management response form



Audit Wales use only

Audited body	Hywel Dda University Health Board
Audit name	Are cancer services improving?
Issue date	09 July 2026

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	The Health Board should develop a fully costed, organisation-wide strategic cancer improvement plan to support sustainable delivery of the cancer strategy as demand increases. This should be aligned to the National Cancer Strategy which is due to be published in February 2027.	Agreed. Strategic Cancer Improvement Plan to support future year sustainable delivery to be developed, to align with the priorities and principles of the National Cancer Strategy due to be published in February 2027.	July 2027	Chief Operating Officer

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R2	The Health Board should improve how it tracks cancer improvement actions by ensuring each action has a clear owner, timeline, and expected outcomes. This will support better monitoring and strengthen accountability.	Agreed. Cancer pathway transformation is one of the 4 proposed workstreams which will report into the newly established Planned Care Transformation Group which commences in October 2026. Whilst the October meeting will focus on Outpatient and Theatre improvement workstreams, the Cancer Improvement workstream will commence in November 2026 and will track all related improvement actions.	November 2026	Director of Operational Planning & Performance
R3	The Health Board should work with Public Health Wales NHS Trust to agree, as soon as possible, a full set of data on screening services. This should include: Timeliness at each stage of all current cancer screening pathways, and lung screening once fully rolled out.	Agreed. Data set to be agreed with PHW NHS Trust to be reflected within the Strategic Cancer Improvement Plan referenced in R1.	July 2027 (to align with development of the HDUHB Strategic Cancer Improvement Plan).	Director of Public Health

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
	date on screening uptake, with analysis by population groups (including age, location, sex (where relevant), and ethnicity (paragraph 37).			
R4	The Health Board should strengthen reporting of cancer improvement activity by adopting a single, consistent approach to reporting all improvement actions (paragraph 44).	Agreed (as per R2). Cancer pathway transformation is one of the 4 proposed workstreams which will report into the newly established Planned Care Transformation Group which commences in October 2026. Whilst the October meeting will focus on Outpatient and Theatre improvement workstreams, the Cancer Improvement workstream will commence in November 2026 and will track all related improvement actions.	November 2026	Director of Operational Planning & Performance

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R5	The Health Board should improve cancer reporting to the Board and its committees by including average waiting times, tumour-specific performance, and outcomes data. This will support stronger scrutiny and more targeted assurance (paragraph 45).	Agreed. Regular deep-dive reports in respect cancer pathway transformation and performance to be reported to Finance & Performance Committee.	December 2027	Chief Operating Officer
R6	The Health Board should make greater routine use of cancer outcomes data, such as stage at diagnosis, mortality, quality of life and patient experience, to inform decision-making, governance and improvement priorities (paragraph 58).	Agreed (as per R1 & R3). Cancer outcome data to inform and be reflected in the Strategic Cancer Improvement Plan to be published by July 2027.	July 2027	Chief Operating Officer

4 - NWSSP – Audit and Assurance Services - Internal Audit

4.1

10:25 AM, 5 Mins

4.1 - Internal Audit Plan Progress Report

James Johns
(NWSSP - Internal
Audit)

| For assurance

Attachments

[Internal Audit Plan Progress Report ARAC 15 October 2026.pdf](#)

[HDdUHB Internal Audit Progress Report October 2026.pdf](#)



Pwyllgor Archwilio a Sicrwydd Risg/ Audit and Risk Assurance Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	15 October 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit and Assurance Services Progress Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mr James Johns, Head of Internal Audit
SWYDDOG ADRODD: REPORTING OFFICER:	Mr James Johns, 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 and Assurance Services progress report provides the Audit and Risk Assurance Committee (ARAC) with an update in relation to the delivery of the approved Internal Audit Plan for 2026/27, any updates to the plan and outcomes from audit work.

Cefndir / Background

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

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

Asesiad / Assessment

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

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to **TAKE ASSURANCE** with regard to the delivery of the Internal Audit plan and from the outcomes of the finalised audit reports.

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

Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	All Planning Goals Apply
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	10. Not Applicable
Model Cymdeithasol ar gyfer Iechyd a Llesiant : (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing : (complete for strategic change and/or significant service changes)	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Internal Audit Plan, Mandate and Charter Individual Internal Audit reports. Evidence gathered from the Health Board as part of the delivery of audit assignments. Health Board Risk Registers. Board and Committee Papers.
Rhestr Termau: Glossary of Terms:	Contained within the reports.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Director of Corporate Governance Audit & Risk Assurance Committee Chair Executive Directors and Senior Managers relevant to the individual audits.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable

Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Tegwch Iechyd: Health Equity:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

Hywel Dda University Health Board

Audit & Risk Assurance Committee

October 2026

Audit & Assurance Services Internal Audit Progress Report

CONTENTS

1. Introduction
2. Outcomes from Finalised Audits
3. Delivery and Planning Update

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 2026/27 Internal Audit Plan, 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
Pathways of Care Delays	 Reasonable
Workforce Planning	 Reasonable
Staff Experience & Wellbeing	 Reasonable

3. Planning and Delivery Update

- 3.1** The assignment status schedule highlighting progress with the delivery of the 2026/27 plan is shown in Appendix A.
- 3.2.** The table below highlights the other audits originally scheduled for this meeting of the Committee.

Audit	Current Position/ comments
Finance Grip & Control Assessment	The UHB have asked that the audit is paused while the self-assessment is reviewed and updated.
Operational Structure OCP	Progress with the audit has been delayed as key information has not been able to be provided by the UHB as a result of operational pressures.
Radiology Information System Programme	A draft report has now been issued for this audit. At draft stage it is reasonable assurance.

- 3.3** Audit fieldwork, for six of the audits planned for the December meeting of the Committee, is already in progress, with a further seven audits at the planning stage.
- 3.4** Regular meetings with the Director of Corporate Governance have continued, along with meetings taking place with Executive Directors and senior managers in relation to audits currently being planned and delivered. The UHB Board meetings have been observed and liaison with Audit Wales has continued.

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

Audit Output	Executive Lead	Planned start	Planned ARAC	Progress Status	Assurance
Regional Joint Committee	Chief Executive	Q3/4	April		
Operational Governance Arrangements	COO	Q3	Feb		
Financial Management: Grip & Control	Finance	Q2	Oct	WIP/Paused	
Cost Management & Savings Schemes	Finance	Q2/3	Dec	Planning	
Organisational Change Process Operational Structure (Advisory)	COO	Q2	Oct	WIP/Delayed	
Pathways of Care Delays	COO	Q1/2	Oct	FINAL	Reasonable
Health & Safety	AHPHS	Q3	Dec	WIP	
Workforce Planning	WOD	Q2/3	Oct	FINAL	Reasonable
Staff Experience & Wellbeing	WOD	Q2	Oct	FINAL	Reasonable
Radiology Informatics System Programme	Finance	Q2	Oct	DRAFT	Reasonable
Patient Demographic Information	Finance	Q2/3	Dec	WIP	
Capital Equipping	Strategy & Planning	Q1/2	Aug	Final	Limited
Complaints	NQPE	Q3	Feb	Planning	
Quality Management System	NQPE	Q2	Dec	planning	
Rostering	WOD	Q2	Dec	WIP	
Primary Care Prescribing	COO	Q2	Dec	WIP	
Cleanliness Standards	AHPHS	Q3/4	April	Planning	
Validation of Emergency Department Performance & Waiting Time Data	COO	Q4	April	planning	
Business continuity - Emergency Escalation	COO	Q4	April	planning	

Audit & Risk Assurance Committee Progress Report

Management of Service Change	COO	Q3	Feb		
Theatre Stock System Implementation	COO	Q4	April		
Primary Care Community by Design	COO	Q4	April		
Vaccination & Immunisation	Public Health	Q4	April		
Follow Up and Agreed Action Implementation Tracking	Corporate Governance	Q2-4	Feb		
Digital Partner Contract	Finance	Q2/3	Dec	WIP	
Artificial Intelligence & Robotic Process Automation	Finance	Q3	Feb	Planning	
Heath Records Management	Finance	Q3	Feb		
Estates Assurance – Control of Contractors	Strategy & Planning	Q2/3	Feb		
Capital Systems - Targeted Estates Funding	Strategy & Planning	Q3/4	Feb		
Integrated Audit & Assurance Plans – Aseptic Scheme	Strategy & Planning	Q1/2	Dec	WIP	



Office details: Audit & Assurance Services West Team

Contact details: james.johns@wales.nhs.uk

Webpage: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

4.2 - Pathways of Care Delays (Reasonable Assurance)

*James Johns
(NWSSP - Internal
Audit), Sophie
Corbett (NWSSP -
Audit & Assurance
Services), Andrew
Carruthers (Hywel
Dda UHB - Chief
Operating Officer),
Anna Chiffi (Hywel
Dda UHB - Assistant
Director of Nursing,
Patient Safety,
Quality)*

| For assurance

Attachments

[HDU-2627-17 Pathway of Care Delays Final IA Report.pdf](#)

Pathways of Care Delays

Final Internal Audit Report

2026/27

Hywel Dda University Health Board



Reasonable Assurance

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Findings & Agreed Action Plan	3
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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

HDU-2627-17

July - August 2026

24 September 2026

October 2026

Andrew Carruthers, Chief Operating Officer

James Johns, Head of Internal Audit

Sophie Corbett, Deputy Head of Internal Audit



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



Executive Summary

Purpose

To review systems in place for the management of patient discharges including a focus on arrangements implemented after the previous audit reviews.

Overview

The implementation of the Miya patient flow system has streamlined the recording of discharge data and interaction with established platforms such as Welsh Nursing Care Records (WNCR) system and Welsh Patient Administration System (WPAS). The rollout of the Miya system included clear engagement with staff through ward walkarounds and training, whilst a support model was established for staff post rollout.

Internal controls have been embedded with the validation of patient records to ensure all pathways of care delays (POCD) are accurately captured on Miya as part of the census information submitted to Welsh Government. A monthly Regional POCD Validation meeting is also in place to collate and verify the information in conjunction with local authority representatives. Governance arrangements are established with a dedicated West Wales Optimal Flow and Discharge Delivery Group feeding into the Six Goals Programme Workstream Integrated Operational Group. POCD data is regularly reported to the Finance and Performance Committee and Health Board. The Quality Improvement and Service Transformation (QIST) Team continue to provide ongoing support to wards and services.

These internal controls and actions implemented have potentially contributed to the reduction in the number of POCD discharges from 250+ (July 2023) to approximately 200 (July 2026) and total days delayed for POCD discharges from 10k+ (July 2024) to 6k (July 2026).

Three medium priority findings were identified during this review in regards of links to national documents not working in the *Hospital Discharge Guidelines* document, non-attendance of key personnel outlined in national guidance at board round meetings and instances of incomplete patient information on the Miya system.

We have concluded **Reasonable** assurance on this area. Whilst noting the positive implementation of actions and improvements in systems and internal controls since the previous internal audit review, discharge delays remain an ongoing risk for the Health Board with sustained longer-term improvements and actions needed with external stakeholders to address these challenges.

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

Scope & Assurance Summary

Objectives ¹		Related Findings	Assurance
1	Policies and procedures are in place for discharge management that reflect the requirements of the Welsh Government's <i>Hospital Discharge Guidance</i> and the <i>Discharge to Recover and Assess (D2RA) Pathways Guidance</i>	1	Reasonable
2	Processes and resources support the timely discharge of patients including allocation to a specified D2RA pathway discharge stream and identification of an Expected Discharge Date (EDD) at the point of admission	2 & 3	Reasonable
3	Pathways of care delays are reviewed and analysed to understand the circumstances and actions taken to address areas of poor performance and low/non-compliance	-	Substantial
4	Governance arrangements are established to provide oversight and monitoring of discharge management	-	Substantial

¹ The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Management Actions

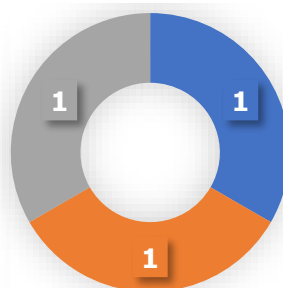


High Priority



Medium Priority

Themes



- Information, Data Quality & Data Accuracy
- Policies & Procedures
- Quality, Safety & Patient Experience

Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Delayed Patients Census - At a Glance

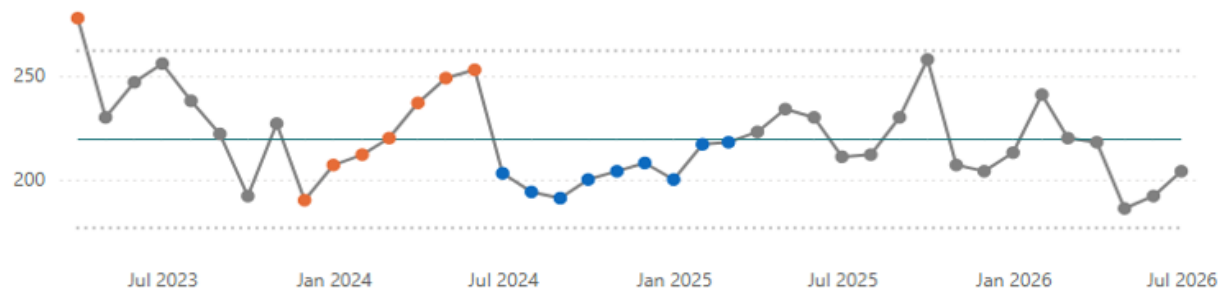
Patient count for delays at census date: 15th July 2026

A patient is defined as a delayed discharge, 48 hours after they have been declared clinically fit to progress to their next stage. This data tracks delayed discharges over time to assess improvement. The SPC chart for the census count of the number of patients delayed is showing usual variation, and that the census count has increased in July. The total days delayed (cumulative) is showing improving variation with a significant reduction in May and July. Whilst the number of delayed patients is still high, the time they are delayed has reduced. However, there is still a system wide issue with discharge delays.

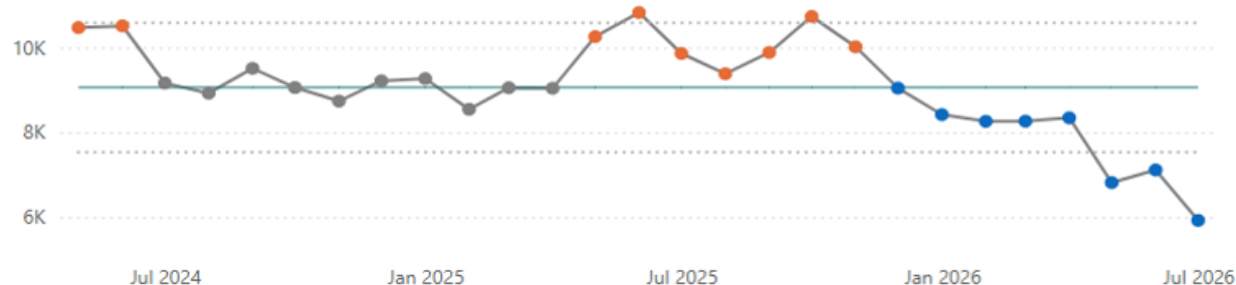
Number of Pathways of Care delayed discharges

Key

- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition



Total days delayed for Pathways of Care delayed discharges



NOTE: This slide provides a snapshot of patients delayed from discharge in one of our hospitals, regardless of their area of residence i.e. **includes** patients living outside of the Hywel Dda area (Carmarthenshire, Ceredigion and Pembrokeshire).

Findings & Agreed Action Plan

Objective 1: Policies and procedures are in place for discharge management that reflect the requirements of the Welsh Government’s <i>Hospital Discharge Guidance</i> and the <i>Discharge to Recover and Assess (D2RA) Pathways Guidance</i>	Reasonable
--	-------------------

Overview / Summary of Observations

The Health Board has an approved *Hospital Discharge Guidelines* document that was published in April 2024 with the aim of supporting staff with ensuring patient discharges are safe, timely and appropriate. The *Hospital Discharge Guidelines* document is an adoption of the Welsh Government (WG) guidelines document that was issued in September 2024 with a subsequent updated version published in January 2025. The WG guidance document is available on the organisation’s dedicated discharge SharePoint site.

The *Hospital Discharge Guidelines* document outlines its aims and objectives, roles and responsibilities, summary of key discharge related information including D2RA pathways guidance and listed supporting documentation. The *Hospital Discharge Guidelines* document also contains a link to the September 2024 WG guidelines document rather than the updated version. However, this link does not work. **[Finding 1]**

Key Findings		Risk & Impact	Agreed Management Action
1	Hospital Discharge Guidelines Document	Staff do not adhere to current guidance impacting on the quality and safety of patient care.	Agreed Action: Review and update the <i>Hospital Discharge Guidance</i> document
	The <i>Hospital Discharge Guidelines</i> document contains a link to the WG guidelines that does not work and is referring to the older version of the guidelines.		Expected Evidence of Implementation: Updated <i>Hospital Discharge Guidance</i> document
		Medium Priority	Officer: Anna Chiffi (Assistant Director of Nursing, Patient Safety & Quality)
Theme: Policies & Procedures		Control Design	Target Implementation Date: 31 January 2027

Objective 2: Processes and resources support the timely discharge of patients including allocation to a specified D2RA pathway discharge stream and identification of an Expected Discharge Date (EDD) at the point of admission	Reasonable
---	-------------------

Overview / Summary of Observations

In 2025, the Health Board replaced the Frontier system with the Miya patient flow system. The introduction of Miya included interactive screens replacing whiteboards in wards that allowed staff to record and view patients’ ‘live’ data with the WNCR and WPAS systems feeding into the Miya system.

The rollout of the Miya system was undertaken by the Digital Project Team with support from the Clinical Informatics Nurse Team who facilitated the training of ward and department staff, whilst day-to-day support continues to be provided by the QIST Team. Clear plans to ensure the

successful implementation of the Miya system were evident in the approach taken by the Digital Project Team including engagement with all staff, creation of digital inclusion support plans, dedicated demonstration days and a support model following the rollout. Discussion with a sample of ward managers at Withybush, Glangwili and Prince Philip Hospitals confirmed that they had received training from the Clinical Informatics Nurse Team during the rollout of the Miya system

A sample of 15 wards at three acute hospital sites confirmed that all interactive screens displayed key elements of the discharge process whilst daily board rounds are undertaken. However, not all key personnel listed in national guidance attend the daily board rounds, including social workers, pharmacists and community representatives. **[Finding 2]**

An output report from the Miya system for the 27 July 2026 was tested to ensure the completeness and accuracy of key information was recorded for listed patients across all acute wards. Whilst testing identified evidence that key data elements listed in national guidance were captured in the Miya system, we noted incompleteness with some elements including reasons for POCD, D2RA pathway, EDD, SORT and Red2Green principles. Discussions with ward managers and the QIST Team noted the root cause for incomplete data was due to either (i) patients' records not updated in real time due to workforce demands on the ward, and/ or (ii) training weaknesses of individuals. Whilst compensatory controls have been implemented to address these issues, including the ongoing support to wards and departments by the QIST Team including additional Miya training and regional POCD validation meetings (see Objective 3 for detailed review) ensures a retrospective check and updating of POCD reasons for patients in the Miya system as part of the census review, challenges around the completeness of data remain. **[Finding 3]**

Key Findings		Risk & Impact	Agreed Management Action
2	Board Round Non-Attendance Of the 15 sampled wards tested, instances of non-attendance at board round meetings by key personnel (as outline in the national guidance) were identified, including Discharge Liaison Nurses, flow coordinators, social workers, pharmacists and community representatives.	Patients' quality and safety of care is impacted due to non-attendance of key personnel at board rounds resulting in increased number of delayed discharges.	Agreed Action: A review of multidisciplinary board round attendance arrangements will be undertaken to identify barriers to attendance and opportunities to strengthen representation from key professional groups, including Discharge Liaison Nurses, Flow Coordinators, Social Workers, Pharmacists and Community Representatives. Expectations regarding attendance will be reinforced through existing governance structures, interprofessional operational standards, and consideration will be given to alternative arrangements where physical attendance is not always possible. Expected Evidence of Implementation: - Review of current board round attendance arrangements completed. - Agreed expectations and attendance requirements communicated to relevant teams. - Board round attendance monitoring mechanism established.
		Medium Priority	Officer: Marilize Preez (Improvement & Transformation Lead)

	Theme: Quality, Safety & Patient Experience	Control Operation	Target Implementation Date: 31 December 2026
3	Completeness of Patient Information Testing identified evidence that key data elements listed in national guidance were captured in the Miya system, we noted incompleteness with some elements including reasons for POCD, D2RA pathway, EDD, SORT and Red2Green principles. Discussions with ward managers and the QIST Team noted the root cause for incomplete data was due to either (i) patients' records are not updated in real time due to workforce demands on the ward, and/ or (ii) training weaknesses of individuals.	The quality and safety of patients is impacted due to incomplete patient records resulting in delayed discharges	Agreed Action: The QIST Team will continue to work with wards and clinical teams to strengthen data quality and compliance with national guidance. This will include targeted training and support, regular review of data quality reports, feedback to ward teams, and reinforcement of expectations regarding the real-time updating of patient records. Opportunities to simplify processes and improve system utilisation will also be explored through existing patient flow governance arrangements.
		Medium Priority	Expected Evidence of Implementation: • Refreshed guidance and training materials issued to ward teams. • Delivery of targeted MIYA training sessions and support. • Regular data quality audits/reports monitoring completion of key data fields, including PoCD reason, D2RA pathway, EDD, SORT and Red2Green.
	Theme: Information, Data Quality & Data Accuracy	Control Operation	Officer: Marilize Preez (Improvement & Transformation Lead) Target Implementation Date: 31 December 2026

Objective 3: Pathways of care delays are reviewed and analysed to understand the circumstances and actions taken to address areas of poor performance and low/non-compliance

Substantial

Overview / Summary of Observations

The Health Board have established a POCD validation process to ensure the accuracy and reliability of patient information prior to formal monthly submission of census data to Welsh Government. The validation process has been captured in a standard operating procedure document.

Walkthrough testing of the validation process confirmed (i) circulation of clinically optimised patient lists issued to county representatives, (ii) engagement of counties with local authority representatives, Long Term Care and Allied Health Professional colleagues to corroborate and accurately code discharge delays, (iii) attendance of county representatives at the Regional Validation Meeting following validation of their data, and (iv) submission of validated county cohort master lists to the Regional Validation Chair for submission to the Welsh Government.

To support the delivery of discharge improvement initiatives and POCD reduction, SharePoint sites have been created for the Optimal Hospital & Patient Flow Framework (Policy Goal 5) and Miya system that contains reference to policies, procedures and other supporting documentation that is available to Health Board employees.

The QIST Team present monthly data validation and performance reports to county leads that provides a breakdown of performance positions for D2RA pathway allocations, discharge and deconditioning related data. In addition, the QIST Team also deliver training sessions, facilitate improvement methodologies for targeted areas, and provide on-site implementation support throughout the year to ward and departments.

A weekly report is submitted to the Executive Team that provides a summary of the delayed patient census performance position. A breakdown of reasons for delays by county of residence in the 11 August 2026 weekly report highlighted that many of the delays are due to external parties – see position below. Engagement with local authorities and Regional Partnership Board to identify sustained longer-term improvements to address external-related POCD is currently ongoing.

DELAY REASON	TOTAL PATIENT COUNT	TOTAL DAYS DELAYED
External parties’ delays	145 (71%)	4606 (78%)
Health Board delays	33 (16%)	934 (16%)
Joint delays (Health Board and external parties)	26 (13%)	379 (6%)
TOTAL	204	5919

The rollout of the Miya system combined with the support of the QIST Team and POCD validation process appears to have contributed towards an improved POCD performance position with a reduction in the number of:

- 1. POCD discharges from 250+ (in July 2023) to approximately 200 (in July 2026)
- 2. total days delayed for POCD discharges from 10K+ (in July 2024) to approximately 6k (in July 2026) with significant downward trend evident over the past 12 months

The above performance positions were taken from the weekly report submitted to the Executive Team on 11 August 2026 with graphical representation reflected on page 2 of this report.

Objective 4: Governance arrangements are established to provide oversight and monitoring of discharge management

Substantial

Overview / Summary of Observations

A West Wales Optimal Flow and Discharge Delivery Group was formed as part of the Six Goals Urgent Emergency Care Programme (Safe Hospital Care Workstream) responsible for providing strategic oversight, supporting collaborative system improvement across health, social care and partners, with Pathways of Care Delays (POCD) a key element of the group's scope. A draft terms of reference was listed as an item on the group's July 2026 agenda for ratification.

During 2025-26, updates from the West Wales Optimal Flow and Discharge Delivery Group would be included in the highlight reports submitted to the Six Goals Programme Workstream Integrated Operational Group. In addition, a Regional POCD Action Plan 2026-27 was submitted that provided updates on identified actions to address POCD within the organisation.

Oversight of POCD discharge performance positions and supporting narrative were included in integrated performance assurance reports submitted to the Finance and Performance Committee (FPC) and Health Board in 2026, whilst focused papers such as the Performance Deep Dive Alerts and Hospital Flow Process reports were submitted to the FPC in June and April 2026 respectively. Key actions identified in the minutes of the FPC meetings included engagement with local authorities and Regional Partnership Board to identify sustained longer-term improvements to address external-related POCD.

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

Disclaimer

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

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

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.

Global Internal Audit Standards

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



4.3 - Workforce Planning (Reasonable Assurance)

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Gostling (Hywel Dda
UHB - Director of
Workforce &
OD/Deputy CEO),
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(Hywel Dda UHB -
Assistant Director of
People Planning)*

| For assurance

Attachments

[HDU-2627-08 Workforce Planning Final IA Report.pdf](#)

Workforce Planning

Final Internal Audit Report

2026/27

Hywel Dda University Health Board



Reasonable Assurance

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Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

HDU-2627-08

September 2026

5 October 2026

October 2026

Lisa Gostling, Director of Workforce & Organisational Development

James Johns, Head of Internal Audit

Sophie Corbett, Deputy Head of Internal Audit

Executive Summary

Purpose

To review the effectiveness of the development, implementation and monitoring of the Health Board’s workforce plan.

Overview

The Health Board has a structured and consistent approach to workforce planning through the use of a standardised workforce plans aligned to the Workforce Regeneration Framework. Governance and monitoring arrangements are in place that are supported by the Workforce Planning Team. Plans are regularly reviewed with effectiveness of initiatives monitored against workforce intelligence and performance information. A walkthrough of the in-year workforce adjustments process confirmed changes are supported with justifying evidence. We have identified three matters requiring management attention include:

- Instances of services not having a current workforce plan in place *[High Priority]*
- Instances of incompleteness of key information within service workforce action plans *[Medium Priority]*
- Unable to evidence a clear repository or formal cross-service mechanism for capturing and sharing lessons learned *[Medium Priority]*

This review has considered the workforce planning arrangements of the whole organisation from corporate level, in the development of an overarching Health Board workforce plan, to individual service and department plans. We have therefore concluded **reasonable** assurance on this area. Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives ¹		Related Findings	Assurance
1	Workforce plans (short, medium and long-term) have been developed in line with the principles and requirements of national guidance and local priorities.	1 & 2	Reasonable
2	Monitoring arrangements are in place to assess the impact and effectiveness of workforce plans across departments and services	3	Reasonable
3	In-year workforce adjustments for departments or services are justified and supported by evidential data	-	Substantial

Management Actions

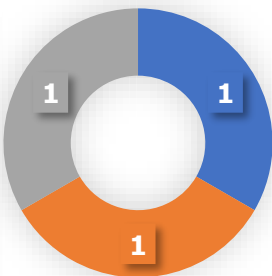


High Priority



Medium Priority

Themes



- Information, Data Quality & Data Accuracy
- Lessons Learnt
- Planning, Delivery & Deadline Management

Risk Types

Quality or Safety Issues
Financial Loss

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: Workforce plans (short, medium and long-term) have been developed in line with the principles and requirements of national guidance and local priorities

Reasonable

Overview / Summary of Observations

The Health Board has embedded workforce planning arrangements across the organisation to aid services and departments to develop their own plans. This has been achieved through the development of a workforce plan template that all services and departments are required to complete. The template plan ensures a consistent approach to every plan and includes dedicated sections that align to the Workforce Regeneration Framework.

The Health Board has established an iterative approach in the development and updating of workforce plans is with services and departments responsible for undertaking this process, whilst the Workforce Planning Team provide support, oversight and challenge where required. Key stakeholders including Finance and Informatics also provide supporting information to aid in the development of plans.

A review of the Workforce Planning Team central tracker indicated that approximately 25% of services did not have a workforce plan for 2026-27 in place. Whilst noting that many of the services without a plan were low-risk areas, we did identify high-risk areas such as Theatres, Anaesthetics, Long Term Care and Primary Care Nursing. A sample of these services confirmed that a current workforce plan had not been developed due to national/ regional workforce transformation programmes or organisational changes impacting their ability to produce a local plan. Whilst acknowledging these events, the lack of a workforce plans impacts on the delivery of services and their inability to address issues such as vacancy gaps, sickness rates and variable pay. This is evident in the Finance Deep Dive Medical Variable Pay report submitted to the Finance and Performance Committee in August 2026 where Anaesthetics had spent approximately £712k on variable pay, as at Month 3, due to reliance on additional sessions to deliver planned care activity. **[Finding 1]**

A review of four services (Cardiology, Neurology, Ophthalmology and Speech & Language Therapy) where completed workforce plans were in place, confirmed the inclusion of the following key elements:

- service change drivers, benefits, constraints and future service models had been recorded
- new service activities had been outlined with the identification of the skills needed, types and numbers of staff required explicitly stated
- supporting performance information such as workforce demographics, sickness rates, turnover, and retirement projections/ risks have been documented

Action plans had also been developed by the sampled four services to identify the steps and activities needed to implement the schemes and projects outlined in the workforce plans. Whilst action plans have also been produced for the four sampled services, testing identified instances of incompleteness including lack of action owners, review and completion dates. **[Finding 2]**

A review of the organisational workforce plan confirmed the inclusion of key risks themes and issues that are identified in the services workforce plans, whilst outlined schemes and projects were noted that contribute to the organisation’s short, medium and long-term planning arrangements including alignment to Clinical Service Plans.

Key Findings		Risk & Impact	Agreed Management Action
1	Service Workforce Plans A sample of these services confirmed that a current workforce plan had not been developed due to national/ regional workforce transformation programmes or organisational changes impacting their ability to produce a local plan. Whilst acknowledging these events, the lack of a workforce plans impacts on the delivery of services and their inability to address key performance areas such as vacancy gaps, sickness rates and variable pay. No evidence in the escalation of this risk to respective executive directors or Clinical Care Group leads was evident.	No actions are implemented to address known workforce issues resulting in continued financial and workforce risks	Agreed Action: Management accepts the finding. The central tracker will be risk-rated and services without a current plan will be required to complete a workforce plan or an agreed interim plan. High-risk gaps will be escalated to the relevant Clinical Care Group lead and Executive Director, with progress reported through SPPEG. To add, based on our experience with MHLD CCG – it may be helpful to share the approach as “good practice” with wider CCG leaders for adoption.
		High Priority	Expected Evidence of Implementation: Risk-rated tracker; completed or interim plans; escalation records; and SPPEG progress reports.
	Theme: Planning, Delivery & Deadline Management	Control Operation	Officer: Dan Owen (Workforce Planning Lead) Target Implementation Date: 31 March 2027
2	Completeness of Action Plans Testing of the four sampled services workforce action plans identified instances of incompleteness including lack of action owners, review and completion dates.	Workforce risks and opportunities identified in short, medium and long terms plans are not delivered due to incomplete actions plans.	Agreed Action: Management accepts the finding. The workforce planning template and guidance will be revised to require a named owner, delivery date, review date, outcome measure and status for every action. To add, based on our experience with MHLD CCG – it may be helpful to share the approach as “good practice” with wider CCG leaders for adoption.
		Medium Priority	Expected Evidence of Implementation: Risk-rated tracker; completed or interim plans; escalation records; and SPPEG progress reports.
	Theme: Information, Data Quality & Data Accuracy	Control Operation	Officer: Dan Owen (Workforce Planning Lead) Target Implementation Date: 31 March 2027

Overview / Summary of Observations

Monitoring arrangements to assess the implementation, impact and effectiveness of workforce plans across departments and services have been established with the Workforce Planning Team implementing a risk-based approach in the prioritisation of resources to target higher-risk services and departments.

The Workforce Planning Team maintains a central tracker to monitor workforce planning activity with evidence of engagement with services to support the development of plans. However, as noted in Objective 1, some services and departments do not have a workforce plan in place. We were unable to evidence whether the risk of services and departments not having a current workforce plan in place had been escalated to respective executive directors or Clinical Care Group leads. **[Finding 1]**

Progress against operational workforce action plans are monitored through workforce intelligence reports and minimum dataset information that provide updates on key workforce performance indicators, including vacancies, turnover, sickness absence, retention, recruitment outcomes, and workforce-related risks. Supply and pipeline information, including education and apprenticeship programmes, and 'grow your own' schemes, are also monitored through dedicated workforce planning trackers. Where ineffective elements of the workforce plan have been identified, in-year changes are developed and proposed for consideration – see detailed testing of this process below in Objective 3.

The Workforce Planning Team were able to provide examples of lessons learned for schemes and initiatives identified and implemented by services from previous years and evidence of review groups focusing on CSPs. We were unable to evidence a clear repository or formal cross-service mechanism for capturing and sharing lessons learned that could aid in addressing recurring planning weaknesses or missed opportunities for improvement. **[Finding 3]**

Formal governance arrangements are established with updates on the progress of service workforce plans reported through to the Strategic People Planning and Education Group (SPPEG) via Workforce Intelligence Groups, with assurance from SSPEG provided to the Health Board via the People, Organisational Development and Culture Committee (PODCC) including an annual report that was submitted at the August 2026 meeting.

A review of the governance arrangements confirmed management were provided with oversight of workforce sustainability, risks, pipeline capacity and the delivery of workforce planning interventions enabling plans to be reviewed and refined in response to emerging pressures and organisational priorities. However, a review of minutes and papers of the identified groups above highlighted the operational risks that the Health Board continues to face including persistent vacancies gaps covered through variable spend, organisational changes and the need to balance strategic planning with immediate service pressures.

Key Findings		Risk & Impact	Agreed Management Action
3	Lessons Learned We were unable to evidence a clear repository or formal cross-service mechanism for capturing and sharing lessons learned	Lessons learned are not captured resulting weakness	Agreed Action: Management accepts the finding. A standard lessons-learned template and central repository will be established for significant workforce initiatives. Learning will be reviewed periodically

	that could aid in addressing recurring planning weaknesses or missed opportunities for improvement.	or risks not being addressed.	through Planning Co-ordination Group & SPPEG and used to inform future planning guidance and service support.
			Expected Evidence of Implementation: Approved template; accessible repository; completed learning records; and governance minutes demonstrating review and reuse of learning. Evidence of how learning had been used to improve workforce planning practice and/or workforce redesign etc
		Medium Priority	Officer: Dan Owen (Workforce Planning Lead)
Theme: Lessons Learnt		Control Operation	Target Implementation Date: 31 March 2027

Objective 3: In-year workforce adjustments for departments or services are justified and supported by evidential data

Substantial

Overview / Summary of Observations

All workforce adjustments and changes are managed through an established governance and approval processes. A walkthrough test of this process was undertaken for Endoscopy Services with workforce adjustments driven by the following service demand, workforce risks, recruitment challenges and capacity pressures:

1. difficulties in recruiting to Consultant Gastroenterologist posts
2. high vacancies rates in nursing and medical roles resulting in a reliance on temporary staffing
3. nursing workforce is a limiting factor in expanding service capacity due to a lack of investment
4. surgeons' availability for endoscopy sessions is constrained by other clinical commitments
5. significant proportion of staff posing a retirement risk (within 5-10 years) with no succession planning developed

A demand and capacity review for Endoscopy Services identified an anticipated capacity gap of waiting lists. To bridge this gap, an opportunity was identified to train individuals into the role of a Clinical Endoscopist. The aim of the initiative formed part of the broader workforce strategy designed to improve service resilience, address current workforce gaps and support the long-term sustainability of the service. This initiative aligns with the 'Redevelop and Reskill (Build)' element of the Workforce Regeneration Framework.

To facilitate the development of the Clinical Endoscopist training programme, an Annex 21 assessment form was used to justify and gain approval for recruiting trainee Clinical Endoscopists under the NHS Wales Annex 21 provisions.

A recovery plan was also produced that outlined the interim initiatives that would be implemented whilst the first individual was being trained in the role of Clinical Endoscopist. The recovery plan detailed the initiatives, cost timeline and the expected output. Additional supporting evidence relating to workforce profiles, risk register and retirement projections was also evident.

The proposal for the recruitment of trainee Clinical Endoscopists was submitted to the Clinical Education and Governance Group, approved at the Financial Control Subgroup and Annex 21 Panel. To date, one individual has been successfully recruited into the role of Clinical Endoscopist whilst another individual is current undergoing training.

We noted other schemes and initiatives included within service workforce plans such as nursing apprentice programme (Endoscopy Services), recruitment of Health Care Science Associate Practitioner in Respiratory and Sleep speciality via Annex 21 training (Cardiology) and development pathways for Clinical Fellows and middle-grade doctors (Pathology).

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.
	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.
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4.4 - Staff Experience and Wellbeing (Reasonable Assurance)

*James Johns
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| For assurance

Attachments

[HDU-2627-09 Staff Experience and Wellbeing Final IA Report.pdf](#)

Staff Experience & Wellbeing

Final Internal Audit Report

2026/27

Hywel Dda University Health Board



Reasonable Assurance

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

HDU-2627-09

July – September 2026

October 2026

October 2026

Lisa Gostling, Director of Workforce & OD

James Johns, Head of Internal Audit

Sophie Corbett, Deputy Head of Internal Audit



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
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Partnership
Audit and Assurance Services



Executive Summary

Purpose

To provide assurance over the arrangements established within the Health Board for ensuring staff wellbeing and improving staff experience.

In March 2026, the Health Board recorded a new corporate risk (2305), "*Risk to staff wellness due to the pace and breadth of organisational change,*" replacing the previous risk (1821) relating to staff welfare under current demands. The risk is currently scored at 20 (red), reflecting the significant pressure on the workforce to manage financial constraints while maintaining patient safety, further exacerbated by uncertainty and challenges associated with major organisational change programmes.

The review assessed whether appropriate governance, support mechanisms, and monitoring processes are in place support staff experience and wellbeing.

Overview

The Health Board demonstrates a clear commitment to improving staff experience and wellbeing embedded in strategy, organisational objectives and internal escalation arrangements. A range of wellbeing services, leadership development programmes, workforce initiatives and feedback mechanisms are in place, and there is regular oversight through Board and Committee structures. Staff feedback is utilised to inform targeted support, and a new dashboard is being developed to enhance workforce intelligence.

However, there is little evidence to demonstrate action taken at operational/service level to address staff experience and wellbeing issues arising from the NHS Staff Survey. Each area has been asked to develop an action plan to address the top three themes arising from the survey however, at the time of reporting only five action plans had been received by the Culture & Workforce Experience Team. **[Finding 1]**

Furthermore, instances were identified where People Culture Plans had not been developed following targeted support and engagement between services and the respective OD Relationship Managers. **[Finding 2]**

We have concluded **Reasonable** assurance with one high and one medium priority findings. Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
1	Staff experience and wellbeing are embedded within organisational strategy, with appropriate mechanisms in place to promote and support wellbeing.	-	Substantial
2	Workforce data and staff feedback are effectively utilised to inform decision-making and support continuous improvement	1, 2	Reasonable
3	Governance and oversight arrangements provide effective assurance over staff experience and wellbeing	-	Substantial

Management Actions



High Priority



Medium Priority

Themes



■ Planning, Delivery
& Deadline
Management

Risk Types

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: Staff experience and wellbeing are embedded within organisational strategy, with appropriate mechanisms in place to promote and support wellbeing	Substantial
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The Health Board has established a comprehensive and well-developed strategic framework for staff experience and wellbeing, with clear alignment between its strategic objectives, wellbeing objectives, workforce strategy and culture change programmes. Staff experience and wellbeing are embedded within the Health Board's overarching strategy *Healthier Lives, Well Lived*, where 'Thriving Teams' is a core strategic objective supported by two planning goals aligned to Executive Leads and Board Committees (figure 1).

This is reinforced through the Board Assurance Framework; the Workforce, Organisational Development and Education Strategy; People Culture Framework; Strategic Equality Plan (SEP); Values and Behaviours Framework; and workforce retention programmes, all of which place staff wellbeing, engagement, inclusion, compassionate leadership and positive workplace culture at the centre of organisational development.

Strategic Objective	Planning Goals and what they aim to achieve	Executive Leads	Committee alignment
Thriving Teams	PG1: Healthy Thriving Teams - <i>To achieve a sustainable workforce across hospital and community settings, while shaping a positive organisational culture and celebrating success to promote innovation</i>	Workforce and OD	People, Organisational Development and Culture (PODCC)
	PG2: Customer Service Excellence - <i>To promote a culture where staff feel safe to speak up, while advancing equality, diversity and inclusion, and providing excellent bilingual services</i>	Nursing, Quality and Patient Experience	Quality, Safety and Experience (QSEC)

Figure 1

Policies and procedures are available to staff to provide support for mental, physical, emotional and financial wellbeing and they are up to date, accessible and aligned with national standards. Hywel Dda demonstrates a strong organisational commitment to staff wellbeing with comprehensive services on offer for example Staff Psychological Wellbeing Support, Occupational Health services, SilverCloud online cognitive behavioural therapy resources, wellbeing webinars, stress risk assessments and manager support resources.

The Health Board is collaborating with Swansea Bay UHB to develop a regional Health & Wellbeing model that improves staff health outcomes, reduces absence and turnover, and delivers consistent high-quality support across both health boards, while maximising efficiency and value for money. The programme is in infancy stages – short- and medium-term objectives for 2026/27, associated risks and success criteria have been identified. Key programme milestones were being developed at the time of our review.

Compassionate leadership is recognised as a key factor in improving staff experience, engagement and organisational culture and the Health Board has a range of leadership development programmes, coaching, mentoring and wellbeing resources available. The Leadership Engagement with Awesome People Programme (LEAP) participants undertake pre- and post-programme assessments, and programme evaluations are reported through governance arrangements with positive improvements in participants' self-reported leadership confidence, self-awareness, collaborative working and leadership capability reported.

NHS Staff Survey

The NHS Staff Survey collects feedback from employees working in NHS Wales to understand their experiences, perspectives, and insights related to their work environment, job satisfaction and overall wellbeing. The completion rate shows a year-on-year improvement at Hywel Dda and was 21.9% for 2025 this however remains below the Wales average of 30%. The report presents a mixed picture with staff highly committed to patients, supportive of each other, and generally positive about their immediate teams and managers. However, there are growing concerns about engagement, involvement in decision-making, workload pressures, burnout and staffing levels. This has been reflected in the corporate risk register.

The Health Board is moving from simply monitoring staff survey participation and engagement metrics towards actively monitoring local accountability. Staff engagement and NHS Wales Staff Survey participation rates are now key workforce metrics for the internal escalation process with effect from April 2026. Survey outcome reports have been shared with CCGs/functions who are required to identify three priority themes and develop action plans by 11 September 2026 to address areas for improvement. At the time of reporting, only five action plans had been submitted to Workforce. **[Finding 1]**

Other Feedback Mechanisms

The Health Board employs a range of mechanisms to measure staff experience and capture ongoing feedback including pulse, new starter and culture surveys; Speak Up Make Meaningful Change; and exit interviews. Outputs are captured and triangulated in the Staff Experience dashboard which is used by the Culture & Workforce Experience Team to identify areas requiring targeted support by the Organisational Development Relationship Managers (ODRMs) through the Health Board's Culture Change Programme (see below). Outputs from the new starter surveys and exit interviews also feed into the Health Board's Retention Groups, which focus on reducing staff turnover.

Culture Change Programme

The Health Board recognised, through staff surveys and feedback, that improvements were needed in staff experience, leadership behaviours, engagement, wellbeing, retention and organisational culture. Rather than imposing cultural change centrally, ODRMs were introduced to work alongside operational teams and help embed cultural change through the development of local 'People Culture Plans' to address localised issues identified through the mechanisms outlined above. We reviewed a sample of areas where ODRMs have or are engaging with services and noted instances where People Culture Plans have not been developed. **[Finding 2]**

Workforce Metrics

The Workforce Performance dashboard collates key workforce metrics including sickness rates and trends and underlying causes of absence, PADR compliance, vacancies and turnover. It is available to all staff via the intranet. Additional workforce intelligence is available to the Culture & Workforce Experience Team via the Staff Voice dashboard, which brings together outputs from culture surveys, Speaking Up Safely, new starter surveys, exit interviews and pulse surveys. This intelligence is used to inform targeted interventions by ODRMs.

The Building a Positive Workforce Culture paper to Board (July 2026) demonstrates an emerging approach to workforce intelligence triangulation, bringing together staff survey, sickness absence, turnover, vacancy, agency utilisation and patient experience data. However, the analysis remains relatively high level and does not incorporate key workforce culture indicators such as employee relations cases, speaking up concerns or broader trend analysis. There is opportunity to strengthen triangulation of workforce intelligence through the inclusion of wider workforce employee relations metrics. This is also recognised in the 2025/26 People, Organisational Development & Culture Committee (PODCC) self-assessment, which identified an opportunity to further triangulate workforce, wellbeing and equality data to provide clearer evidence of organisational impact and risk, alongside improvements in the use of workforce intelligence to support assurance and decision-making. We understand that development of a Workforce Intelligence Dashboard is being explored by the Workforce Intelligence Group.

Key Findings		Risk & Impact	Agreed Management Action
1	NHS Staff Survey – Action Plans The Executive Director of Workforce & OD wrote to all Executive Directors on 25 July 2026 to reaffirm that the internal WOD escalation measures in 2026-27 include Staff Survey measures as part of the staff experience domain. Each area has been asked to develop an action plan for their top three themes, as identified within the survey reports shared in June 2026, and share this with the Culture and Workforce Experience Team by 11 September 2026. Progress against priorities will then form part of the review within the escalation process with effect from October 2026. At the time of reporting, only five (of approx. 120) action plans had been received by the Culture and Workforce Experience Team.	Potential risk that staff feedback is not acted upon to improve culture, staff experience, and wellbeing.	Agreed Action: The development of NHS Staff Survey action plans will be monitored as part of internal escalation processes with ongoing support provided by the OD teams.
			Expected Evidence of Implementation: Action plans in place for all areas.
	Theme: Planning, Delivery & Deadline Management	High Priority Control Operation	Officer: Lisa Gostling, Director of Workforce & OD Target Implementation Date: 30 November 2026
2	Culture Change Programme We reviewed a sample of five areas where the ODRM team was supporting local management to improve staff experience and organisational culture. Three areas reviewed did not have a People Culture Plan – a dynamic document that evolves throughout the engagement process demonstrating planned improvements, interventions and progress achieved. In one service area, the management action element of the plan was incomplete and did not contain sufficiently SMART actions to support effective implementation and monitoring. Furthermore, the plan had not been updated for a considerable period and there was limited evidence of management oversight or review of progress against agreed actions.	Potential risk that staff feedback is not acted upon to improve culture, staff experience, and wellbeing.	Agreed Action: A review will be undertaken to identify areas that have completed the exploration phase but do not have a People Culture Plan in place. This will include confirming that the rationale for the absence of a plan is appropriately documented or, where required, ensuring that a People Culture Plan is developed with the service.
			Expected Evidence of Implementation: List of areas that have completed exploration phase and evidence of checking that they have a PCP in place, or documented rationale for the absence of a plan.
	Theme: Planning, Delivery & Deadline Management	Medium Priority Control Operation	Officer: Corinna Lloyd-Jones, Interim Assistant Director of Workforce & OD Target Implementation Date: 31 December 2026

The Health Board has established a clear governance framework linking staff experience and wellbeing to strategic objectives, planning goals and risk management arrangements.

The People, Organisational Development & Culture Committee (PODCC) is responsible for monitoring delivery of planning goal 1 *Healthy Thriving Teams* and providing assurance to the Board in relation to organisational culture, staff engagement and workforce wellbeing and development. PODCC receives regular information relevant to staff experience and wellbeing, including:

- NHS Wales Staff Survey results
- Speak Up Make Meaningful Change programme updates
- Cultural Progression updates
- Workforce Strategy updates
- Performance assurance and workforce metrics reports
- Delivery against planning objectives aligned to the PODCC
- Employee Relations updates
- Equality, Diversity & Inclusion reports

While governance and oversight arrangements are well established, the Health Board acknowledges that challenges remain around workforce sustainability, staff morale, psychological safety and evidencing the impact of wellbeing interventions. PODCC noted positive trends in wellbeing support, reduced vacancies and falling sickness absence; and continued to identify concerns regarding staff morale, confidence in raising concerns, psychological safety and workforce pressures. Specific concerns raised included staff wellbeing pressures linked to workforce shortages and organisational change. This is reflected on the health board risk register.

The Board receives regular reporting on staff experience and wellbeing through dedicated staff and patient experience reports, Integrated Performance Assurance Reports, workforce and culture updates, and routine (3A's and annual) reporting from PODCC. The Board also maintains oversight of strategic workforce and wellbeing risks through the Board Assurance Framework and considers the impact of workforce wellbeing on the delivery of organisational objectives, demonstrating that staff experience and wellbeing matters are regularly monitored, scrutinised and escalated where appropriate.

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

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

Disclaimer

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

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

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

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

Global Internal Audit Standards

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



4.5

11:15 AM, 0 Mins

4.5 - Organisational Change Process Operational Structure

James Johns
*(NWSSP - Internal
Audit)*

- **Deferred to 10 December 2026**

| For assurance

4.6

11:15 AM, 0 Mins

4.6 - Financial Management: Grip & Control

James Johns
(NWSSP - Internal
Audit)

- **Deferred to 10 December 2026**

| For assurance

4.7

11:15 AM, 0 Mins

4.7 - Radiology Informatics System Programme
(RISP)

James Johns
(NWSSP - Internal
Audit)

- **Deferred to 10 December 2026**

| For assurance

5 - Clinical Audit

5.1

11:25 AM, 15 Mins

5.1 - Clinical Audit Update

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

| For assurance

Attachments

[Clinical Audit Update ARAC 15 October 2026.pdf](#)



Pwyllgor Archwilio a Sicrwydd Risg/ Audit and Risk Assurance Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	15 October 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Clinical Audit Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mark Henwood, Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Ian Bebb, Clinical Audit Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/ For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This report provides the Audit and Risk Assurance Committee with assurance on the performance, risks and impact of the Health Board's Clinical Audit function, including national audit compliance, progress in implementing the Audit Management and Tracking (AMAT) software system, levels of engagement across services and key improvements delivered during 2026-27.

Cefndir / Background

During 2025-26, significant structural and digital changes have helped reshape the Clinical Audit function, including the roll-out of AMAT, integration with Clinical Care Groups and improved alignment with strategic priorities. These changes enable more consistent tracking, stronger re-audit cycles and clearer visibility of risk areas.

The Health Board delivers an annual Clinical Audit Programme (CAP) that is aligned to organisational priorities and directly supports assurance on the quality and safety of clinical care. The programme sets out a targeted suite of audit projects selected to address key areas of clinical risk, variation, and improvement, and is delivered operationally through Clinical Care Groups and relevant services. In addition to locally-defined priorities, the CAP incorporates all mandatory audits required through the National Clinical Audit and Outcome Review Plan and other national bodies, ensuring full compliance with external standards. Participation in these audits enables the Health Board to benchmark performance nationally, identify variations in clinical practice, and access advanced analysis that informs improvement actions and strengthens overall governance.

National Clinical Audit

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

Non-participation in mandatory national clinical audits presents a material risk to the Health Board, as it prevents us from benchmarking our clinical practice against other organisations and limits our ability to evidence compliance with key professional standards and national guidelines. While non-participation does not, in itself, indicate deficiencies in clinical care, it creates a gap in the assurance available to the Board by reducing the breadth and depth of comparative data.

The Health Board does utilise a wider range of quality and safety intelligence such as Quality Improvement activity, the Safety Dashboard, performance indicators, National Institute of Clinical Excellence (NICE) compliance processes and service evaluations to assess the overall health of services. However, national audits remain a critical component of our assurance framework, providing external comparison, independent scrutiny, and visibility of variation that cannot be replicated through local mechanisms alone.

Some specialties have identified that full participation in all mandatory national audits is not achievable without additional investment. Where this is the case, the Health Board has taken proactive steps to ensure that risks are understood, owned, and mitigated. Services are required to assess the impact of limited participation and incorporate the associated risks into their specialty risk registers, business cases, and annual planning objectives.

Clinical Care Groups and the Clinical Audit Team are working with these specialties to prioritise audit participation based on clinical risk, patient outcomes, and national expectations. This includes agreeing phased engagement plans, identifying resource gaps, and ensuring that areas with the greatest potential quality benefit are supported first.

This approach enables the Health Board to continue demonstrating the value of audit participation—through targeted improvements, clearer visibility of variation, and strengthened assurance—while ensuring that constraints are actively managed rather than becoming barriers to clinical quality improvement.

Key findings from 2025-26:

- 192 standard audits completed in 2025-26 via AMAT with 36 remaining in progress, representing a significant increase in transparency and re-audit opportunities
- A total of 2,412 improvement actions were completed prior to 2026/27, with a further 359 actions remaining in progress, evidencing continued implementation of recommendations identified through the Nursing Audit Programme.
- Full or near-full participation in most mandatory National Clinical Audits, with additional escalation processes being developed for exceptions.
- Improved clinical leadership capacity following new appointments in Diabetes and Care of the Elderly.
- Clinical Care Group escalation saw an increase in the submission of clinical audit action plans. However, several projects had delayed submissions for action plans, and a small number of projects remain significantly behind.

Asesiad / Assessment

Audit Management and Tracking Software

The Ward and Area module continues to expand with a current total of 27 active audits that are being carried out Health Board wide. The software acts as a data collection platform and audit results and actions can be tracked through dashboard displays with instant outputs. These audits all fall primarily under the nursing remit. Outputs are monitored through various groups and actions are embedded within AMAT and are being carried out regularly. 10 additional audits are being planned.

Audit activity has provided consistent assurance for several projects that have maintained high levels of compliance. Examples below (% current compliance):

- Bare below the elbows 99.1%
- Hand hygiene 96.8%
- Personal Protective Equipment 98.9%
- Medicines Management (Patient Audit) 85.9%
- Medicines Management (Ward Audit) 90.0%
- Supportive Practice Review (Health Visiting) 91.8%
- Positive Patient Identification 96.9%
- Paediatric Early Warning Audit 88.4%
- Medical Emergency Trolley Audit 93.0%

Other audit activity has provided opportunities for improvement, and the Health Board can evidence patient safety improvements, for example:

- Mealtime (Patient Audit) 82.6% increased to 88.7%
- Controlled Drugs Audit 95.6% increased to 100%
- Falls Extensive Check Audit 65.6% to 71.1%

Across these Ward based audits there have been approximately 763 improvement actions completed since April 2026. A further 686 improvements are being progressed. Whilst each action may only have a small (or varying) impact, this does represent instances of safer, timely or effective care for patients. Evidence for these actions has also been uploaded to the AMAT system. Once the programme has been fully rolled out this number will increase significantly.

Specific examples of improvements across the portfolio of audits include:

- Multi- factorial Risk Assessment for Falls
- Usage of the falling star (Patient Status at a Glance)
- Blue plate initiative for those with cognitive impairments
- Review of the adequacy of mealtime intake for patients
- NEWS – Management plan in place for escalated patients
- Rostering improvements for nursing staff
- Waste/excess medication protocols

All actions on the Ward module are tracked to a specific Ward Area and improvements are highly targeted. Areas of poor compliance are easily identified utilising this software and the system will automatically highlight low compliance.

Participation remains below expected levels with an average participation across the 25 live projects of 48%. This is an increase of 10% from April 2026. However, some audit participation remains exceptionally low ranging from 14.2% - 100%. The Clinical Audit Department have met several times with Senior Nursing representatives who will continue to focus on participation levels for the current portfolio of audits to ensure Health Board wide consistency, assurance and improvement.

There are currently 80 open “standard” clinical audits live on the system with 45 of these being added in 2026-27. A total of 48 audits have been completed on the system since April 2026 which represents 48 opportunities for assurance and quality improvement with multiple improvements stemming from any given project. All this information is available for all users to view and learn from as the system offers high levels of transparency. This allows the Health Board to focus more on re-audits in needed areas as opposed to “orphan” (e.g. single cycle) projects.

National Clinical Audit

Hywel Dda University Health Board (HDdUHB) continues to meet the majority of national audit participation requirements with contributions to the national programme at approximately 93%. Completion of appropriate improvement plans remains the biggest challenge with compliance at around 59%. The Health Board continues to see an increase in engagement and the timely completion of these improvement plans.

The main areas requiring strengthened engagement in 2026/27 are Planned Care and Specialist Services, Care of the Elderly and Diabetes. This remains the same as it did in April 2026. Improvement plans have not yet been agreed for all areas, and the Clinical Audit Department continue to escalate exceptions through standardised processes. More engagement will be required if the Health Board is to be compliant with the National Clinical Audit Programme. There has been an increase in engagement across most of these areas, however, only a small number of areas have made progress.

Any exceptions to expected participation or good practice have been:

- Escalated to senior management within the respective services
- Reported to the relevant Clinical Care Group(s)
- Reviewed at the Clinical Audit Scrutiny Panel (CASP)
- Escalated to Effective Clinical Practice Advisory Panel
- Continually monitored

The table below indicates audits that are currently non-compliant for participation (either data collection or delayed improvement plans). All projects are escalated through the Clinical Care Group (CCG) structures regularly at monthly forums. Outstanding concerns are also raised through the Clinical Audit Scrutiny Panel and escalated further to the Effective Clinical Practice Advisory Panel (last reported 21.05.2026). Clinical Leads and Service Delivery Managers are also aware of outstanding concerns.

Audit Title	Escalation Route
National Maternity and Perinatal Audit (NMPA)	Women & Family Health CCG Planned Care & Specialist Services CCG
NCAORP Epilepsy 12	Women & Family Health CCG

National Audit of Metastatic Breast Cancer (NAoMe)	Planned Care & Specialist Services CCG Effective Clinical Practice Advisory Panel
National Ovarian Cancer Audit (NOCA)	
Comparative Audit of Critical Care Unit Adult Patient Outcomes (ICNARC)	Planned Care & Cancer Services CCG Planned Care & Specialist Services CCG Effective Clinical Practice Advisory Panel
National Emergency Laparotomy Audit (NELA)	
National Bowel Cancer Audit (NBOCA)	
National Non-Hodgkin Lymphoma Audit (NNHLA)	
National Kidney Cancer Audit (NKCA)	
National Prostate Cancer Audit (NPCA)	
National Lung Cancer Audit (NLCA)	County Community & Integrated Medicine CCGs
National Audit of Dementia (NAD)	Health Board Community & Integrated Medicine CCG
National Audit of Care at the End of Life (NACEL)	Effective Clinical Practice Advisory Panel
National Diabetes Foot Care Audit (NDFA)	
National Core Diabetes Audit (NCDA)	
National Diabetes Inpatient Safety Audit (NDISA)	
National Audit of Cardiac Rehabilitation (NACR)	Cardiology Q&S Forum County Community & Integrated Medicine CCGs Health Board Community & Integrated Medicine CCG Effective Clinical Practice Advisory Panel

A full list of national audits can be found in the accompanying attachment.

Discussions with audit and service leads are underway for all areas where low participation or engagement has been identified. Where participation shortfalls are identified and not mitigated, services are asked to include details within the relevant risk register. Services also have the option of applying to the Quality Impact Assessment Panel for further support.

All audits that are currently not being contributed to are on the respective services risk register.

National audit findings have driven targeted improvements across multiple specialties, sites and for many patient groups. Several action plans are currently being compiled. Completed examples since April 2026:

- Improved care for patients with Kidney Cancer through multi-disciplinary team (MDT) discussions and nephron sparing treatment and increased review from specialist consultants
- Educational events for GPs regarding Lymphoma diagnosis to support patients with Non-Hodgkin Lymphoma
- Increased support for national audit data collection across cancer, cardiology audits and joint registry
- Increased Governance through discussion of National Joint Registry reports at key Governance meetings
- Equitable access to surgery for Hip Fracture patients
- Improved shared learning from falls related incidents

- Introduction of Clinical Care Unit-based treat and transfer process at Prince Philip Hospital (PPH) to support timely transfer of Non-ST-Segment Elevation Myocardial Infarction (NSTEMI) patients to Morriston Hospital.
- Introduction of a Band 4 Healthcare Support Worker (HCSW) role to undertake routine physical health assessments for patients with Psychosis
- Spirometry hubs have been established to support primary care

There have also been some notable improvements in sampling and patient identification for the Cardiology and Children and Young Persons Asthma Audits. Refining these samples ensures that we are focusing on the correct patient cohort, maximising the efficiency of the audits as well as audit outcomes.

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

Clinical Audit Programme 2026/27

The Clinical Audit Department have been working on some key projects this year.

- The Internal Operational Standards Audit focused on patient flow through Accident and Emergency Units and other Acute Assessment areas. This audit was carried out by the Clinical Effectiveness Team and reported and acted on at Senior Level within the Health Board.
- An Evidence Based Intervention audit programme has been started in collaboration with the Clinical Effectiveness Team and Senior Quality Improvement Leads and AMDs. This work focuses on Interventions that should not be undertaken without meeting specific criteria (for example, Tonsillectomy, Carpal Tunnel Repair and Inguinal Hernia).

The new 6 monthly programme is now in development, and key groups have been written to. There is expected to only be a small number of additions during this second window for inclusion in the 2026-27 programme.

A large portion of the audits now on the CAP are “continuous” in nature or are regular re-audits. This holds a lot of value as the audit cycles will be repeated and improved upon.

The current programme is available on request and on SharePoint.

Shared Learning

The CAD are continuing to hold Whole Hospital and Whole Health Board Audit meetings. They also contribute to other Medical Directorate forums, newsletters etc. as well as EQIIP, Clinical lead forums, Clinical Care Groups.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to:

- **TAKE ASSURANCE** from the performance improvements evidenced through AMAT and the volume of completed improvement actions.

- **TAKE ASSURANCE** that services with low national audit engagement are implementing agreed improvement plans.
- **NOTE** the services that are experiencing delays in participation or improvement plans
- **TAKE ASSURANCE** from the continuation of most mandatory national audits and the processes followed for escalation
- **TAKE ASSURANCE** from the continued shared learning through WHAM and other activities

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	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, Teitl a Sgôr Risg 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:	1. Striving teams
Nodau Cynllunio 2026/27 Planning Goals 2026/27	Not Applicable
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	3. Create people-centred employment and development opportunities that support workforce transformation, reflect the changing needs of the modern NHS
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (<i>complete for strategic change and/or significant service changes</i>)	Not Applicable
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 cyfarfod hwn: Parties / Committees consulted prior to this meeting:	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.
Tegwch Iechyd: Health Equity:	Not Applicable
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

6 - Financial Focus

6.1

11:40 AM, 15 Mins

6.1 - Financial Assurance Report

***Huw Thomas (Hywel
Dda UHB - Director
of Finance)***

| For approval

Attachments

[Financial Assurance Report ARAC 15 October 2026.pdf](#)

[Financial Assurance Report 1 July 2026 to 31 August 2026.pdf](#)

[Appendices 1-4 Financial Assurance Report 1 July 2026 to 31 August 2026.pdf](#)

[Appendix 5 Financial Assurance Report 1 July 2026 to 31 August 2026.pdf](#)



Pwyllgor Archwilio a Sicrwydd Risg/ Audit and Risk Assurance Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	15 October 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Financial Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Tim John, Head of Accounting and Statutory Reporting

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/ For Decision

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

The Standing Orders require that ARAC provides assurance to the Board that the University Health Board's assurance processes are operating effectively.

Critical to this is Financial Assurance, which cannot be measured only by the Health Board's main finance report and requires further information in order to assess the control environment in place; the risk assessment and management process; and the control activities.

Asesiad / Assessment

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

ALERT:

No issues to report

ADVISE:

- The Committee is advised of the breaches of Standing Financial Instructions (SFIs), in respect of retrospective purchase orders, which are reported in **Appendix 1b**. Where these breaches occur, they are reviewed by local NWSSP Procurement for appropriate re-education, and the relevant director is informed.
- While the level of staff overpayments increased from 44 to 55 in July and August 2026, the value decreased by £8,440 compared to the previous period. The average recovery period remained broadly with the previous period and further details are provided on Schedule 3 of the Report. The target is to have no overpayments; however, the total overpaid during July and August 2026 represents 0.23% of the average monthly net pay costs (May and June 2026 – 0.24%).
- There were no individual losses exceeding £5,000 in July and August 2026. There were losses and write offs less than £5,000 in the period totalling £23,305, a decrease on the previous two-month period for this category of loss. Details are provided on Schedule 4 of the Report

ASSURE:

- Purchase To Pay (P2P)
 - No Purchase Order, No Pay. The Health Board actively enforces the No Purchase Order, No Pay policy and whilst there have been zero invoices paid without a purchase order, preventative control checks are in place to ensure that proactive management minimises the potential for non-compliance in the future and any delays for vendor payment. This preventative control is called invoices on hold (IOH).
 - Public Sector Payment Policy (PSPP) compliance remains on target for delivery for the year – the target is to pay 95% of all non-NHS invoices within 30 days. Budget holders are continually pursued to authorise invoices promptly, as e-mail requests from NWSSP Accounts Payable are often ignored.

A joint Hywel Dda and NWSSP action plan has been agreed to address IOH through three linked areas: process and system improvements, targeted supplier interventions, and focused management of aged items. Early progress has been made on the CTM receipting reminder pilot, the potential use of Scan4Safety, benchmarking with other Health Boards, and review of managed print arrangements.

The next phase will focus on translating these actions into measurable reductions in invoice holds, strengthening compliance arrangements, and eliminating invoices aged over 180 days by 31 October 2026, excluding targeted supplier categories. ARAC support is being sought for the overall approach, including the potential to escalate persistent non-compliance where appropriate.

- Single Tender Actions (STAs) and contracts awarded are carefully controlled. Two STAs were awarded during the July and August 2026 owing to urgent required repairs to MRI scanners in WGH. Aside from these two STAs, no STAs have been made since March 2024.
- NHS bodies in Wales must publish a payment compliance notice every six months where they have made a payment, or a sum has become payable, under a public

contract. The first reporting period ended on 30 September 2026, and the notice must be published by 30 October 2026. Work is being undertaken in conjunction with NWSSP to ensure compliance requirements are met (further details are provided in **Appendix 5**).

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to:

- **SCRUTINISE** the award of contracts listed in Appendix 1a.
- **DISCUSS** losses as detailed in Appendix 3 and **APPROVE** the loss in excess of £5,000.
- **DISCUSS** the breaches of Standing Financial Instructions as detailed in Appendix 1b.
- **DISCUSS** the staff overpayments as detailed in Appendix 2 and seek assurance that actions to control them are sufficiently embedded; and
- Take **ASSURANCE** from the actions taken to:
 - Improve Purchase To Pay compliance;
 - Manage Single Tender Actions; and
 - Comply with new reporting requirements of the Procurement Act 2023.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	2.4 The Committee's principal duties encompass the following: 2.4.2 Seek assurance that the systems for financial reporting to Board, including those of budgetary control, are effective, and that financial systems processes and controls are operating. 3.10 The Committee will be responsible for reviewing the UHB's Standing Orders and Standing Financial Instructions and Scheme of Delegation annually, (including associated framework documents as appropriate), monitoring compliance, and reporting any proposed changes to the Board for consideration and approval. 3.13 Approve the writing-off of losses or the making of special payments within delegated limits. 3.15 Receive a report on all Single Tender Actions and extensions of contracts.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	BAF SO9-PR20 BAF SO10-PR33
Parthau Ansawdd: Domains of Quality	Not Applicable

Quality and Engagement Act (sharepoint.com)	
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	Not Applicable
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	10. Not Applicable
Model Cymdeithasol ar gyfer Iechyd a Llesiant : (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing : (<i>complete for strategic change and/or significant service changes</i>)	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Monitoring returns to Welsh Government based on the Health Board's financial reporting system. Activity recorded in the AR and AP modules of the Oracle business system and activity recorded in the procurement Bravo system.
Rhestr Termiau: Glossary of Terms:	AP - Accounts Payable AR – Accounts Receivable BGH – Bronglais Hospital CAT – Core Accounting Team CF – Counter Fraud COS – Contracted Out Service VAT EOY – End of Year

	ERs NI – Employers National Insurance GGH – Glangwili 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 PSP – Public Sector Payment Policy SFI – Standing Financial Instructions SLA – Service Level Agreement STA – Single Tender Action VAT – Value Added Tax WGH – Withybush Hospital WRP – Welsh Risk Pool
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	HDdUHB Finance Team HDdUHB Management Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Financial implications are inherent within the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	Risk to our financial position affects our ability to discharge timely and effective care to patients.
Gweithlu: Workforce:	Overpayments are reported within this report.
Tegwch Iechyd: Health Equity:	Not Applicable
Risg: Risk:	Financial risks are detailed in the report.
Cyfreithiol: Legal:	The Health Board 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 Health Board's financial plan will affect our reputation with Welsh Government, Audit Wales and with external stakeholders.
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable



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Financial Assurance Report 1 July 2026 to 31 August 2026

Audit and Risk Assurance Committee

15 October 2026

Compliance requirements for ARAC - Overview



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Requirement	Reporting	Frequency	Status	Reference
Scheme of delegation changes	Exception reporting for approval	As appropriate	Compliant	N/a – no changes
Compliance with Purchase to Pay requirements	Breaches of the No PO, No Pay policy/Instructions for noting	Bi-monthly	Assure Committee	Schedule 2a
	Public Sector Payment Policy (PSPP) compliance	Bi-monthly	Assure Committee	Schedule 2a
	Tenders awarded for noting	Bi-monthly	Assure Committee	Schedule 2b
	Single tender action	Bi-monthly	Assure Committee	Schedule 2b
	Breaches of Standing Financial Instructions (SFIs)	Bi-monthly	Advise Committee	Schedule 2b
Compliance with Income to Cash requirements	Overpayments of staff salaries and recovery procedures for noting	Bi-monthly	Advise Committee	Schedule 3
Losses & Special payments and Write offs	- Write off schedule - Approval of losses and special payments	Bi-monthly	Advise Committee	Schedule 4
Compliance with Capital requirements	- Scheme of delegation approval for capital - Project Bank Accounts	As appropriate/ Following approval of annual capital plan	Compliant	Schedule 5
Compliance with Tax requirements	Compliance with VAT requirements	Bi-monthly	Compliant	N/a – no changes
	Compliance with employment taxes	Bi-monthly	Compliant	N/a – no changes
Compliance with Reporting requirements	- Changes in accounting practices and policies - Agree final accounts timetable and plans - Review of annual accounts progress - Review of audited annual accounts and financial statements	Annually	Compliant	Schedule 5

2a. Compliance with Purchase to Pay requirements

IOH

July and August 2026

No. 137; Value £1,443k

May and June 2026

No. 96; Value £905k

Cumulative to end August 2026

No. 245; Value £2,317k*

Cumulative to end June 2026

No. 200; Value £1,495k

PSPP

Non – NHS (statutory target > 95%)

July 2026 – 95.0%

August 2026 – 96.8%

Cumulative to 31 August 2026

96.0%

NHS (no statutory target)

July 2026 – 82.2%

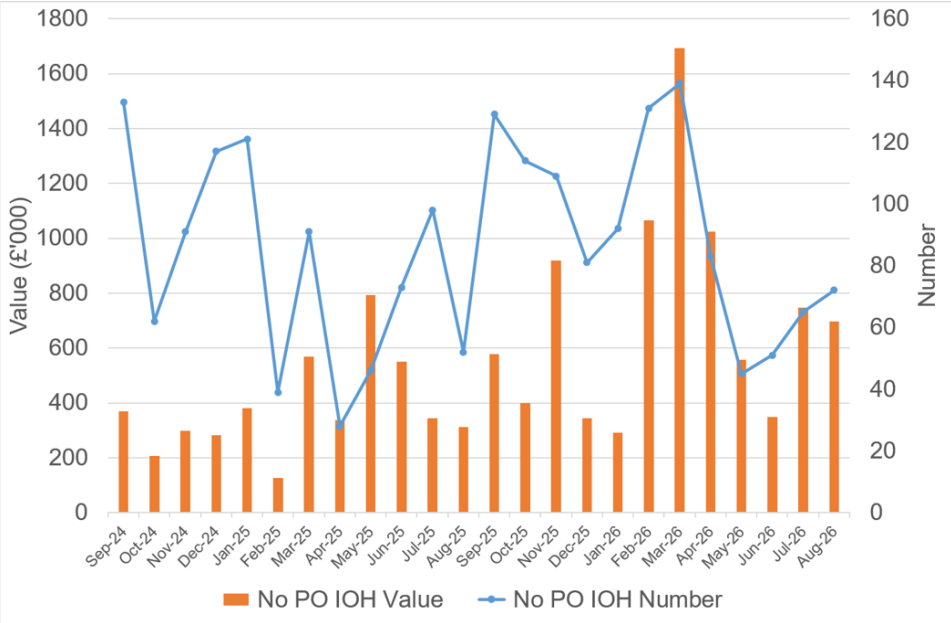
August 2026 – 88.8%

Cumulative to 31 August 2026

81.4%

*Increase in cumulative value due in the main to additional invoices in respect of ID Medical insourcing costs (£299k) and Healios Ltd for provision of Autism Spectrum Diagnostics (£498k).

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



Reducing IOH (invoices on hold)		
Supplier Non-Compliance exceeding £50,000:	No. of invoices	Value £
Suppliers		
Healios Ltd	1	498,000
Everlight Radiology Ltd	2	295,866
ID Medical	20	276,031
Royal Mail Group Plc	3	96,823
Health Board Non-Compliance exceeding £50,000:	No. of invoices	Value £
Clinical Care Groups/Executive function		
Mental Health & LD/various	12*	514,630
Operational Allied Health and Health Sciences/various	2	295,866
Planned and Specialist Care/various	25	281,879
Community and Integrated Medicine/various	10	53,738
*includes one invoice, Healios Ltd - £498,000 for provision of Autism Spectrum Diagnostics		
Of the 49 invoices above (totalling £1,146k) 36 have now been released from IOH and paid in full. 13 invoices totalling £178k remain as IOH, including 12 invoices in respect of Planned and Specialist Care/Endoscopy, Anaesthetics, Bowel Screening and Critical Care (ID Medical - insourcing costs).		

2b. Compliance with Purchase to Pay requirements



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STA

July and August 2026
No. 2; Value £86,497*

May and June 2026
No. 0; Value £0

**Tenders
Awarded
(>£25k)**

July and August 2026
No. 12; Value £4,725,854

May and June 2026
No. 11; Value £13,629,343

Consultancy

July and August 2026
No. 0; Value £0

May and June 2026
No. 0; Value £0

*Single Tender Actions relate to urgent MRI scanner repairs at WGH

Top 5 Tenders Awarded (>£25k)

Supplier	Description	Value £	Department
N/a Multiple	Construction Framework for HDUHB and Swansea Bay UHB	4,000,000	Estates
Trustmarque Solutions Limited	SQL Server Subscription Renewal	221,280	Digital
Navigate Education	Relational Care Training	99,000	Public Health
Curtins Consulting Limited	RAAC Management and Re-inspection at WGH	73,201	Estates
Change Healthcare UK Holdings Limited	Cardiology PACS System Renewal	67,763	Digital / Cardiology Services
Total		4,461,244	

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

Contracts Awarded	Number	Value £	Details
Single Tender Award	2	86,497	Appendix 1a
Direct awards via Framework agreement	4	404,744	Appendix 1a
Extension/Open Tender/PSR/MultiQuote	6	4,234,613	Appendix 1a
Total	12	4,725,854	
Consultancy Contracts	-	-	-
Breaches of SFIs	3	74,916	Appendix 1b
Contract Awards reported retrospectively	-	-	-

3. Compliance with Income to Cash

Salary
Overpayments

July and August 2026
No. 55; Value £60,364
(Appendix 2)

May and June 2026
No. 44; Value £68,804

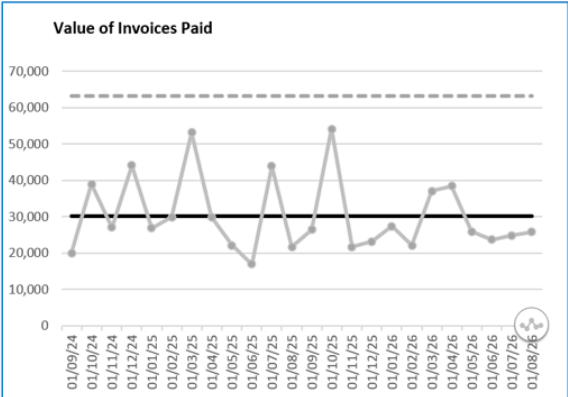
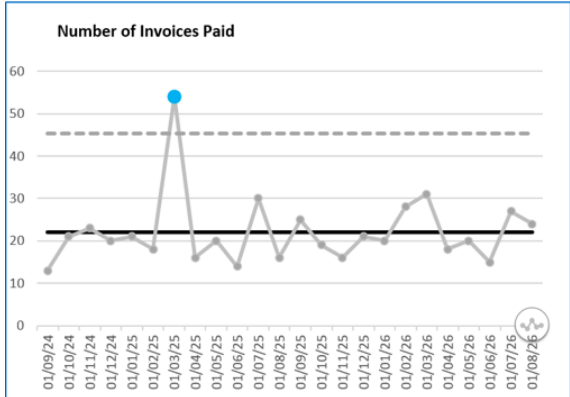
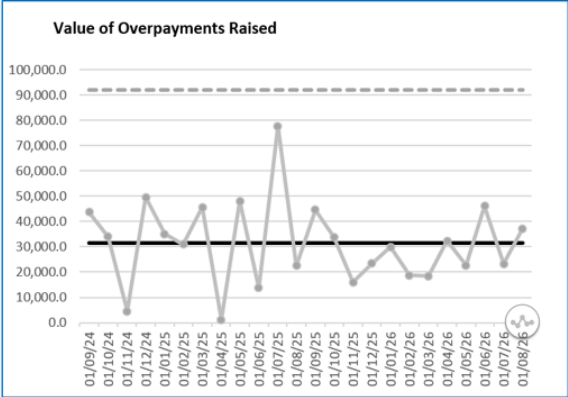
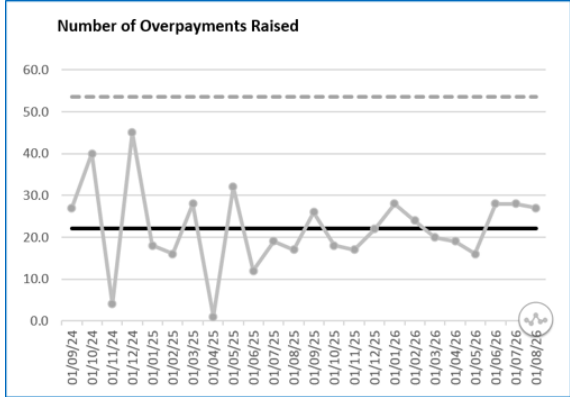
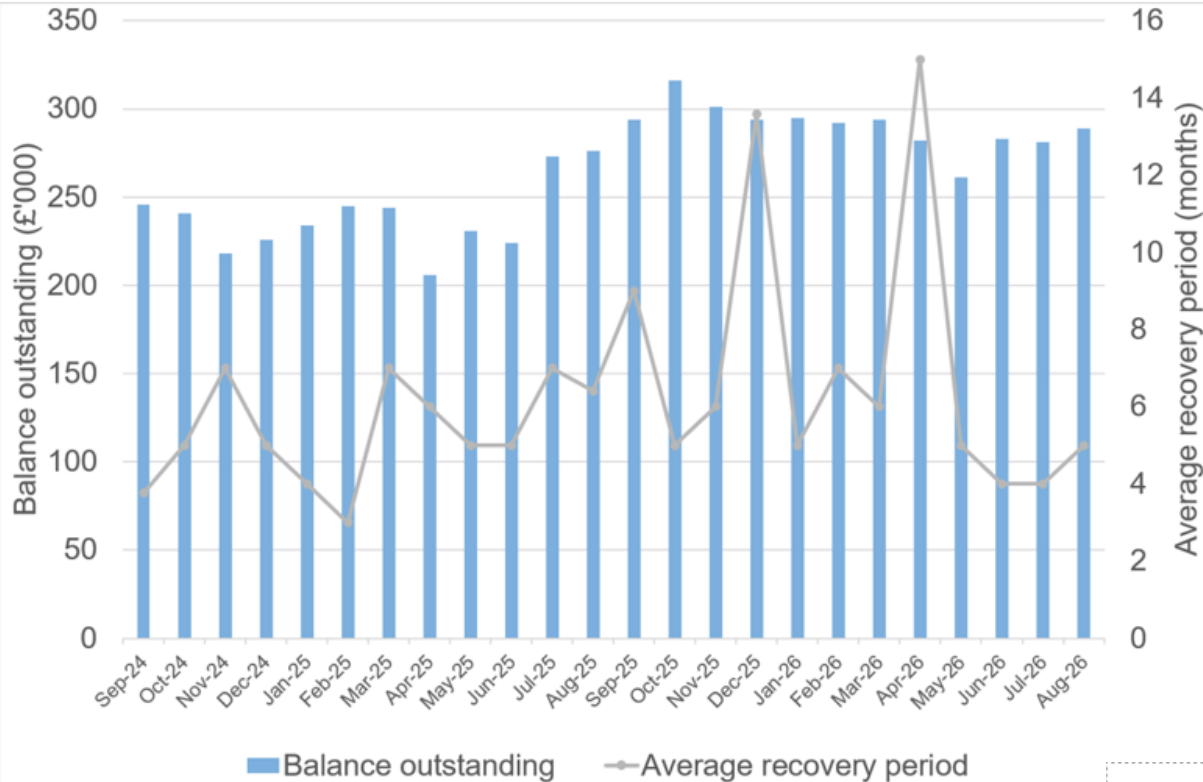
Debt balance at 31 August
2026: £289k; average recovery
period of 5 months

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

	Aug-26	Jun-26
Avg no of invoices raised	22	22
Avg value	£31k	£31k
Avg no paid	22	22
Avg value	£30k	£31k

Underpayments July and August 2026 - £6,919
May and June 2026 - £22,867

Trend of aged overpayments and recoveries



4. Losses and Special Payments



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**Losses £5k and
over requiring
ARAC Approval**

**July and Aug 2026
£Nil**

*May and June 2026
£5,676*

**Losses under £5k
approved by DoF
and CEO**

**July and August 2026
£23,305**

(Appendix 3)
*May and June 2026
£25,610*

Losses – Requiring Approval from ARAC	£
N/a	Nil
All Other Losses	
Ex gratia	1,264
Overpayments of salaries, salary sacrifice, accommodation, Wagestream, private patient income, overseas patient income etc	1,386
4b Other causes* - expired stock, wastage, breakages	20,655
Total Losses	23,305

* 4b Other causes

In accordance with the Health Board's Losses and Special Payments Procedure (Procedure number: 066) category 4b is defined as:

4) Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to:

a. culpable causes e.g. theft, fraud, arson or sabotage whether proved or suspected, neglect of duty or gross carelessness

b. other causes

5. Other Areas

Compliance with Capital Requirements

Project Bank Account (PBA)

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

Compliance with Tax Requirements

Compliance with VAT Requirements

Completion of all VAT recovery activities in respect of expenditure incurred in the 2025/26 financial year; total VAT recovered £9.8m (see **Appendix 4** for further details).

Compliance with Employment Tax Requirements – No updates to report.

Compliance with Reporting requirements

Annual Accounts 2026/27

Discussions are ongoing between Welsh Government and Audit Wales to agree the timetable for preparation and submission to Welsh Government and Audit certification by the Auditor General for Wales.



Appendices 1-4

Appendix 1a: Contracts awarded (Highlighted element represents award during period)

Title	Route to Market	Supplier	Term	Contract End Date Inc Extensions	Directorate	Initial Total Contract Value ex VAT	Extension Value ex VAT	Consultancy Y/N	Professional Services Y/N	Date of Board Approval
Construction Framework for HDUHB and Swansea Bay University Health Board	Extension	N/A - Multiple	9 Months with no option to extend further	30/04/2027	Estates	£ 16,000,000.00	£ 4,000,000.00	No	No	Jul-26
SQL Server Subscription Renewal	Direct Award via Framework Agreement	Trustmarque Solutions Limited	1 Year with no option to extend	30/06/2027	Digital Services	£ 221,279.94	£ -	No	No	Jul-26
Dental Patient Administration System	Extension	Carestream Dental Limited	2 Years with no option to extend further	31/07/2028	Dental/Digital Services	£ 79,324.68	£ 30,902.98	No	No	N/A
Relational Care Training	Open Tender	Navigate Education	1 Year with no option to extend	30/06/2027	Public Health	£ 99,000.00	£ -	No	No	N/A
Risk Ledger Software	Direct Award via Framework Agreement	Trustmarque Solutions Limited	2 Years with an option to extend for a further 2 Years	30/06/2030	Digital Services	£ 42,500.00	£ 46,900.00	No	No	N/A
Bereavement Services for North and South Ceredigion	PSR	Aberystwyth and District Hospice at Home Volunteers T/A HAHAV (HAHAV)	2 Years with an option to extend for a further 1 Year	30/06/2029	Primary Care	£ 49,865.86	£ 24,932.94	No	No	N/A
Reinforced Autoclaved Aerated Concrete (RAAC) Management and Re-inspection at Withybush General Hospital (WGH)	Direct Award via Framework Agreement	Curtins Consulting Limited	1 Year with no option to extend further	12/08/2027	Estates	£ 73,201.04	£ -	No	Yes	N/A
Cardiology PACS System Renewal	Direct Award via Framework Agreement	Change Healthcare UK Holdings Limited	1 Year and 4 Months with no option to extend	30/11/2027	Digital/Cardiology Services	£ 67,763.12	£ -	No	No	N/A
Fortinet Azure Firewalls Extension	Extension	Switchshop Limited	1 Year with no option to extend further	31/07/2027	Digital Services	£ 30,056.68	£ 29,844.52	No	No	N/A

Appendix 1a: Contracts awarded (continued)

Urgent MRI scanner repairs at GGH	STA	Siemens Healthcare Diagnostics Limited	1 Month	31/07/2026	Radiology Services	£ 47,659.00	£ -	No	No	N/A
Urgent MRI scanner repairs at WGH	STA	Siemens Healthcare Diagnostics Limited	1 Month	31/07/2026	Radiology Services	£ 38,838.00	£ -	No	No	N/A
Direct Payments Scheme	MultiQuote Exercise	People Places Lives	1 Year with no option to extend	14/06/2027	Primary Care	£ 25,000.00	£ -	No	No	N/A

Appendix 1b: Breaches of SFIs

Title	Supplier	Recurring or One Off	Contract Start	Contract End	Total Value ex VAT	L4 Directorate	Action Taken	If recurring added to Workplan
Magic Notes Licences	Beam Up Limited	Recurring	27/04/2026	27/04/2027	£ 30,000.00	Digital	End User & Budget Holder Educated with Template Email and Relevant Director Informed for Awareness and Action. Also, breach added to Workplan	Yes
Security Services to BGH	Diogel Events Limited	Recurring	01/07/2026	31/07/2026	£ 24,658.00	Community and Integrated Medicine	End User & Budget Holder Educated with Template Email and Relevant Director Informed for Awareness and Action. Also, breach added to Workplan	Yes
Inspection of Electrical Infrastructure to establish if the new generator can be accommodated within the existing system at PPH.	Consilium Solutions Group LLP	One Off	12/03/2025	18/03/2025	£ 20,258.40	Estates and Facilities	End User & Budget Holder Educated with Template Email and Relevant Director Informed for Awareness and Action	No

Appendix 2: Overpayment of Salaries

	Period covered by this report: 1 July 26 – 31 August 26		
Ref	Reason for Overpayment	Value (£)	Number of invoices
1	Processing Error	5,606.46	5
2	Late Notification of Changes	14,972.82	25
3	Late Notification of Termination	33,101.72	17
4	Late Notification of Absence	6,683.36	8
5	No Notification of Return to Work	-	-
		60,364.36	55

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

2026/27	WRITE OFF LIST	
	Period covered by this report:	1st July to 31 August 2026
	Losses and Special Payments Category	Value (£)
		Explanation
	Total Write Off	-
	4b Other	1,047.78 P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1,252.80 P05-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	1,350.00 P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	1,762.56 P05-27 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	Total Other/Ex Gratia	5,413.14
	Total	5,413.14

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

2026/27	WRITE OFF LIST		
Period covered by this report:		1st July to 31 August 2026	
Losses and Special Payments Category	Value (£)	Explanation	
SALARY SACRIFICE	0.05	UNDERPAID OF INVOICE	
OVERPAYMENT OF SALARY	0.33	UNDERPAID OF INVOICE	
OVERPAYMENT OF SALARY	22.61	COLLECTION EFFORTS EXHAUSTED - NOT VIABLE FOR CCI	
OVERPAYMENT OF SALARY	51.33	COLLECTION EFFORTS EXHAUSTED - NOT VIABLE FOR CCI	
SALARY SACRIFICE	52.65	COLLECTION EFFORTS EXHAUSTED - NOT VIABLE FOR CCI	
OVERPAYMENT OF SALARY	58.29	COLLECTION EFFORTS EXHAUSTED - NOT VIABLE FOR CCI	
SALARY SACRIFICE	93.12	COLLECTION EFFORTS EXHAUSTED - NOT VIABLE FOR CCI	
OVERSEAS PATIENT	101.44	COLLECTION EFFORTS EXHAUSTED - NOT VIABLE FOR CCI	
SALARY SACRIFICE	107.19	COLLECTION EFFORTS EXHAUSTED - NOT VIABLE FOR CCI	
SALARY SACRIFICE	132.15	COLLECTION EFFORTS EXHAUSTED	
SALARY SACRIFICE	217.31	COLLECTION EFFORTS EXHAUSTED	
SALARY SACRIFICE	218.62	COLLECTION EFFORTS EXHAUSTED	
SALARY SACRIFICE	330.08	COLLECTION EFFORTS EXHAUSTED - NOT VIABLE FOR CCI	
Total Write Off	1,385.17		
4b Other	- 224.40	P04-27 Bronglais Hospital~~B EXPIRED STOCK BGH	
4b Other	- 17.71	P04-27 Bronglais Hospital~~B EXPIRED STOCK BGH	
4b Other	- 8.27	P04-27 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH	
4b Other	- 0.04	P05-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH	
4b Other	0.02	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	0.03	P05-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH	
4b Other	0.03	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	0.05	P05-27 Bronglais Hospital~~B EXPIRED STOCK BGH	
4b Other	0.06	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	0.11	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other	0.12	P04-27 Withybush Hospital~~W WASTAGE / BREAKAGES WGH	
4b Other	0.12	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other	0.12	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	0.13	P04-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH	
4b Other	0.15	P04-27 Withybush Hospital~~W WASTAGE / BREAKAGES WGH	
4b Other	0.15	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	0.19	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other	0.22	P05-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH	
4b Other	0.23	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	0.26	P05-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH	
4b Other	0.27	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other	0.28	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	0.29	P04-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH	
4b Other	0.33	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	0.39	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other	0.42	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	0.42	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	0.45	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other	0.45	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	0.48	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	0.49	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	0.50	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	0.57	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	0.60	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	0.64	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	0.66	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	0.75	P05-27 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH	
4b Other	0.76	P05-27 Withybush Hospital~~W WASTAGE / BREAKAGES WGH	
4b Other	0.78	P04-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH	
4b Other	0.78	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other	0.79	P05-27 Bronglais Hospital~~B EXPIRED STOCK BGH	
4b Other	0.81	P04-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH	
4b Other	0.81	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	0.90	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	0.91	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other	1.00	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH	
4b Other	1.01	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	1.04	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH	
4b Other	1.06	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH	

4b Other	1.09	P04-27 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	1.13	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	1.16	P04-27 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	1.16	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	1.19	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	1.25	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	1.39	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	1.41	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	1.45	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	1.46	P05-27 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	1.80	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	1.83	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	1.85	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	2.02	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	2.04	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	2.23	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	2.27	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	2.33	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	2.42	P04-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
4b Other	2.93	P05-27 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
4b Other	3.01	P05-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	3.23	P05-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
4b Other	3.30	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	3.31	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	3.46	P04-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
4b Other	3.52	P04-27 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
4b Other	3.53	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	3.62	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	3.69	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	3.74	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	3.83	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	4.04	P05-27 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
4b Other	4.10	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	4.26	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	4.43	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	4.76	P04-27 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	4.80	P05-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	4.86	P04-27 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	5.56	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	5.96	P04-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
4b Other	6.72	P05-27 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
4b Other	6.85	P04-27 Prince Philip Hospital~~P EXPIRED STOCK PPH
4b Other	6.95	P04-27 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
4b Other	7.71	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	8.15	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	8.26	P04-27 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	8.92	P04-27 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	9.47	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	9.48	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	10.08	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	10.16	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	10.80	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	10.86	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	11.02	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	11.18	P04-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
4b Other	11.18	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	11.69	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	11.76	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	12.35	P05-27 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
4b Other	12.59	P05-27 Prince Philip Hospital~~P EXPIRED STOCK PPH
4b Other	13.06	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	13.59	P04-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
4b Other	13.63	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	14.21	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	14.40	P04-27 Prince Philip Hospital~~P EXPIRED STOCK PPH
4b Other	14.40	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	14.40	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	14.40	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	14.68	P04-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
4b Other	14.87	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH

4b Other	14.88	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	15.54	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	15.67	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	15.98	P05-27 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
4b Other	16.33	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	16.64	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	17.00	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	17.30	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	17.40	P04-27 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	17.40	P05-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
4b Other	18.23	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	18.32	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	18.96	P05-27 Prince Philip Hospital~~P EXPIRED STOCK PPH
4b Other	19.19	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	19.36	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	19.47	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	19.82	P04-27 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	20.44	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	21.02	P05-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
4b Other	21.25	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	22.04	P04-27 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	22.32	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	22.39	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	22.52	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	22.90	P04-27 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	25.14	P05-27 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
4b Other	25.46	P04-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
4b Other	26.40	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	26.50	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	27.00	P04-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
4b Other	27.43	P05-27 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	27.60	P04-27 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	27.65	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	28.33	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	28.33	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	28.33	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	28.75	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	29.05	P04-27 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	30.48	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	30.60	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	30.70	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	30.86	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	31.68	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	32.34	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	32.36	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	32.40	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	32.92	P05-27 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
4b Other	33.90	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	33.90	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	34.94	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	35.35	P04-27 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	35.57	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	36.00	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	36.48	P05-27 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	38.56	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	38.56	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	39.28	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	39.86	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	41.70	P05-27 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
4b Other	42.22	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	43.20	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	43.20	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	43.37	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	43.48	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	43.92	P05-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	44.74	P05-27 Prince Philip Hospital~~P EXPIRED STOCK PPH
4b Other	45.41	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	47.40	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	47.50	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	47.94	P05-27 Bronglais Hospital~~B EXPIRED STOCK BGH

4b Other	49.20	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	49.20	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	49.20	P05-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
4b Other	50.40	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	50.40	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	51.17	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	52.14	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	52.79	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	53.10	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	55.70	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	56.66	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	57.60	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	60.00	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	60.71	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	61.56	P05-27 Prince Philip Hospital~~P EXPIRED STOCK PPH
4b Other	63.76	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	64.70	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	64.97	P05-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	68.11	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	69.74	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	69.89	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	72.00	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	72.00	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	74.45	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	77.60	P05-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	81.82	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	84.49	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	85.00	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	88.34	P05-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	88.80	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	91.81	P05-27 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
4b Other	94.47	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	96.00	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	98.07	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	108.00	P04-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
4b Other	112.80	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	120.52	P04-27 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
4b Other	124.80	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	124.80	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	127.51	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	127.92	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	129.41	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	132.74	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	133.71	P05-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	134.22	P05-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	140.50	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	146.04	P04-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
4b Other	148.76	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	152.40	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	152.85	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	153.38	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	153.50	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	154.24	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	155.10	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	163.20	P05-27 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	184.18	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	185.84	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	186.78	P04-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
4b Other	192.00	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	212.39	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	219.21	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	246.49	P04-27 Bronglais Hospital~~B EXPIRED STOCK BGH
11 EX-GRATIA	254.00	Ex-Gratia - Replace Damaged Glasses
4b Other	277.93	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	281.42	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	296.64	P05-27 Bronglais Hospital~~B EXPIRED STOCK BGH
4b Other	298.08	P05-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	335.85	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	358.92	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	371.52	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK

4b Other	393.60	P04-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	403.30	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
4b Other	436.29	P04-27 Withybush Hospital~~W EXPIRED STOCK WGH
4b Other	457.75	P04-27 Bronglais Hospital~~B EXPIRED STOCK BGH
11 EX-GRATIA	500.00	Ex-Gratia - Lost Property
11 EX-GRATIA	510.00	Ex-Gratia - Lost Property
4b Other	645.70	P04-27 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
4b Other	794.40	P04-27 Glangwili Hospital~~G EXPIRED STOCK GGH
4b Other	979.20	P05-27 Aseptics - HDUHB~~Z ASEPTICS EXPIRED STOCK
Sub total	16,506.35	
Total	17,891.52	

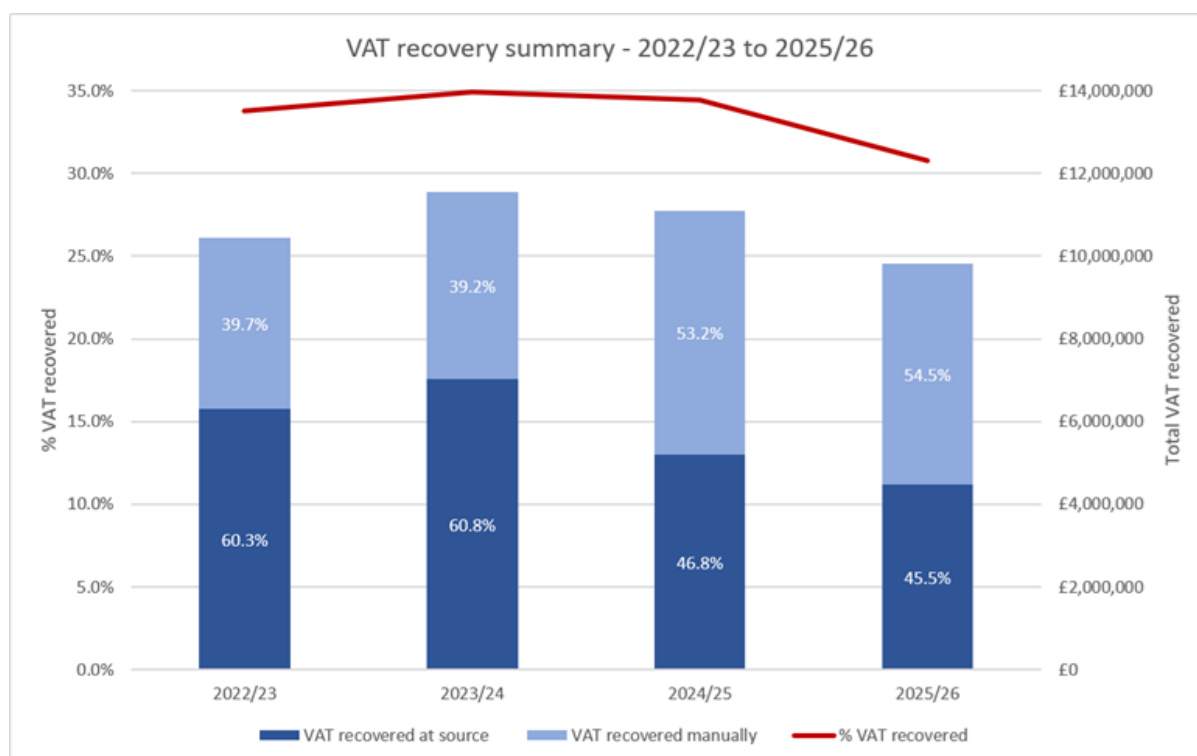
Appendix 4: Compliance with VAT Requirements

Further to the completion of all VAT recovery activities in respect of expenditure incurred in the 2025/26 financial year, Figure 1 summarises the Health Board's performance for the year in respect of the identification of recoverable VAT and compares this with its performance for the previous three financial years.

Total VAT recovered in 2025/26 decreased to £9.8m from £11.1m in 2024/25. VAT recovered as a percentage of VAT incurred similarly decreased to 30.8% in 2025/26 from 34.4% in 2024/25. Driving the above change was a £1.4m reduction from 2024/25 to 2025/26 in the amount of VAT incurred on supplies of agency nurses, in respect of which the VAT incurred is wholly recoverable. This followed a similar £1.4m decrease in VAT incurred on nurse agency expenditure from 2023/24 to 2024/25.

Due to the relatively straightforward VAT recovery criteria which applies to supplies of nurses, all VAT on supplies of nurses is automatically recovered "at source" via the Procure to Pay process (rather than by manual accounting journal). The above reduction in expenditure therefore also drove the small decrease in the overall proportion of VAT recovered at source between 2024/25 and 2025/26. The Health Board continues its joint effort with the Procurement department to increase the proportion of VAT recovered at source over the longer term.

Figure 1: VAT recovery summary 2022/23 to 2025/26



Procurement Act 2023: payment compliance notices for NHS bodies in Wales

Short briefing for Directors of Finance

Purpose

This paper summarises what NHS bodies in Wales must do to meet the new statutory payment reporting requirement and the actions needed before the first publication deadline of **30 October 2026**.

Key requirement

Each NHS body must publish a payment compliance notice every six months where it has made a payment, or a sum has become payable, under a public contract. The first Welsh reporting period ends on **30 September 2026**, and the notice must be published by **30 October 2026**.

Each notice must be approved by the relevant Director of Finance, or equivalent officer, and published through Sell2Wales on the central digital platform. Each NHS body requires a separate notice.

Information to be reported

- the Contracting Authority and reporting period;
- the date the report is being filed;
- the approving Director of Finance, name and job title;
- the average number of days taken to pay invoices;
- the percentage of invoices made within 1–30 days, 31–60 days and 61 days or more;
- proportion of invoices paid in accordance with the term in section 68(2) of the Procurement Act 2023 during the reporting period; and
- Any accompanying narrative required to provide context

Further details are included in the Welsh Government guidance:

[Procurement Act 2023 guidance: Payments compliance notices \[HTML\] | GOV.WALES](#)

Implications for NHS Wales

NWSSP provides Procurement and Accounts Payable services across NHS Wales and can produce the data, confirm contract scope and support publication if required. Each NHS body remains legally responsible for collating, reviewing, approving and publishing its own notice.

Existing PSPP compliance calculations and reporting arrangements vary between NHS bodies. Some adjustments for disputed invoices are recorded in the Oracle Financial Management System (Oracle), while others form part of established local manual adjustment reporting processes.

To support completion of the notices, a payment compliance dashboard has been developed as part of the PSPP dashboard capability within QlikSense. The dashboard can only report data directly from Oracle and will not include any manual adjustments that are undertaken outside of Oracle for PSPP reporting. Data can be extracted from the dashboard to identify which invoices are included within each category of the compliance notice. Where manual adjustments are undertaken by organisations to adjust for disputed invoices to report PSPP compliance, these will also need to be manually adjusted for in the Procurement Act compliance calculation if these are valid disputes. A clear audit trail of all adjustments to system reported compliance will need to be maintained within organisations. Longer-term opportunities to align system settings or payment terms can be considered through the existing governance arrangements after the first submission in October.

Immediate actions

1. **Confirm accountability:** the P2P Senior Oversight Lead provides senior oversight through the existing Purchase to Pay (P2P) governance arrangements; the Accounts Payable Lead leads Accounts Payable delivery; and the Procurement Lead leads Procurement input. Each NHS body needs to confirm its compliance notice contact, approval route and authorised Sell2Wales submitter.
2. **Agree and reconcile the reporting basis:** Organisations need to review the payment compliance requirements and confirm they are content with the definitions and exclusions used within the payment compliance dashboard when reviewing their data. Where Organisations make manual adjustments outside of Oracle for disputed invoices – they must also consider how they will reflect this within the compliance notice, supported by a clear audit trail.
3. **Approve and publish:** Organisations to provide their Directors of Finance with dashboard data and evidence of adjustments (if required) to reconcile back to

the compliance notice to enable approval. Notice to be published through Sell2Wales by 28 October, with 30 October as the statutory deadline.

4. **Review after submission:** consider opportunities for greater all-Wales alignment of methodology, system settings and controls for future reporting periods. This will be undertaken via the All Wales Purchase to Pay Governance Group monthly meetings.

Separate decision: proposed 28-day payment term

Each NHS body is asked to endorse a prospective change to the standard Oracle payment term from 30 to 28 days. This would allow time for payment transmission and reduce the risk that funds reach suppliers after the statutory 30-day period. The change would affect the timing of each body's cash flows and therefore requires its explicit approval. Existing P2P governance should coordinate the proposal, but approval remains with each NHS body. The change should not affect the first reporting-period calculation or delay publication of the first notice.

Indicative implementation timeline from 28 September 2026

Date	Action	Lead / outcome
28 September – 2 October	Request confirmation of agreed leads, approval routes and Sell2Wales access; request approval for the 28-day payment-term proposal to NHS bodies for decision; close the dataset.	P2P Senior Oversight Lead, Accounts Payable Lead, Procurement Lead and NHS body leads. Ownership and P2P oversight confirmed. Approval of 28-day payment term to be confirmed at All Wales P2P Governance Group on 12th October
3–16 October	NWSSP Accounts Payable, Procurement and NHS body leads to review payment compliance dashboard definitions, scope and exclusions and confirm if manual adjustments are required to dashboard reports. Organisations to complete first draft of compliance notice with support from Accounts Payable and Procurement where required	NWSSP and NHS body leads – reporting basis agreed. Agreed figures, narrative and evidence pack.
19–23 October	Complete P2P assurance and obtain Director of Finance approval.	NWSSP and each NHS body. Approved notice ready to publish.

26–28 October	Publish approved notices through Sell2Wales and retain evidence.	Authorised submitters, supported by the Procurement Lead. Publication completed.
29–30 October	Confirm all-Wales completion and escalate any outstanding issue. 30 October is the statutory deadline.	P2P Senior Oversight Lead, Accounts Payable Lead, Procurement Lead and NHS body leads.
By 16 November	Review lessons and agree improvements for the next period.	NWSSP and NHS body representatives. Future process to be discussed and agreed at AWP2P Governance Group on 16 th November.

Assurance and recommendation

Delivery by 30 October is achievable through the agreed approach. The key assurance requirements are complete capture of local adjustments, consistent treatment across NHS bodies, a clear audit trail and sufficient time for review and approval. NWSSP and Health Boards/Trusts/SHAs should use the existing dashboard alongside a documented reconciliation for each body, with progress and exceptions overseen through existing P2P governance. Evidenced returns should reach Directors of Finance in time for approval and publication by 28 October; wider alignment should be considered after submission.

Sources

- [Procurement Act 2023, section 69.](#)
- [Procurement \(Wales\) Regulations 2024, regulation 39.](#)
- [Welsh Government guidance: Payments compliance notices.](#)

6.2

11:55 AM, 10 Mins

6.2 - Counter Fraud Update

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

| For information

Attachments

[Counter Fraud Update ARAC 15 October 2026.pdf](#)

[Counter Fraud Update October 2026.pdf](#)

[Appendix A Audit Wales NFI Privacy Notice.pdf](#)

[Appendix B Thematic Engagement Exercise.pdf](#)



Pwyllgor Archwilio a Sicrwydd Risg/ Audit and Risk Assurance Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	15 October 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Counter Fraud Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Benjamin Rees, Head of Local Counter Fraud Services

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Gwybodaeth/ For Information

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

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

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

Cefndir / Background

Main Report:

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

Asesiad / Assessment

Main Report:

The Health Board is compliant with the Welsh Government Directives.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is invited to **RECEIVE** and **NOTE** the Counter Fraud Update Report and appended items.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.2 In particular, the Committee will review the adequacy of: 3.2.4 the policies and procedures for all work related to fraud and corruption as set out in National Assembly for Wales Directions and as required by the Counter Fraud and Security Management Service.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	3. Effective 4. Efficient
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	Not Applicable
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	10. Not Applicable
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer	Not Applicable

newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing : (complete for strategic change and/or significant service changes)	
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	Not Applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Tegwch Iechyd: Health Equity:	Not Applicable.
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable

Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

HYWEL DDA UNIVERSITY HEALTH BOARD

COUNTER FRAUD UPDATE

Audit and Risk Assurance Committee 15 October 2026

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

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

Overall resource utilisation remains broadly proportionate at this stage of the reporting period, with 211 days recorded against the 440-day annual plan as of 30 September. Activity continues to be balanced across proactive prevention, deterrence and awareness work, alongside reactive investigation activity.

AREA OF ACTIVITY	2026/27 Resource (days)	Resource Used as at 30/09/2026	Resource Used (%) as at 30/09/2026)
PRO-ACTIVE RELATED ACTIVITY	255	119 Days	47%
REACTIVE RELATED ACTIVITY	185	92 Days	49%
TOTAL	440	211 Days	48%

Work Area	Summary of work areas completed
Pro-active related activity	• All new inductees are required to complete the Health Board's induction programme and the Counter Fraud mandatory training e-learning package. • Counter Fraud content was delivered to Nurses by way of presentations on the Medicines Management programme and to new students via Aberystwyth University. • Counter Fraud delivered a fraud awareness session to Royal College of Nursing members at their local AGM. The session outlined the role of the service, how members can help prevent and report fraud, and the risks associated with working multiple jobs, working while on sick leave and failing to submit declarations of interest. The presentation was well received and reinforced the importance of declaring potential conflicts of interest and complying with Health Board policies and procedures. • Counter Fraud currently participates in the quarterly HDdUHB Local Intelligence Network (LIN), where advice is provided on current fraud trends associated with controlled drugs. Where relevant, the team also provides wider advice to raise awareness of fraud risks within the NHS. • October will see the exchange of data between Hywel Dda University Health Board / NHS Wales and the National Fraud Initiative. To that end, relevant privacy notices have been issued to staff via Viva Engage, Payroll Messaging and the Health Boards intranet site. Further details on the initiative can be accessed here: National fraud initiative (NFI). In addition, a copy of the privacy notice issued by Audit Wales has been appended to this report, Appendix A refers. • The department continue to provide regular news bites to staff via the viva engage platform, the most recent highlighting a case where an individual was convicted for an offence of personating a medical professional. • To strengthen controls and reduce the risk of employees working while on sick leave, Counter Fraud has been authorised to review and fraud-proof sickness absence documentation. Proposed amendments will prompt

	employees to declare secondary employment or other relevant interests at the start of an absence. Where a potential conflict is identified, employees will be reminded of their obligations under their contract of employment, where applicable, and the Health Board's Standards of Behaviour Policy. The revised forms are intended to encourage more open and effective dialogue between employees and their supervisors or line managers. - Three proactive exercises have commenced, all of which will focus on procurement and risks associated with: 1 – Procurement conflicts and compliance: Assurance that conflicts of interest are declared and managed, and procurement thresholds, approvals and framework requirements are followed. 2 – Capital assets: Assurance that capital procurement and asset controls protect public funds and assets, with weaknesses or potential fraud escalated appropriately. 3 – Construction frameworks: Assurance that contracts over £25,000 are transparently and properly awarded, distinguishing administrative issues from control failures or potential fraud and corruption. Further information on the exercises has been provided within the in-committee paper.
Reactive related activity	New referrals have been received by the department over the last two months, with significant work undertaken to progress those matters. A detailed report covering all new, existing, and closed investigations has been provided to the Committee separately through the In-Committee report.
Strategic Governance	- Quarterly statistics have been submitted to Counter Fraud Services Wales in accordance with Welsh Government directions. - On 22 January 2026, the NHS Counter Fraud Authority (NHSCFA) conducted an engagement visit with HDdUHB Counter Fraud. NHSCFA representatives met with the Chair of the Audit and Risk Assurance Committee, the Executive Director of Finance, the Director of Corporate Governance/Fraud Champion and the Counter Fraud Team. The visit assessed compliance with the GovS 013 NHS Requirements, explored how NHSCFA and the

Fraud Hub could support the Local Counter Fraud Service and the Health Board, and identified good practice for sharing across the sector. The findings were subsequently reported to relevant stakeholders.

The final report has now been received and shared with the Chair of the Audit and Risk Assurance Committee, the Executive Director of Finance, the Director of Corporate Governance/Fraud Champion and the Counter Fraud Team. The relevant recommendations have been recorded and are being tracked, with the following management response noted:

The Counter Fraud Department welcomes the thematic engagement findings and accepts the recommendations. The first two recommendations have been implemented.

The Local Counter Fraud Service has adopted the Government Counter Fraud Profession fraud risk assessment methodology, providing a consistent, evidence-based approach to identifying, assessing, and managing fraud risk. NHSCFA guidance is now used to plan, undertake and record Local Proactive Exercises. To support this work, both HDdUHB Local Counter Fraud Specialists recently completed a Counter Fraud Authority programme leading to certification as Government Counter Fraud Professionals. The Health Board currently requires completion of the ESR fraud awareness e-learning module on a “one in, one out” basis. However, it will consider reintroducing the module on a three- or five-year revalidation cycle, taking account of organisational training priorities and the need to maintain an appropriate baseline of fraud awareness.

A copy of the final report has been appended to this report, Appendix B refers.

Report Provided by:

Benjamin Rees – Head of Local Counter Fraud Services

For presentation: 15 October 2026.

Report agreed by:

Huw Thomas

Executive Director of Finance

Date issued: June 2020

Data Matching Privacy Notice

This notice tells you about how your personal information is processed in connection with the Auditor General for Wales' data matching exercises, which include participation in the data matching exercises conducted by the National Fraud Initiative (NFI).

The Data

The information to which data matching relates is personal information that you provide when:

- Making a claim or applying for:
 - personal budget/social care
 - pension
 - taxi driver licence
 - market trader licence
 - personal alcohol licence
 - social housing (current tenants and individuals on a housing waiting list)
 - right to buy (completed and in progress)
 - transport pass and permit
 - council tax reduction scheme
 - blue badge
 - state benefits, including universal credit and housing benefit
 - COVID-19 support payments or grants
- Seeking payment of an invoice from an organisation that takes part in the NFI. This is referred to as trade creditor standing and payment history data.
- Seeking payment for employment from an organisation that takes part in the NFI. This is referred to as payroll data.
- Registering to vote. This is referred to as Electoral Register data.

We also process information that you provide in relation to:

- Your council tax.
- Your business rates.
- Residents in a private care home supported by an organisation that takes part in the NFI.

Data specifications providing more information about the data we process in the above areas can be accessed on our website.

Criminal Convictions

If data matching through the NFI results in a prosecution, then this may also be recorded by participating organisations.

Special Categories of Personal Information

Some special categories of personal information (sensitive personal data) are included in the above.

Housing benefit and student loan data includes an indicator of physical or mental health or condition. This disability flag, which does not identify the specific condition, is required as disability has an impact upon a student's entitlement to claim housing benefit.

The personal budget (direct payment) match uses data relating to individuals who have a specified range of social care needs because they have a particular disability.

We collect information on blue badge holders (and applicants). While we do not hold information on the medical condition that entitles the individual to a badge we do know who has a badge.

Where personal data have not been obtained from you, your personal data were obtained by us from participants including local authorities, police forces fire authorities, NHS bodies, the Welsh Government, the Wales Audit Office and some housing associations and Welsh government sponsored bodies.

This notice tells you about how your personal information is processed in connection with the Auditor General for Wales' data matching exercises, which include participation in the data matching exercises conducted by the National Fraud Initiative (NFI).

Purpose

In accordance with statute, the Auditor General for Wales (the Auditor General) conducts data matching exercises to assist in the prevention and detection of fraud.

What is done with your data

Data matching involves comparing sets of data, which includes your data, such as the payroll or benefits records of a body, against other records held by the same or another body to see how far they match. The data matching allows potentially fraudulent claims and payments to be identified. Where a match is found it may indicate that there is an inconsistency that requires further investigation. No assumption can be made as to whether there is fraud, error or other explanation until an investigation is carried out.

All bodies participating in the Auditor General's data matching exercises receive a report of matches that they should investigate, to detect instances of fraud, over- or under-payments and other errors, to take remedial action and update their records accordingly.

This notice tells you about how your personal information is processed in connection with the Auditor General for Wales' data matching exercises, which include participation in the data matching exercises conducted by the National Fraud Initiative (NFI).

Legal Basis of Processing

The processing of data (including special category data) by the Auditor General for Wales in a data matching exercise is carried out under his statutory powers in the Public Audit (Wales) Act 2004. It does not require the consent of the individuals concerned under data protection legislation.

In the case of sensitive personal data, it is processing which is necessary for reasons of substantial public interest for the exercise of a function of the Auditor General.

The legal basis for processing criminal convictions data is paragraphs 6 and 10 of schedule 1 to the Data Protection Act 2018.

Further information about the Auditor General's powers is set out in his Code of Data Matching Practice which is available on our website.

Recipients

Your personal data will be shared by us as necessary for the purposes of preventing and detecting fraud with equivalent audit bodies in Northern Ireland and Scotland, the Cabinet Office in England and the bodies who participate in data matching exercises on a mandatory or voluntary basis, such as local authorities and NHS bodies, central government departments and private sector organisations such as the Insurance Fraud Bureau and credit reference agencies.

Disclosures are made by the Auditor General in accordance with the relevant statutory provisions in sections 64D and 64E of the Public Audit (Wales) Act 2004.

We may share records containing personal data with HMRC. These will be matched against HMRC records and additional HMRC information appended and returned. The HMRC matching will seek to identify persons at the address provided and relevant income related information.

National Fraud Initiative (NFI)

Information about the NFI is set out in **Appendix 1** of the Auditor General's Code of Data Matching Practice which is available on our [website](#).

Retention

Your personal data will be kept by us for the periods set out in our Documents and Records Management Policy, and in relation to the NFI for the periods specified in the Cabinet Office Data deletion Schedule which is available [here](#).

Your Rights

You have the right to request information about how your personal data are processed, and to request a copy of that personal data. You have the right to request that any inaccuracies in your personal data are rectified without delay. You have the right to request that your personal data are erased if there is no longer a justification for them to be processed. You have the right in certain circumstances (for example, where accuracy is contested) to request that the processing of your personal data is restricted.

The processing of your data is necessary for reasons of substantial public interest in the exercise of official authority vested in the Auditor General for Wales and other data matching controllers. You have the right to object to the processing of your personal data on grounds relating to your particular situation. If you object, we must demonstrate compelling legitimate grounds for the processing.

Contact Details

If you wish to discuss any objections or concerns, or obtain a copy of the current personal information held about you, please write to:

Martin Peters

Data Protection Officer

Wales Audit Office

24 Cathedral Road

Cardiff

CF11 9LJ

or by email to: infoofficer@audit.wales

Any questions about data matching exercises should be addressed to:

NFI Co-ordinator

Wales Audit Office

24 Cathedral Road

Cardiff

CF11 9LJ

Or by email to: nfi@audit.wales

The Information Commissioners Office

If you require further information in relation to your rights under data protection law or want to complain about with how we are handling your personal data, you may contact the Information Commissioner at:

Information Commissioner's Office

Wycliffe House

Water Lane

Wilmslow

Cheshire

SK9 5AF

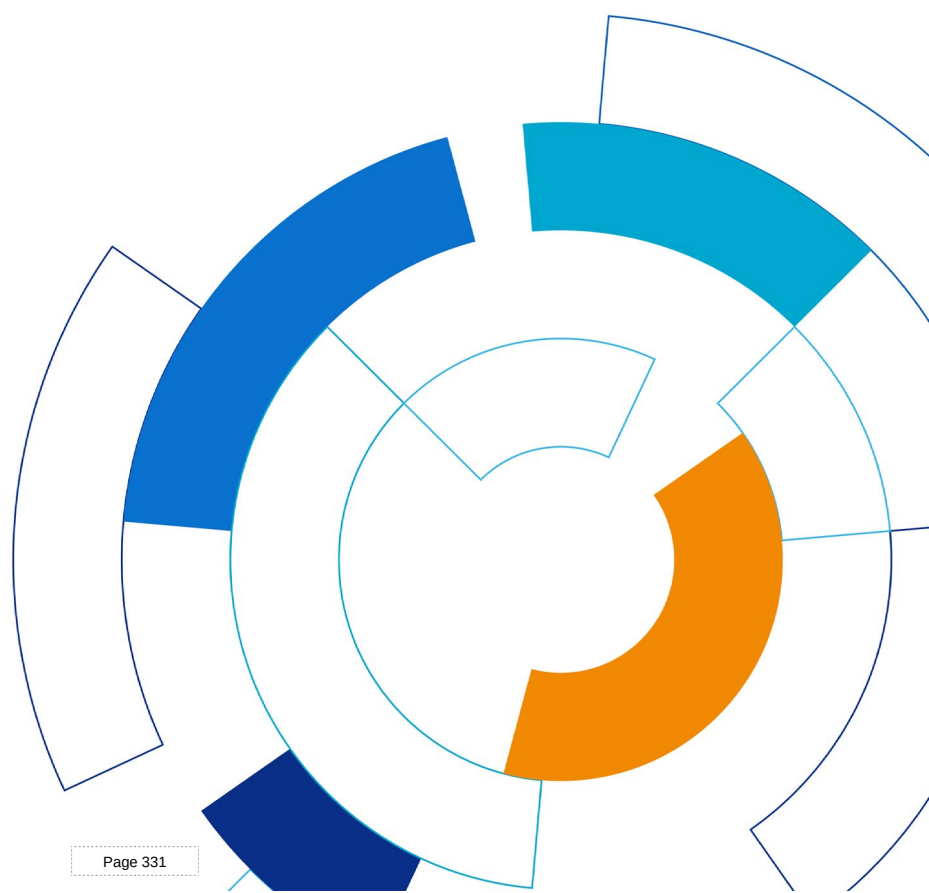
email: casework@ico.gsi.gov.uk

Thematic Engagement Exercise – Hywel Dda University Health Board

August 2026

Version 1.0

**Working together, to find,
report and stop NHS fraud**
Report NHS fraud
0800 028 4060
www.cfa.nhs.uk/reportfraud



Version control

Version	Name	Date	Comment
0.1	Ruth Barker-Jones	July 2026	Initial version
0.2	Fiona McIlwraith	July 2026	Comments
1.0	Ruth Barker-Jones	August 2026	Draft version
2.0	Ruth Barker-Jones	September 2026	Final version

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Executive summary

Background

The NHS Counter Fraud Authority (NHSCFA) is a Special Health Authority, established on 1 November 2017 and charged with identifying, investigating and preventing fraud within the NHS and the wider health group. The NHSCFA is independent from other NHS bodies and is directly accountable to the Department of Health and Social Care.

In Wales, the NHSCFA provides specialist counter fraud support functions to the Welsh Government under section 83 of the Government of Wales Act 2006. On 1st November 2017, a new section 83 arrangement was finalised and signed by both parties following the establishment of the NHSCFA.

Since April 2021, all NHS funded services have been required to provide assurance against the Government Functional Standard GovS 013: Counter Fraud to the DHSC and the Public Sector Fraud Authority. To enable NHS funded services to meet the Government Functional Standard, the NHSCFA released a suite of NHS requirements in January 2021. These requirements provide a detailed description of the necessary counter fraud arrangements and how to meet them to comply with the Functional Standard, and organisations are required to provide an annual statement of compliance with the twelve NHS requirements via an on-line Counter Fraud Functional Standard Return (CFFSR).

In April 2023, the NHSCFA created the Fraud Hub. The purpose of the Fraud Hub is to provide a gateway to a range of support services for the whole counter fraud community working across the NHS and seeking to bring the national and local counter fraud response together to work in partnership. The Fraud Hub consists of four teams. Engagement, Enforcement, Prevention, and the CLUE team. The four teams work independently to support LCFS with specific requirements and are also able collaborate to support LCFSs and organisations in delivering a comprehensive counter fraud service and achieving outcomes. The learning academy has also recently been created within the Fraud Hub, but at the time of publishing this report is in the process of being established.

The Fraud Hub Engagement team developed a workstream to actively support some of the largest health bodies based on the size of annual budget and resulting inherent risk. The aim of this programme of work was to offer health bodies and LCFSs the opportunity to collaborate with the Fraud Hub and wider NHSCFA to use its resources to develop existing working practices where necessary and share good practice identified.

The purpose of the workstream and engagement visits is to explore where the Fraud Hub can collaborate to better support ongoing counter fraud work, within the organisation and across the sector. Organisations were selected for this engagement based on meeting budgetary criteria and not yet receiving an engagement visit.

Summary of Findings

We would like to thank Hywel Dda University Health Board (the organisation) for their hospitality and professionalism during this exercise. Ruth Barker-Jones and Gareth Williams, Senior Fraud Hub Engagement Officers visited the organisation on 22nd January 2026.

During the engagement visit, we spoke with Ben Rees as the Head of Local Counter Fraud Services and LCFS Terry Slater, as well as Huw Thomas as Executive Director of Finance (DoF) and Rhodri Evans as Audit Committee Chair (ACC), and Director of Corporate Governance and nominated Counter Fraud Champion (CFC) Joanne (Jo) Wilson.

The nature of the visit was to establish how NHSCFA, with the resources available, can support the LCFS and organisation's approach to counter fraud, with consideration to the fraud risks associated with a significant budget, in excess of £1 billion. It was also an opportunity to identify good practice at the organisation, which the NHSCFA can publicise to support other LCFSs and organisations across the sector in their continued work to counter fraud.

In advance of the visit, we reviewed data available to us through documentation shared by Ben, information as submitted in the most recent Counter Fraud Functional Standard Return and data contained within the NHSCFA approved case management system, Clue.

Ben advised of considerable support for counter fraud within the organisation, including good working relationships with all key individuals and contacts, benefitting all elements of counter fraud work. Positive relationships with the nominated individuals were noted, as well as finance and HR teams. In particular, Jo's counter fraud experience is clearly invaluable in her ability to effectively support the counter fraud team.

As part of the engagement visit, we considered fraud risk assessments (FRAs), system weakness reporting (SWRs) and proactive work carried out at the organisation, starting with FRAs and specifically how they underpin and inform the local proactive work carried out. We discussed the organisation's approach to counter fraud as increasingly and encouragingly proactive in nature, focussing on identifying weaknesses that enable fraud, improving controls and reducing opportunities for fraud to be committed.

We discussed the organisation's perceived fraud risks and fraud risk assessment (FRA) work in detail, with Ben demonstrated to us the system on which fraud risks are recorded and monitored for the organisation, which appears ideal for the purpose.

Ben raised the possibility of recording risks and associated FRAs on Clue as LPEs, with a view to the risk remaining open long-term as actions develop, to enable a record and long term monitoring of actions taken and resulting outcomes. Whilst action taken to reduce or mitigate a risk is likely to be appropriate for recording as an LPE on Clue, it is not recommended for this to remain open indefinitely, but rather scoped out as a defined

exercise based on the risk's current assessed position at the commencement of the activity and closed once the exercise is concluded.

There would be benefit in reviewing the LPE guidance published by NHSCFA to support LPE work and the FRA guidance shared and discussed at the workshop Ben attended in April to ensure the two are appropriately linked but distinct.

We discussed the variety of mechanisms in place to support fraud awareness in the organisation, from e-learning and targeted training to a social media style communication platform called Viva Engage, demonstrating means to communicate with staff at all levels. We also discussed that whilst the e-learning module is mandatory for all staff, it is not currently agreed as ongoing training. We recognise the challenges of the time required to complete mandatory training; however, this is a very effective tool to deliver and maintain a baseline of awareness for staff and as such, it is recommended that further consideration is given to establishing the ESR fraud awareness e-learning module as recurrent training.

The organisation's desire to develop its counter fraud resource was clear, with interest to expand into data analytics opportunities. This could be an excellent opportunity to design the counter fraud team for resilience in the future, and findings from NHSCFA's Project Athena and Project Wise would be a useful resource as it develops.

Next Steps

The NHSCFA shares this report with the organisation and LCFS with the expectation that the recommendations made for the organisation will be used to develop an action plan for implementation. The action plan should be presented to Audit Committee with progress against the action plan subject to monitoring by the Audit Committee until all actions have been fully implemented.

The NHSCFA will assist and continue to provide support to organisations as required to drive up standards and reduce the risk of fraud occurring and can be contacted directly for support in implementing the action plan resulting from this report.

Purpose

The purpose of the engagement visit was to explore how NHSCFA, with the resources available, can support the LCFS and in turn the organisation. The engagement was also an exercise to identify any barriers to conducting effective counter fraud work.

The aim of this workstream is to collaborate to identify potential opportunities to achieve improved outcomes as well as supporting the ongoing work being conducted.

It was also an opportunity to identify good practice at the organisation, which the NHSCFA can publicise to support other LCFSs and organisations across the sector in their continued work to counter fraud.

Methodology

Scope / Out of Scope

The selection of organisations for the purposes of this engagement were based on risk analysis from the data recorded on Clue (approved NHS case management system) and the CFFSR data return for 23/24 and 24/25, focussing on organisations within Wales with a budget exceeding £1 billion.

Organisations were selected for this engagement based on meeting budgetary criteria and not yet having received an engagement visit.

Organisation Overview

Hywel Dda University Health Board is responsible for planning and providing NHS services for almost 385,000 people across Carmarthenshire, Ceredigion and Pembrokeshire.

The organisation employs over 13,000 staff, delivering primary, community, acute, mental health and learning disability services.

The counter fraud service is provided by LCFS directly employed by the organisation. At the time of reporting, the counter fraud service consisted of Ben Rees as the Head of Local Counter Fraud Services, supported by LCFS Terry Slater.

Stakeholder Findings

On Thursday 22nd January, Ruth Barker-Jones and Gareth Williams, Senior Fraud Hub Engagement Officers, visited Hywel Dda University Health Board and met with Ben Rees as the Head of Local Counter Fraud Services and LCFS Terry Slater. We then met with Huw Thomas as Executive Director of Finance (DoF) and Rhodri Evans as Audit Committee Chair (ACC), as well as Director of Corporate Governance and nominated Counter Fraud Champion (CFC) Joanne Wilson.

In advance of the visit, documentation including the organisation's fraud risk assessments (FRAs), counter fraud work plan, annual report and progress reports were requested to enable review to support meaningful discussions during the visit. We also reviewed data submitted in the most recent Counter Fraud Functional Standard Return and contained within the approved case management system, Clue.

We first met with Ben and Terry to gain an understanding of the organisation's current counter fraud position and LCFS resource.

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Ben advised of considerable support for counter fraud in-house, including good working relationships with all key individuals and contacts. The counter fraud team is particularly well embedded with the finance team as, at the time of the visit, their office was based in the same building as finance, which has facilitated invitations to attend and present at finance events to raise awareness. Plans were in motion to move the team into a new building alongside all admin staff, which it is anticipated will further develop relationships with those teams.

We discussed the organisation's perceived fraud risks and fraud risk assessment (FRA) work in detail, with Ben demonstrated to us the system on which fraud risks are recorded and monitored for the organisation. The system facilitates the assigning of risk owners, facilitating monitoring of individual risks and any actions tasked as a result of LPE activity. Ben further advised that risk owner actions are also subject to monitoring by audit committee.

Ben raised the possibility of recording risks and associated FRAs on Clue as LPEs, with a view to the risk remaining open long-term as actions develop, to enable a record and long term monitoring of actions taken and resulting outcomes. Whilst action taken to reduce or mitigate a risk is likely to be appropriate for recording as an LPE on Clue, it is not recommended for this to remain open indefinitely, but rather scoped out as a defined exercise based on the risk's current assessed position at the commencement of the activity and closed once the exercise is concluded.

There would be benefit in reviewing the LPE guidance published by NHSCFA [Guidance for planning, designing, and conducting Local Proactive Exercises](#) to support LPE work and ensure it is informed by but distinct from FRAs.

A workshop on fraud risk was held following the visit, led by the NHSCFA's fraud risk lead and hosted by the Wales CFS, to support with LCFS knowledge and understanding of the FRA process as it develops within the organisation and was attended by Ben and will be valuable to consider as the FRA develops.

In respect of recording fraud risks and FRAs, the most appropriate approach is to follow the organisation's own fraud risk management policy, using established risk management systems and assigning risk owners responsible for the relevant areas to monitor their own risks. The risk system Ben showed us is ideal for this purpose, and it would not be necessary to duplicate the recording of those risks on Clue, particularly as the risk owners would not have access to view them.

We discussed fraud awareness arrangements in the organisation, with Ben advising that whilst the ESR fraud awareness e-learning module is in use and set up as mandatory training, there is currently no requirement for the training to be renewed. Ben advised it was initially set up to require renewal every three years, but as the training is not frequently updated, it was ultimately decided that the training would remain mandatory but no longer require renewal.

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We recognise the challenges of the time required to complete recurring mandatory training; however, this is a very effective tool to maintain a baseline of awareness for staff in a position to identify and report instances of fraud, which is only possible if they're able to understand and recognise it as such. It is recommended that further consideration is given to establishing the ESR fraud awareness e-learning module as ongoing rather than one-off mandatory training.

To mitigate the risk of employees' knowledge and awareness diminishing over time, Ben advised awareness sessions are regularly provided to a range of working groups. The sessions are often also a recommendation following the closure of a case, as a future deterrent measure. In addition, the organisation also uses a social media style communication platform called Viva Engage to support with raising fraud awareness with staff through news briefings, with Ben reporting good levels of interaction. This is beneficial as a supporting means of communicating counter fraud messaging but is not an alternative for ongoing, organisation-wide, training.

Ben further advised he has arranged for some specific training on immigration through the Home Office, bringing the identification of a gap in knowledge following a concern together with a relevant contact from a presentation at an LCFS forum organised by the CFS Wales. Targeted training in high fraud risk areas, particularly where concerns have been identified, is a valuable tool to improve awareness and manage fraud risks.

Ben raised an issue with Wales data not being shared in Clue, for example, where a subject is investigated elsewhere in Wales and a joint investigation might be appropriate. This is not an uncommon occurrence with neighbouring health boards and Ben understands Welsh Government Directions means Wales-wide data sharing agreements are already in place but not enacted through Clue. We agreed to make enquiries on this and established there are limitations with the parameters within Clue that make this more complex than it appears. As the CFS Wales has oversight of all investigations, they are in a position to identify and link investigations with the same subject.

We discussed the good relationship between the counter fraud and workforce teams, comprising monthly meetings, regular communication and advice requests, as well as arrangements for use of HR meeting rooms to conduct interviews under caution (IUCs). This relationship has been developed over time, moving away from the HR team screening concerns and commencing internal investigations before referral to the counter fraud team, so it is encouraging to learn communication has improved substantially and investigations now commence in parallel.

We also discussed the working relationship with Huw, which Ben advised was positive, with Huw very receptive to counter fraud. Occasionally, Huw receives referrals directly, which are passed to Ben. Huw has also supported the team in escalating issues of non-response to actions across the organisation and externally, for example, chasing up data access requests. Ben is assured of further escalation opportunities through audit committee, where necessary.

OFFICIAL

Additionally, Ben advised Jo is very supportive in her role as CFC, facilitating challenging discussions or contentious issues where this might be beneficial. Jo has previously worked as an LCFS and therefore has an operational understanding of some of the challenges an LCFS faces, which is advantageous in her role as CFC.

Ben's role of Head of Local Counter Fraud Services is line managed by the Assistant Director of Finance, who whilst outside of the formal nominated counter fraud roles, Ben advises is supportive and agreeable to assist as required.

We considered the organisation's counter fraud resource, which Ben is broadly satisfied is adequate; however, advised there is discussion around the potential of recruiting a band 5 local counter fraud technician with a data analytics focus. Huw has an interest in this area and is keen to develop data analytics capacity to advance counter fraud activity within the organisation.

As we concluded our discussions, Ben and Terry offered positive feedback on the programme of webinars and drop-in sessions co-ordinated by the NHSCFA's Fraud Hub, in terms of frequency and content covered. This feedback is very helpful and will assist us to ensure the programme remains relevant and valuable to the LCFS community.

We then met with Jo Wilson, who provided more detail of her previous roles as an LCFS in England and for NHS England. It was clear this background in counter fraud has made Jo a valuable asset in supporting the counter fraud team.

Specifically, Jo discussed a fraud referral received against Huw, alleging preferential treatment of a patient, which could have been contentious. As CFC, Jo supported Ben to pursue, specifically by providing an alternative reporting route given the conflict in normal reporting arrangements and the position of influence of the subject. Jo confirmed that following enquiries undertaken, no further action was required but commented on Huw's openness with regard to the allegation. Jo's experience and support during this investigation was clearly of significant value to Ben.

Jo also advised she has supported Ben with action in response to some immigration concerns, which resulted in arranging for a contact from the Home Office contact to present to improve awareness and understanding around this risk area.

We then discussed the organisation's support for counter fraud, with Jo advising counter fraud access to non-executives is well established, with annual, scheduled meetings without inviting officers. This follows the process required by many of the organisation's regulators and is valued by both audit committee members and the counter fraud team, as an opportunity to discuss activity and performance. Through these meetings, audit committee have requested the introduction of an action tracking mechanism to support with completion of agreed counter fraud actions, which has been beneficial as it facilitates follow up action where necessary.

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Overall, Jo provided positive feedback for Ben and Terry as the organisation's counter fraud team, specifically stating both are agreeable to change to achieve desired outcomes, for example through softening language used in letters relating to fraud investigations and related communications, to ensure they are more personable rather than distressing for recipients.

We then met with Huw and Rhodri, who elaborated further on the selection process that resulted in Jo taking on the role of CFC. In addition to Jo's experience with counter fraud, the organisation undertook a True North exercise, to better understand their position from an ethical, whistleblowing and raising concerns perspective, which identified Jo as a good fit for this role.

We discussed the organisation, with Huw describing the complexities of providing all elements of primary and secondary care, as well as challenges stemming from the geographical area, which is significant and covers a large and remote area, which increases risks in terms of reduced control. Rhodri added the organisation has numerous challenges and risks in respect of counter fraud, but he is satisfied the Ben approaches and manages these appropriately.

Rhodri advised he attends meetings of audit committee chairs across Wales and recognises national and local fraud trends discussed. Ben's position as the counter fraud lead is elevated by establishing regular discussion with the ACC, not restricted to audit committee meetings. Both Huw and Rhodri confirmed they are confident and willing to challenge, where needed.

Rhodri also discussed his view of the organisation against his experience with local government, commenting on the comparative transparency within the organisation, which he views as very positive. This is supported by mechanisms within the organisation that contribute to the counter fraud position, such as mandatory declarations of interest for high risk teams and training for all independent members.

Huw discussed his awareness with the review of LCFS arrangements in Wales, and the potential drive for regional joint working. At present, there seems little development or change and as such, it is not possible to propose action until more information is shared.

Huw also raised concern about the length of time taken for investigations undertaken by CFS Wales to conclude. Delays with investigations submitted to CPS is a common issue and NHSCFA is in communication with CPS to establish opportunities to minimise delays where possible.

We discussed the annual self-assessment against the NHS Requirements, the CFFSR, with Huw and Rhodri confirming they do not feel the need for all requirements to be rated green. Instead, they are satisfied to use amber or red ratings as a development opportunity, where this is more appropriate. This is an excellent approach as it drives improvement where areas for improvement are identified.

Huw raised the possibility of sharing examples of good practice linked to the requirements. Unfortunately, it is not possible to share full, prescriptive, examples of what good would look like, as this varies significantly between organisations based on local risks and local factors that contribute to their overall counter fraud position, and as such, what constitutes good in one organisation may not be good in another. Where practical, we share findings that contribute to good performance and may be replicable elsewhere in sector reports and articles on Ngage or in the monthly bulletin, and we recommend review of this content to identify opportunities for the organisation to develop its counter fraud position further.

Huw advised his responsibilities include the internal data analytics team and he would be interested to explore opportunities to develop this further for counter fraud, particularly regarding workers across neighbouring organisations, a common theme of investigations. NHSCFA's findings from Project Athena and Project Wise may be a good starting point to explore possibilities and support this development.

Recommendations

We make the following recommendations based upon the discussions that took place on 22nd January 2026.

- The LCFS should use the guidance shared in the FRA workshop April 2026 as an opportunity to direct the development of FRAs in the organisation to align with Government Counter Fraud Profession's FRA methodology and guidance. Any questions or requests for support with FRAs can be directed to strategicfraudrisk@nhscfa.gov.uk.
- The organisation should utilise LPE guidance that was published by NHSCFA - [Guidance for planning, designing, and conducting Local Proactive Exercises](#).
- The organisation should give further consideration to introducing the ESR fraud awareness e-learning module as recurrent mandatory training, as an effective means to maintain a baseline of fraud awareness across the organisation.

The recommendations made in this report are some of the opportunities that presented themselves in our initial conversation on the day of NHSCFA's visit. This list is not exhaustive, and over the course of the partnership work of the next 12 months, more opportunities to refine and improve counter fraud measures may present themselves to which we will adapt.

Links to the NHSCFA external reporting suite

ACC / DoF Link - <https://sway.cloud.microsoft/mPrJBPIWesJOidNk?ref=Link>

OFFICIAL

LCFS / CFC Link - <https://sway.cloud.microsoft/LBSHk6PLQWGUg7Xs?ref=Link>

The NHSCFA can be contacted directly for support in implementing the action plan resulting from this report through fraudhub@nhscfa.gov.uk.

7 - Assurance and Risk

7.1

12:05 PM, 10 Mins

7.1 - External Recommendations and Welsh Health Circulars Assurance Report

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

| For assurance

Attachments

[External Recommendations and WHC Assurance Report ARAC 15 October 2026.pdf](#)



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EXTERNAL RECOMMENDATIONS AND WELSH HEALTH CIRCULARS ASSURANCE REPORT

Audit and Risk Assurance Committee

15 October 2026

Situation and Background



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This report aims to provide assurance to the Audit and Risk Assurance Committee (ARAC) on the effectiveness of processes in place across the Health Board to track the progress made to implement recommendations identified by auditors, inspectorates and regulators, and implement Welsh Health Circulars (WHCs) issued by Welsh Government. This is in line with the requirements contained within the Committee's Terms of Reference which state:

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

The Health Board remains in Level 4 status with Welsh Government as a result of challenges relating to financial sustainability, strategy and planning, service delivery and organisational performance. Whilst the Health Board has been de-escalated for 'Leadership and Governance' from Level 3 to Level 1, the Health Board is required to meet the following revised criteria which relate to compliance with external recommendations from auditors, inspectorates and regulators:

- Financial controls at the health board that are robust in both design and implementation, including a self-assessment against model frameworks, review implementation of the Standing Financial Instructions, internal audit reviews, or other control reviews;
- Evidence that all recommendations from the Royal Colleges, Health Inspectorate Wales (HIW) and other reviews specific to Hywel Dda University Health Board (HDdUHB) are discharged and either verified or delivered or scheduled for delivery within the Health Board's longer-term improvement plan;
- Support the implementation and realisation of *Getting It Right First Time* (GIRFT) and the national programme reviews opportunities;
- Support the implementation and realisation of the 'Three Ps' policy, GIRFT, theatre optimisation, Clinical Implementation Networks (CIN) optimisation programmes and related national improvement recommendations; and
- Develop a prompt response to any HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.

Progress since the previous report to ARAC

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

Next Steps	Progress Made
To agree audit and inspection ‘PowerBI’ dashboard specification with the Performance Team, to enable this to be built by August 2026.	The Audit and Inspection Power BI dashboard specification has been finalised, and received stakeholder sign-off from the Quality, Assurance and Safety (QAST) and Health and Safety Teams. An agreed project plan is in place, with publication expected in November 2026.
Following the Chief Operating Officer being informed of the possible escalation by ARAC, Assurance and Risk business partner to meet Community and Integrated Medicine CCG Director on 10 June 2026 to agree a plan to ensure all management responses are added to the Audit Management and Tracking (AMaT) system by the end of June 2026, and to support improvement in the number of recommendations overdue by more 6 months, and the number of recommendations without revised implementation dates.	The Assurance and Risk business partner meets with the Clinical Care Group (CCG) Triumvirate team, together with each integrated system monthly to support improvement of quality of updates on AMaT, including revised dates where appropriate. The Community and Integrated Medicine CCG provided an update to ARAC on progress in addressing audit and inspection recommendations at its meeting in August 2026. It was agreed that management responses and completion dates would be agreed for those reports outstanding within a month, as well as an improvement in the review of recommendations to identify those which may already have been completed, are duplicated, or are not achievable as currently written. A progress is provided on Slide 13 relating to the current performance of the CCG.

Audits and Inspections Summary



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139

Total open reports

April 142 | ▼ 3

1,478

Total recommendations

April 1,404 | ▲ 74

68

Overdue reports

April 50 | ▲ 18

231

Overdue recommendations

April 174 | ▲ 57

30

New reports received

since previous meeting

18

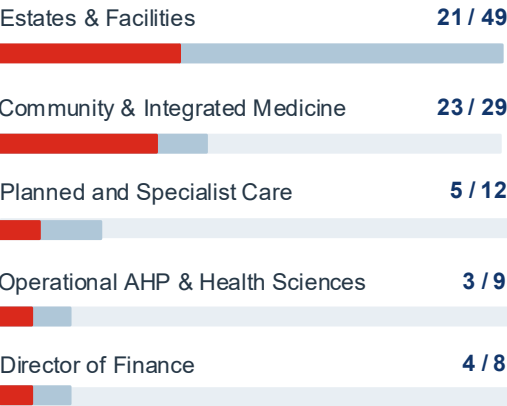
Reports closed

since previous meeting

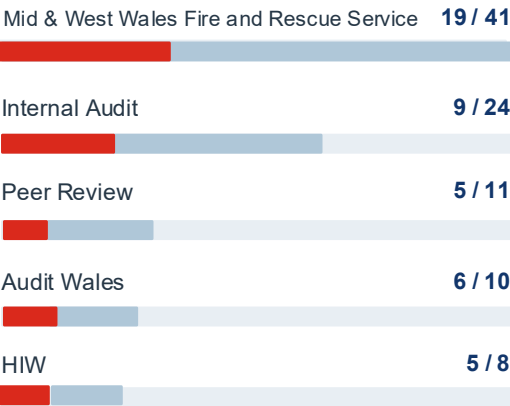
Largest Open Report Profiles (Top 5 CCGs / Functions)

Total open reports Overdue

Care groups / functions



Reviewing bodies



Reports considered overdue as they have one or more overdue recommendations / total open reports.

Recurring recommendation themes include **operational performance, service transformation, fire safety, workforce capacity, digital resilience** and **quality assurance**.

Over half of all open recommendations relate to **long-term improvements** such as **service re-design, infrastructure programmes, digital developments, workforce challenges** and **fire safety schemes** and require additional **funding, capacity** and **wider organisational change programmes**. Implementation can therefore take several years rather than months, highlighting the need to provide realistic timescales for implementation and challenging unachievable recommendations on receipt of new reports, and to provide realistic revised completion dates where original dates have lapsed.

The growing number of aged recommendations indicates the **organisational capacity to deliver change remains a key challenge**. Overdue recommendations are concentrated within specific functions, suggesting that some areas face difficulties in translating planned actions into sustainable implementation within noted timescales.

Recommendations may be reported as overdue where management responses, progress updates, or supporting evidence have not been provided. This can result in actions appearing outstanding despite potential progress having been made. Discussions with service leads indicate that some recommendations may have progressed further than is reflected within AMaT; however, progress cannot be verified until management responses and supporting evidence are provided. Work is currently underway to review the definitions of overdue, external and unable to complete and underpinning processes to ensure their appropriate oversight, detail of which will be provided to ARAC in February 2027.

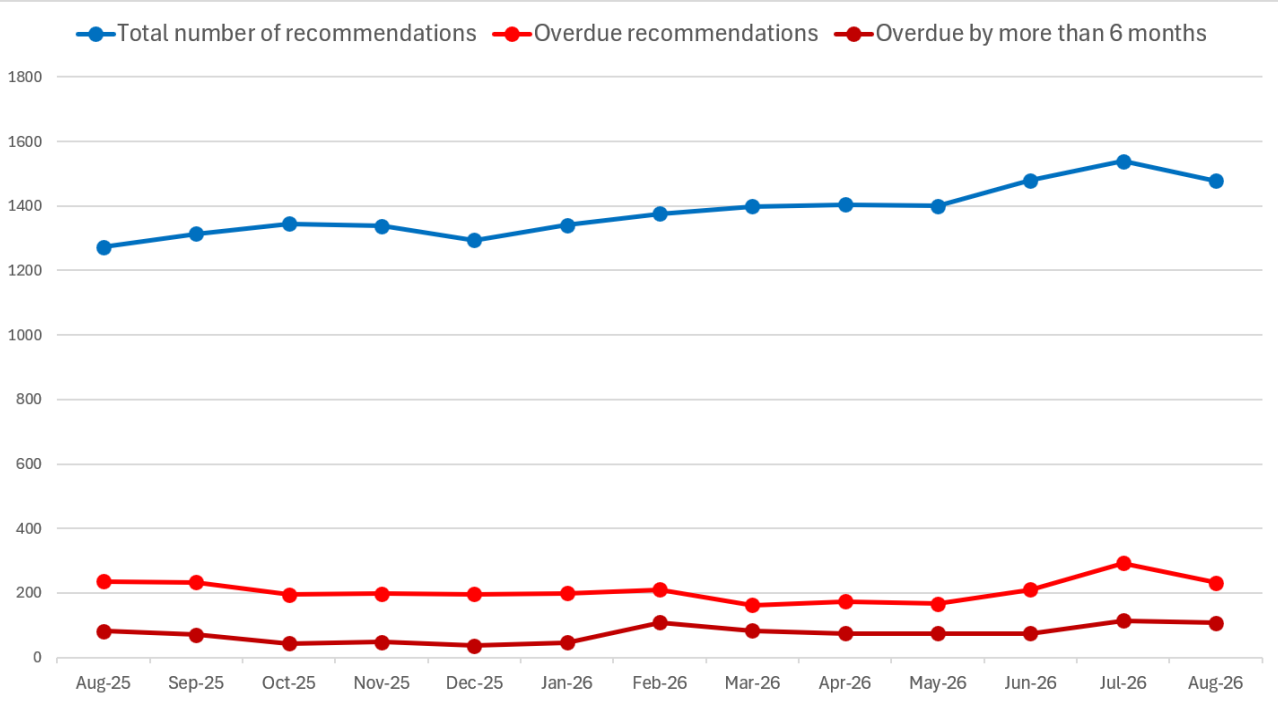
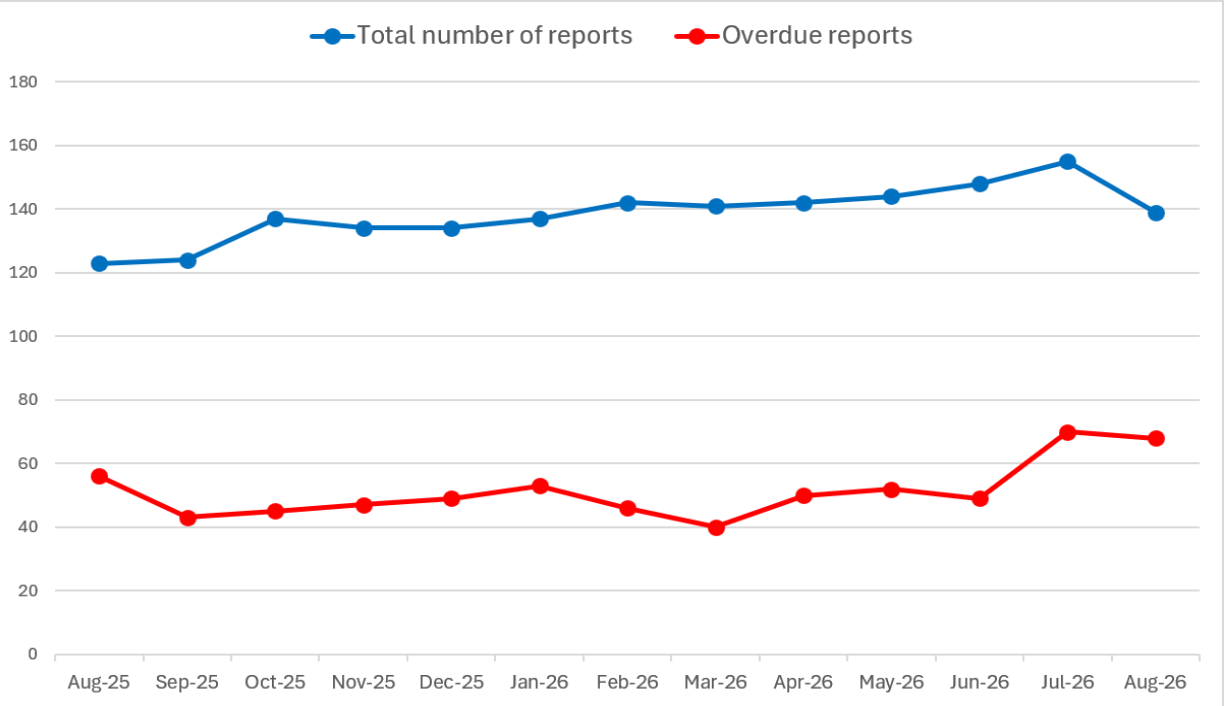
The Assurance and Risk Team continue to provide support via CCG/Clinical Service Groups (CSG)/Executive Functions reporting arrangements and AMaT system training, and the system sends weekly updates to recommendation owners.

Performance of reports and recommendations: Previous 12 months



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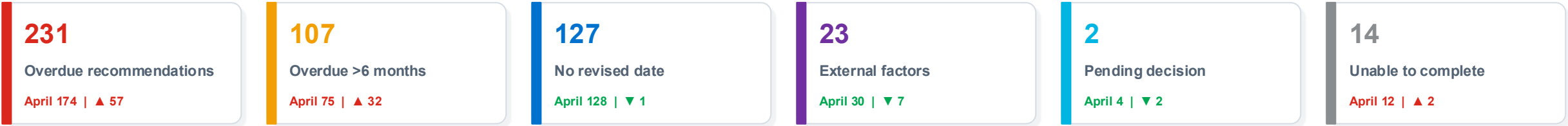


Analysis

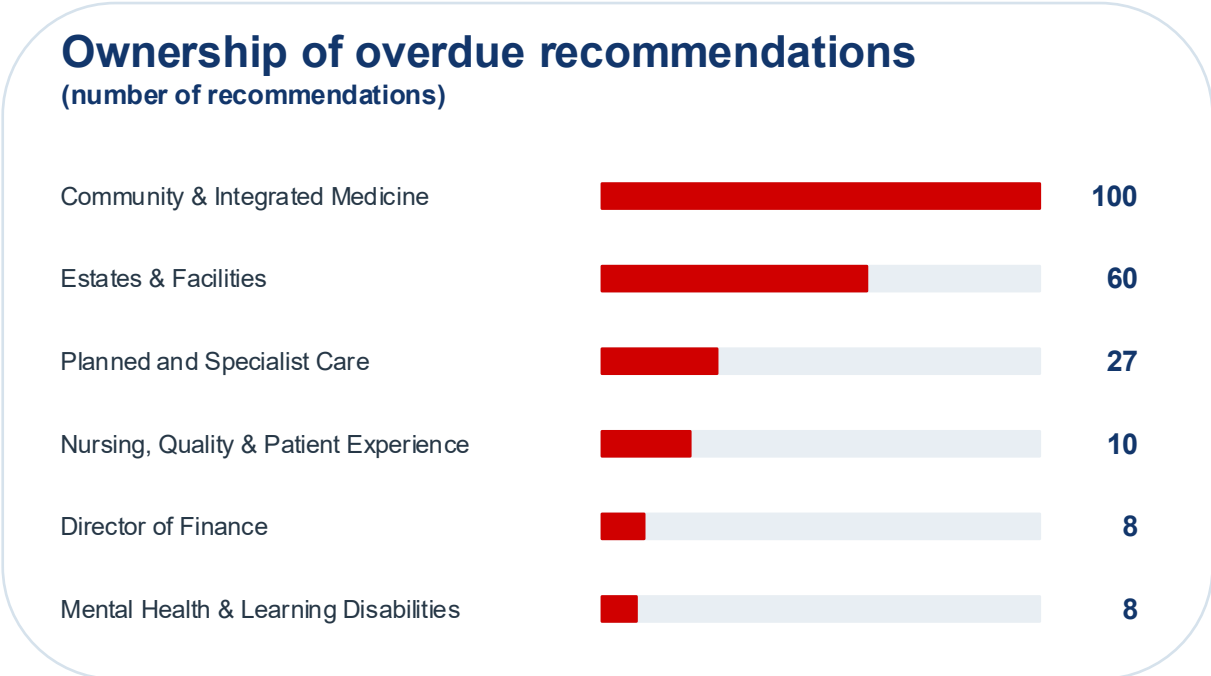
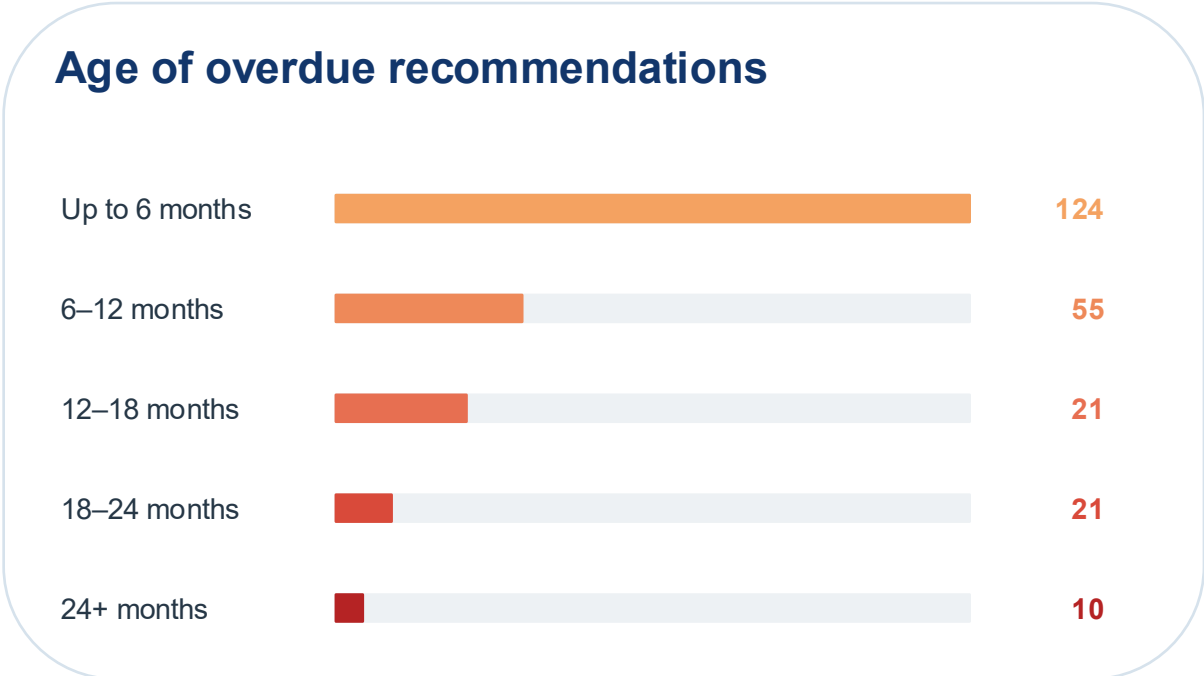
The number of open reports has increased over the previous 12 months, accompanied by a rise in both overdue reports and overdue recommendations. The proportion of open reports classified as overdue has increased from 35% to 49%, reflecting growing challenges in maintaining recommendations within agreed timescales. This trend aligns with concerns previously raised by ARAC and may reflect a combination of implementation pressures, delays in evidencing and recording progress, ambitious implementation dates, and the continued receipt of follow-up reviews and recurring recommendations across multiple services.

Continued management focus will be required to support timely implementation and strengthen the level of assurance to Committees and the Board.

Recommendations Analysis



Definitions of these categories can be found in [Appendix 1](#)



Common barriers to the implementation of recommendations

Progress against recommendations continue to be affected by **workforce capacity**, **funding/capital dependencies**, and **external factors** outside the Health Board's direct control, such as the implementation of national digital systems, or guidance from external bodies. Of the 231 overdue recommendations, 127 (55%) do not have a revised timescale for implementation. Governance and administrative factors, including **outstanding management responses and evidence of completion**, account for over 17% of overdue recommendations and are likely to have the biggest impact on improving the current overdue position. Work is currently underway to strengthen the processes around those recommendations noted as “Unable To Complete” to further support the Health Board's ability to obtain assurance on their delivery and identify barriers to completion, including a review of the category definition and the processes to escalate appropriately via operational governance arrangements.

Recommendations Analysis



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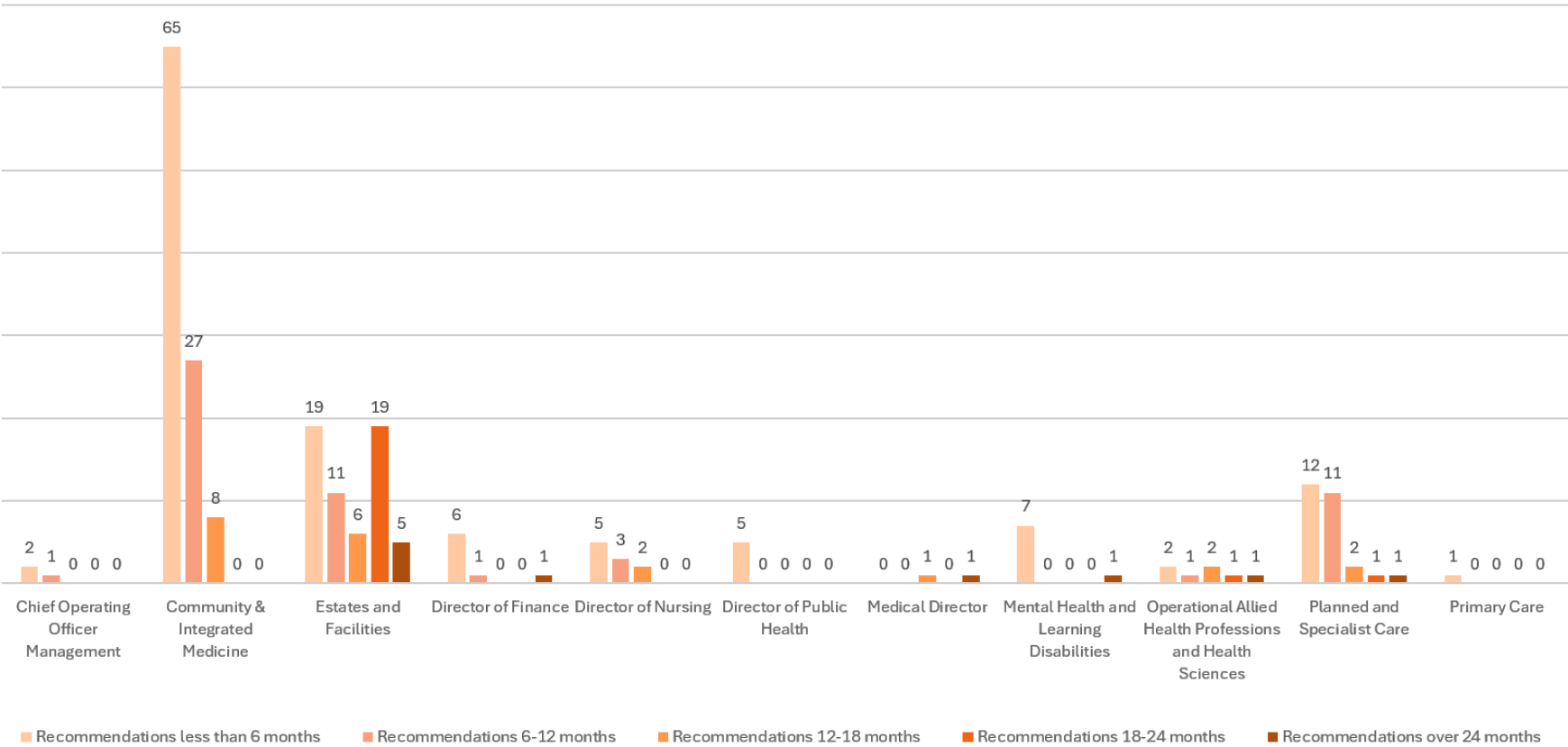
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The profile of overdue recommendations suggests that several long-standing actions relate to **estate infrastructure, fire safety compliance, building configuration and capital investment requirements**. This indicates that some of the most complex and difficult recommendations facing the Health Board are associated with the **condition, suitability and adaptability** of the estates infrastructure, which require external capital funding.

Enhanced oversight arrangements have been introduced within Estates and Facilities, including an agreed one-month deadline for the submission of outstanding documentary evidence. This provides assurance that overdue Letters of Fire Safety Matters (LOFSM) recommendations are being actively managed and that clear actions are in place to address barriers to closure. Subject to evidence being validated, this is expected to support a reduction in overdue recommendations over the coming months.

Community and Integrated Medicine (CIM) continue to hold the largest volume of overdue recommendations (100), of which 41 are overdue due to management responses and implementation plans not yet being fully developed, particularly in relation to urgent and emergency care reviews. **Workforce capacity, recruitment challenges, system-wide dependencies with partner organisations, and the complexity of urgent and emergency care transformation programmes** represent the most common barriers to completion. Further detail on overdue recommendations aligned to CIM is provided on Slide 13.

Overdue recommendations split per Clinical Care Group/Executive Function



Audits and Inspections: Exceptions Analysis – Recommendations

External Recommendations

23

The recommendation is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.

23 recommendations depend on actions outside the Health Board’s direct control, with the largest concentrations as follows:

- Estates and Facilities: 7
- Planned and Specialist Care: 5
- Medical Director: 4
- Mental Health and Learning Disabilities: 3

Common external factors include national policy development, reliance on Welsh Government or HEIW-led programmes, regional service transformation initiatives, digital interoperability solutions, and capital funding approvals. Estates and Facilities accounts for the largest concentration of actions reliant on external factors, reflecting the extent to which progress is dependent on capital investment, infrastructure programmes, external approvals and contractor-led activity.

Next steps:

- Remind services to document external factors, and to continually review and update should external factors change, and progress via appropriate escalation routes
- Review definition and strengthen underpinning processes to escalate recommendations noted as External (where appropriate).

Pending Decision

2

The recommendation is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the recommendation is overdue or not whilst decision pending.

2 recommendations are awaiting a decision before implementation can progress.

Current ownership:

- Community and Integrated Medicine: 1
- Strategy and Planning: 1

Since data was extracted for this report, the recommendation aligned to Strategy and Planning has been noted as "Unable to Complete" and progressed for formal closure by the Executive lead.

Additionally, the status of the recommendation aligned to Community and Integrated Medicine has been amended to “overdue” since data extraction, with evidence being collated to support the closure the recommendation.

Next step:

- Review definition and strengthen underpinning processes to escalate recommendations noted as pending decision

Unable to Complete

14

The recommendation cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.

14 recommendations can no longer be delivered as per the action described in their original management response, with the largest concentrations as follows:

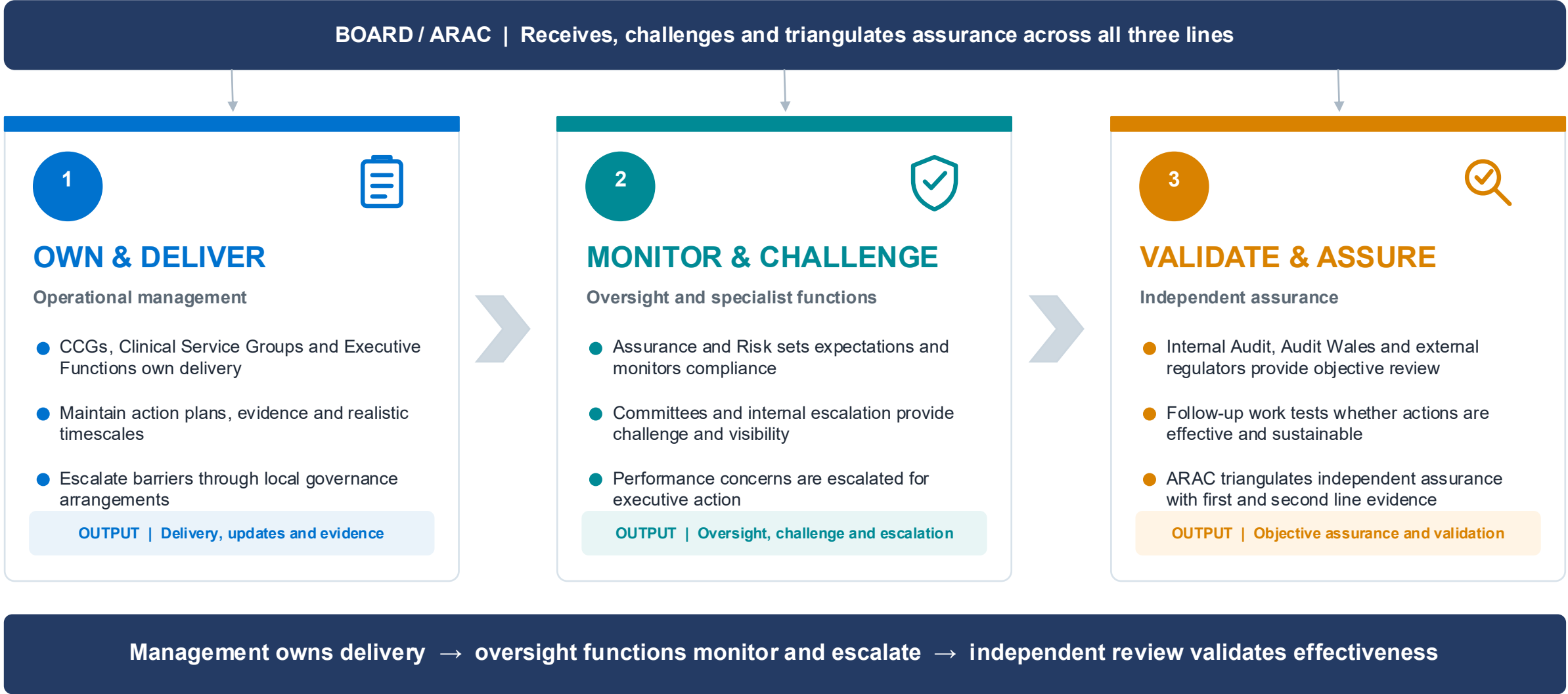
- Primary Care: 4
- Estates and Facilities: 3
- Planned and Specialist Care: 3

Common reasons cited as barriers include **capital funding constraints**, dependency on national programmes and external organisations, **workforce capacity** and **recruitment challenges**, and **reliance on wider service redesign programmes**.

Next steps:

- Document the barriers and associated risk and progress via appropriate escalation and approval route.
- Review definition and strengthen underpinning processes to escalate recommendations noted as unable to complete

Three Lines of Defence



First Line of Defence: Overview of the Audit Tracker per Function

139

Open reports

68

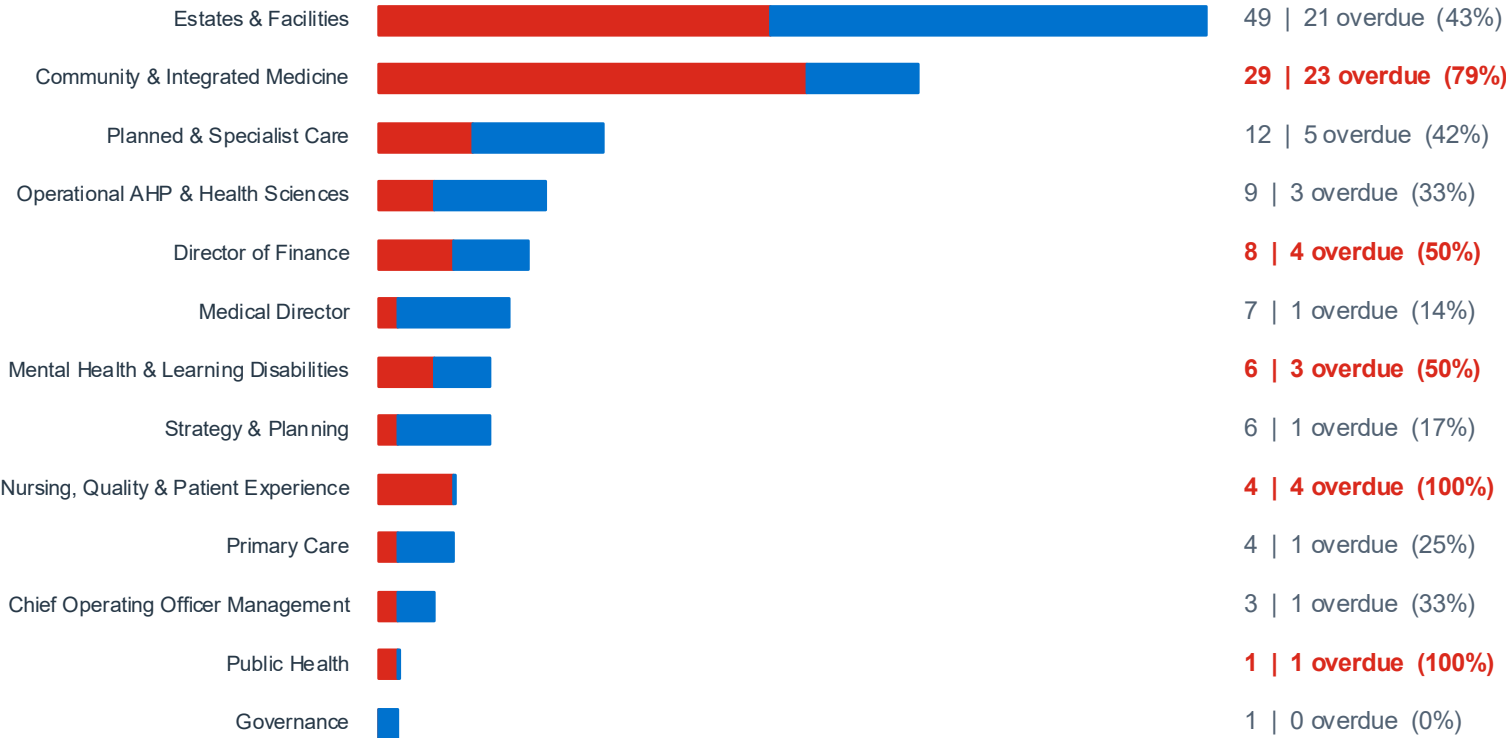
Overdue reports

48.9%

Overall overdue rate

Open reports by CCG / Executive Function

Overdue reports shown in red; remaining open reports shown in blue



Scale: number of open reports

Analysis

The open and overdue report profile is largely **concentrated within a small number of functions managing complex delivery challenges**.

Review of overdue recommendations indicates that delays are most associated with recruitment challenges, infrastructure and estate limitations, funding constraints, dependencies on national programmes and partner organisations, and recommendations linked to wider transformation programmes where implementation is dependent upon strategic decisions or future investment. A smaller but significant proportion also remain overdue pending management responses, evidence submission or formal closure processes.

Many of these issues are reflected within existing risk registers and governance arrangements, indicating that the principal barriers to implementation are generally understood. The continued growth in overdue recommendations suggests that, whilst areas of concern are being identified and monitored, escalation and oversight have not consistently translated into timely implementation to secure the support necessary to achieve delivery.

Second Line of Defence: Governance Domain Levels



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Service	Sept 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	March 2026	April 2026	May 2026	June 2026	July 2026	Aug 2026
Chief Operating Management	1	2	2	2	2	2	1	1	1	1	1	1
Community and Integrated Medicine	3	3	3	3	3	3	3	3	3	3	3	3
Estates and Facilities	1	1	1	1	1	1	1	1	1	1	1	1
Executive Director of Allied Health Professions and Health Sciences	1	1	1	1	1	1	1	1	1	1	1	1
Executive Director of Finance	1	1	1	2	2	2*	2	2	2	2	2	2
Executive Director of Nursing, Quality and Patient Experience	2	2*	2	2	1	1	1	1	1	2	2	2
Executive Director of Public Health	1	1	1	1	1	1	1	1	1	1	1	1
Executive Director of Strategy and Planning	1	1	1	1	1	1	1	1	1	1	1	1
Executive Director of Workforce and Organisational Development	1	1	1	1	1	1	1	1	1	1	1	1
Medical Director	1	1	1	1	1	1	1	1	1	1	1	1
Medicines Management	n/a	n/a	n/a	1	1	1	1	1	1	1	1	1
Governance and Communication	1	1	1	1	1	1	1	1	1	1	1	1
Mental Health and Learning Disabilities	2	2	1	1	1	1	1	1	1	1	1	1
Operational Allied Health Professions and Health Sciences	1	1	1	1	1	1	1	1	1	1	1	1
Planned and Specialist Care	3	2	2	2	3	2	2	2	2	2	2	2
Primary Care	2	2*	2	2	2	2*	1			1	1	1

Level 1 / reasonable assurance

Level 2 / limited assurance

Level 3 / no assurance

Level 4 / no assurance and insufficient actions/engagement

Levels are assigned based on each Function's assessment against prescribed annual targets. Detail on how escalation levels are awarded can be found in [Appendix 3](#).

Implementation of recommendations, alongside governance, risk management, engagement, and compliance with WHCs and MDs has been a key factor in assessing escalation levels.

Since the previous report to ARAC in June 2026, escalation Level 4 has been activated.

Detailed analysis of the **Community and Integrated Medicine CCG** position is provided on the next slide, having sustained a Level 3 position since in August 2025 in respect of the timely implementation of recommendations from audits and inspections.

The escalation framework provides assurance that areas of non-compliance are identified, visible, and subject to enhanced scrutiny through executive and governance arrangements.

* Indicates a CCG / function that has been escalated for factors other than audit and inspection recommendations.

Governance Domain: Level 3 - No Assurance (Audits and Inspections)

Community & Integrated Medicine

446

Total recommendations

100

Overdue

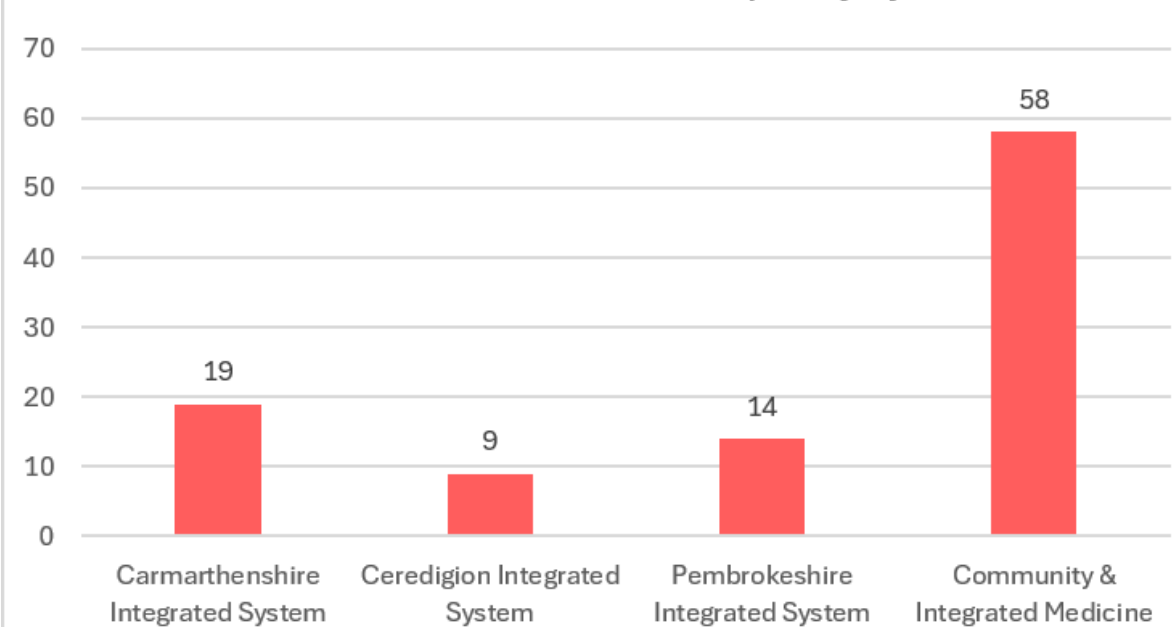
35

Overdue >6 months

80

No revised dates

Overdue recommendations split by system



Key causes

- Barriers to implementing recommendations within original completion dates include **workforce shortages** and **recruitment difficulties**, **dependency on wider organisational programmes/decisions** and **financial constraints**.
- Delays in management responses being provided on AMaT, accounting for 41 of the 100 overdue recommendations.
- Several recommendations have limited AMaT updates and a lack of clear revised completion dates, reflecting the operational pressures within urgent and emergency care.

Next Steps

- Assurance and Risk business partner meeting with CCG Triumvirate team and each integrated system monthly to support improvement of quality of updates on AMaT, including revised dates, where appropriate, and clear barriers to implementation noted.
- As agreed at ARAC in August 2026, all outstanding management responses to be recorded on AMaT by September 2026, with further progress made on their implementation by December 2026
- A formal progress update from the CCG due to be provided to ARAC at a future meeting.

Internal Escalation - Governance Domain: Level 2 – Limited Assurance



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Function	Reason for Level 2	De-escalation criteria
Planned and Specialist Care	27 recommendations overdue (14%) across 7 reports as at 31 August 2026. 11 recommendations are overdue by more than 6-12 months, 2 by 12-18 months, 1 by 18-24 months and 1 by more than 24 months. 18 (9%) overdue recommendations do not have revised implementation dates. <i>Correspondence has been sent directly to the Chief Operating Officer in August 2026 to notify of required actions to support de-escalation.</i>	Implement over 90% of recommendations and provide revised dates for lapsed actions.
Executive Director of Finance	8 recommendations overdue (22%) across 5 reports as at 31 August 2026. 3 of these were long-standing recommendations that have been completed since the data was extracted for this report. 4 outstanding recommendations (spanning 2 reports) are overdue by less than 6 months and 1 recommendation is overdue by 6-12 months. <i>Correspondence has been sent directly to the Director of Finance in August 2026 to notify of required actions to support de-escalation.</i>	Achieve 90% implementation within agreed timescales; volume is low but percentage is above threshold.
Executive Director of Nursing, Quality and Patient Experience	Compliance has remained below 80% for more than 12 months with 10 recommendations overdue (23%) across 4 open reports. <i>Correspondence has been sent directly to the Director of Nursing, Quality and Patient Experience in August 2026 to notify of required actions to support de-escalation.</i>	Implement over 90% of recommendations, provide revised dates for lapsed actions and clearly identify any barriers to completion.

Board and Committee Oversight Audit and Inspections

Both ARAC and the Quality, Safety and Experience Committee (QSEC) have raised concerns regarding the organisation’s delivery of assurance and improvement activity, resulting in correspondence being sent by the Chairs of each Committee to Executives. These concerns have also been escalated to the Board by other Committee Chairs.

ARAC has also raised concerns about early requests in this financial year to defer four internal audits, warning that continued delays risk creating a backlog of reviews and reducing the level of assurance being provided.

QSEC has expressed concern regarding the significant number of overdue audit, inspection and regulatory recommendations, alongside issues relating to ownership, accountability and quality of implementation plans. QSEC noted that progress is not being achieved at the expected pace, with repeated slippage against agreed timescales risking confidence in the Health Board’s ability to translate learning into sustainable improvement.

Both Committees have called for strengthened executive oversight, clearer accountability and improved delivery to ensure audits process as planned, and recommendations are implemented in a timely and effective manner.

The Assurance and Risk team continue to support Clinical Care Groups and Executive Functions via a business partnering approach, which include:

- presentation of Assurance and Risk reports at local governance meetings, which details any areas of concern (including Audits and Inspections) via the 3As approach;
- 1-2-1 meetings with report and recommendation leads to support the development of management responses, and the provision of progress updates; and
- AMaT system training.

Performance is monitored via the Health Board’s internal escalation framework, further detail of which is contained [later in this report](#). Actions raised at Committee meetings are recorded and presented at subsequent meetings, with progress visible via the “Our Actions” dashboard.



Third Line of Defence

Independent assurance on effectiveness



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Independent Assurance (Third line)

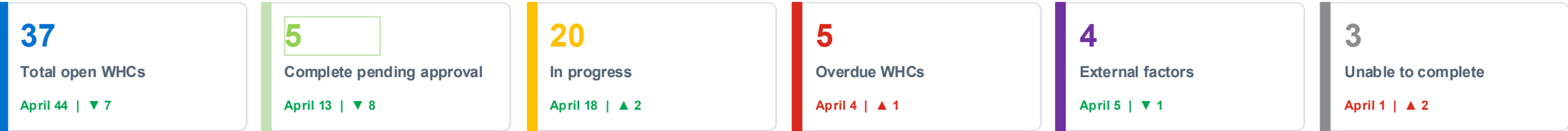
The third line of defence relates to those who provide independent assurance over the management arrangements in place and, where appropriate, can advise on control strategies.

The Health Board obtains third line assurance on its systems and processes for tracking and implementing audit, inspectorate and regulatory recommendations through independent internal and external scrutiny. This includes work undertaken by Internal Audit, External Audit and relevant regulators/inspectorates (for example, HIW), alongside formal assurance reporting to ARAC. These mechanisms provide objective evaluation of the effectiveness of the Health Board's tracking arrangements, governance processes and compliance, and enable triangulation of assurance alongside first- and second-line sources.

There are a number of ways this is provided:

1. Internal Audit - Internal Audit provide an independent review of the documentation submitted on AMAT to evidence the implementation of internal audit recommendations
2. External Audit (Audit Wales) – Through the Structured Assessment process, Audit Wales reviews the Health Board's corporate governance and performance arrangements and in its most recent report in December 2025, reported that 'the Health Board continues to have robust arrangements for tracking audit and review recommendations'. Follow up reviews will also review whether previous recommendations have been implemented in practice.
3. Regulators and Inspectorates - Re-inspections, follow-ups and thematic reviews will validate whether recommendations have been implemented in practice.
4. Formal ARAC oversight - ARAC receives the audit and inspection / WHC assurance reports which provides assurance and the robustness of tracking system.

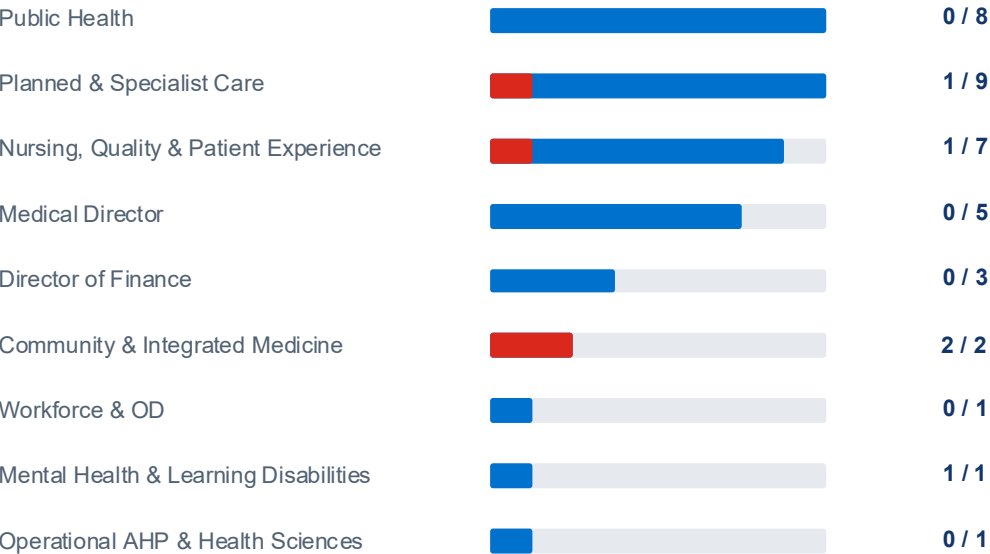
Welsh Health Circulars Summary



Definitions of these categories can be found in [Appendix 1](#)

Open WHC profile

Total WHCs / overdue



Figures show total WHCs / overdue WHCs.

Common barriers to implementing Welsh Health Circulars (WHCs) include **workforce shortages, recruitment difficulties, service capacity constraints** and a **lack of recurrent funding** to support implementation.

3 overdue WHCs have risks noted linked to current non-compliance with their requirements. These relate to ambulance patient handover arrangements, delivery of national guidance for stroke services, and implementing the Welsh standards for competency assurance of non-medical prescribers.

The status of 3 WHCs related to hearing screening pathways and persistent pain services have been updated from "Pending Decision" to "Unable to Complete" since the previous report, reflecting the absence of approved funding required to deliver the outstanding actions necessary to be fully compliant with the requirements of the WHCs.

A summary of the noted WHCs is set out on the next slide.

The principal challenge remains the Health Board's ability to achieve full compliance in areas affected by workforce fragility, estate limitations, funding pressures and reliance on national programmes or external partners.

Welsh Health Circulars: Exception Analysis



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Overdue WHCs

5

The WHC is behind schedule to the timescale provided by the lead officer.

Delays in the implementation of WHCs are a result of several factors including **workforce and service-capacity pressures**, dependencies on **wider transformation plans**, and the need for **input from multiple services** across the Health Board.

In some cases, the requirements of the WHC have been progressed, however revised completion dates are not consistently noted, and others are unable to be closed due to delays in the uploading of relevant supporting evidence.

Associated risks are required to be recorded on Datix where non-compliance presents an ongoing risk.

Next steps:

- Review definition and strengthen underpinning processes to escalate recommendations noted as External (where appropriate).

Reliant on External Factors

4

The WHC is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.

Full implementation of these WHCs are dependent on decisions or developments out of the Health Board's direct control. These principally include **national digital systems and programmes**, publication of **national guidance** and delivery arrangements, **external approvals**, and the **availability of capital funding**.

Dependencies should continue to be actively monitored and updated, reflected within governance and risk arrangements, and escalated where appropriate.

Next steps:

- Remind services to document external factors, and to continually review and update should external factors change, and progress via appropriate escalation routes
- Review definition and strengthen underpinning processes to escalate recommendations noted as External (where appropriate).

Unable to Complete

3

The WHC cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.

The outstanding requirements of these WHCs have been noted by leads as being unable to deliver due to workforce and financial constraints, limited service capacity, or the absence of an approved and sustainable delivery model.

Further progress is likely to require additional investment, an alternative delivery approach, or confirmation that the original requirement remains relevant.

These WHCs should be subject to review and escalation via appropriate operational governance arrangements to ensure appropriate oversight and action.

Next steps:

- Review definition and strengthen underpinning processes to escalate recommendations noted as External (where appropriate).

Governance Domain : Level 3 - No Assurance (Welsh Health Circulars)



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Community & Integrated Medicine

2	WHCs assigned	2	WHCs overdue	1	No confirmed revised date	2	Associated risks recorded
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WHC/2024/041 Ambulance Patient Handover Guidance

Reported as overdue by less than six months

Revised implementation date
30th November 2026

- Linked to corporate risk 1027 (Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity), current risk score 20.
- Ambulance Handover 45 group established between Welsh Ambulance Services University (WAST), Health Board and Local Authority. Site based Ambulance Handover 45 plans developed.

Next Steps:

Programme Plan will be agreed between Health Board and WAST, detailing timescales and owners of actions. Any delay in progress to be escalated through UEC Programme Group and National escalation meetings.

WHC/2024/006 National Clinical Guideline for Stroke

No confirmed implementation timescale

Revised implementation date
N/K

- Linked to operational risk 2409 (Risk of poor outcomes for stroke patients due to fragility of service), current risk score 20.
- Implementation is dependent on the Clinical Services Plan.

Next Steps:

- Ensure the remaining barriers to completion are clearly captured and understood for the Stroke WHC.

Next Steps and Recommendations



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Next Steps

This report has identified the following areas where further improvements can be made:

- Review the definitions and governance process for recommendations and Welsh Health Circulars that have been categorised as either “Pending Decision” or “Unable to Complete”, and to communicate with Functions across the Health Board to improve oversight; and
- To launch the Audit and Inspection Dashboard for the Health Board by November 2026.

Recommendations

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

- on the effectiveness of processes in place across the Health Board to track the progress made to implement recommendations identified by auditors, inspectorates and regulators, and implement Welsh Health Circulars (WHCs) issued by Welsh Government.



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND



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Appendix 1: Definition Status Audits and Inspections and WHCS



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All reports from audits, reviews and inspections carried out across the Health Board, as well as Welsh Health Circulars received from Welsh Government, are logged and tracked on the AMaT (Audit Management and Tracking) system, with progress updated by relevant service leads against each recommendation to demonstrate progress, with the requirement to upload evidence of full implementation.

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

Progress is monitored using a categorisation framework to assess performance against **original completion dates**. Definitions for each category are included in the table below:

Status Category	Definition
Overdue	The report / recommendation / WHC is behind schedule to the timescale provided by the lead officer (or as stipulated in the WHC), or an original implementation date has not yet been provided.
Unable to Complete	The report / recommendation / WHC cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.
Pending Decision	The report / recommendation / WHC is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the recommendation is overdue or not whilst decision pending.
In Progress	The report / recommendation / WHC is currently in progress, and within the agreed original timeframe for implementation.
Reliant on External Factors	The report / recommendation / WHC is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.
Complete Pending Formal	The CCG / Function have completed the report / recommendation / WHC and currently awaiting formal approval to close.
Complete	The report / recommendation / WHC has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.

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

Oversight of the delivery of Recommendations and WHCs has been included in CCG Integrated Governance Group (IGG) Terms of Reference, with the requirement to escalate appropriately in instances of non-compliance.

Appendix 2: Internal Escalation Processes Governance Domain

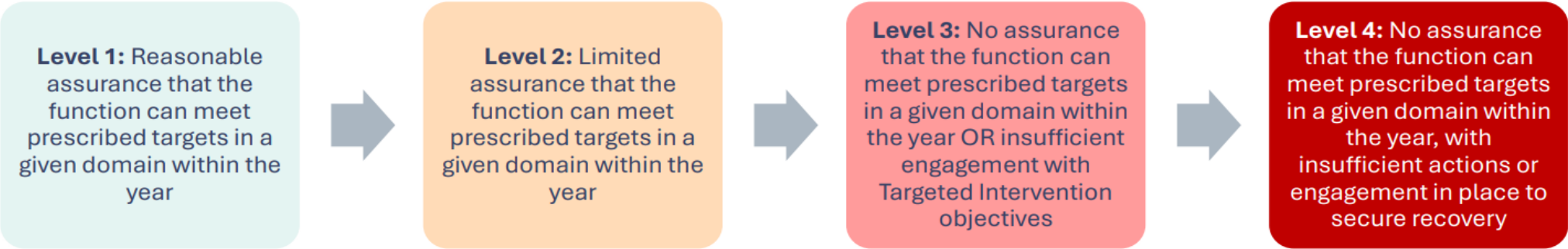
Internal Escalation (Second Line)

The second line relates to the internal oversight mechanisms and specialist functions that are independent of operational delivery, which sets frameworks, monitors compliance and provides expert oversight to provide assurance that controls are appropriate and applied consistently.

All audit, inspectorate, and regulatory reports are aligned to a designated committee to provide assurance that recommendations are implemented within agreed timescales. Progress is monitored and reported through Audit and Risk reports, which are submitted to each committee on a triannual basis.

The Health Board has an internal escalation process, as part of the Executive Improving Together (EIT) Framework, whereby CCG /Executive Functions are assessed monthly against seven domains, including ‘Governance’ (with specific focus on four key areas noted below), to drive improvement in performance, and awarded one of four levels based on their performance:

- Risk Management;
- Implementation of recommendations raised in audits / inspections and regulatory activity;
- Implementation of Welsh Health Circulars and Ministerial Directions;
- Up to date Written Control Documentation; and
- Governance arrangements.



Whilst the four levels within the escalation framework have been agreed, the Executive Team are currently determining processes to support those CCGs or Functions who may be assessed as being in Level 4. At present, CCGs and Functions are assigned as being either level 1, 2 or 3 pending formalisation of these processes.

Appendix 3: Internal Escalation Measures to assess against the Governance Domain - Audit and Inspections



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Levels are assigned based on each Function's assessment against prescribed annual targets.

Level	Criteria
Level 4 – no assurance and insufficient actions / engagement	No plan in place and no engagement, (e.g., no responses to recommendations raised, no revised dates where original completion dates have lapsed). No evidence that recommendations which are unable to be progressed are escalated via CCG management structures where necessary, no engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 3 – no assurance	Responses to recommendations have been developed, but the function is not delivering against revised completion dates, with no realistic revised completion dates provided. Management responses have not been developed within a month of receipt of report. Less than 80% compliance with achieving original and revised completion dates stipulated against recommendations Limited evidence that recommendations which are unable to be progressed are escalated via CCG management structures where necessary, therefore not demonstrating good engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 2 – Limited assurance	Responses to recommendations have been developed, but lack of evidence that original timescales are being achieved. Where original completion dates have lapsed, there is evidence that the service has provided realistic revised completion dates. Between 80-90% compliance with achieving original completion dates stipulated against recommendations Some evidence that recommendations which are unable to be progressed are escalated via CCG management structures where necessary, demonstrating engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 1 – Reasonable assurance	Responses to recommendations have been developed and the function is delivering against original completion dates Over 90% compliance with achieving original completion dates stipulated against recommendations Evidence that recommendations which are unable to be progressed are escalated via CCG management structures where necessary, demonstrating good engagement and the ability for leadership to make informed decisions on prioritisation of resources

Appendix 3: Internal Escalation Measures to assess against the Governance Domain – Welsh Health Circulars



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Internal Escalation - Measures to assess against the Governance Domain – Welsh Health Circulars

Levels are assigned based on each Function's assessment against prescribed annual targets.

Level	Criteria
Level 4 – no assurance and insufficient actions / engagement	No plan in place and no engagement, (e.g., no responses to WHC / MD requirements, no revised dates where original completion dates have lapsed). Where there is non-compliance with the requirements of a WHC / MD, an appropriate risk has not been raised, and a Quality Impact Assessment has not been completed (if applicable). No evidence that in instances of non-compliance, WHCs are escalated via CCG management structures where necessary.
Level 3 – no assurance	Responses to WHCs / MDs have been developed, but the function is not delivering against revised completion dates Limited evidence that in instances of non-compliance with the requirements of a WHC / MD, an appropriate risk has been raised, and a Quality Impact Assessment completed (if applicable). Limited evidence that in instances of non-compliance, WHCs / MDs are escalated via CCG management structures where necessary.
Level 2 – Limited assurance	Responses to WHCs / MDs have been developed, but lack of evidence that original timescales are being achieved. Where original completion dates have lapsed, there is evidence that the service has provided realistic revised completion dates. Some evidence that in instances of non-compliance with the requirements of a WHC / MD, an appropriate risk has been raised, and a Quality Impact Assessment completed (if applicable). Some evidence that in instances of non-compliance, WHCs / MDs are escalated via CCG management structures where necessary.
Level 1 – Reasonable assurance	Responses to WHCs / MDs have been developed, and the function is delivering against original completion dates. Where there is non-compliance with the requirements of a WHC / MD, an appropriate risk has been raised, and a Quality Impact Assessment completed. Evidence that in instances of non-compliance, WHCs / MDs are escalated via CCG management structures where necessary.

8 - Post Payment Verification

8.1

12:15 PM, 15 Mins

8.1 - Post Payment Verification (PPV) Mid-Year Report *Huw Thomas (Hywel Dda UHB - Director of Finance), Amanda Legge (NWSSP - PCS), Sue Tillman (NWSSP - PCS)*

| For assurance

Attachments

[PPV Report Mid Year 2026-2027.pdf](#)

[HDduHB mid-year PPV Report 2026-2027.pdf](#)



Pwyllgor Archwilio a Sicrwydd Risg/ Audit and Risk Assurance Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	15 October 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Post Payment Verification Mid-Year Report April 2026 – Sept 2026
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Amanda Legge, All Wales PPV Manager and Collaboration Amanda Whiting, Head of GMS and Community Pharmacy

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/ For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The Audit and Risk Assurance Committee is asked to take assurance from the contents of this report. It highlights Post Payment Verification (PPV) progress and how practices have been performing over the current cycle. It compares the overall performance of Hywel Dda University Health Board (HDdUHB) against the national PPV visits.

PPV of claims from General Medical Services (GMS), General Ophthalmic Services (GOS) and General Pharmaceutical Services (GPS) are undertaken as a part of an annual plan by NHS Wales Shared Services Partnership (NWSSP).

There are no options included in this report. The report is for assurance and will only detail specific risks, if any, and provides the narrative for what PPV, Primary Care, Finance and Counter Fraud consider to be the best approach to support practices in improving.

Cefndir / Background

At mid-year and end of financial year, the PPV Manager will prepare a report for Health Board audit committees to outline how practices have been performing and highlighting PPV progress. The report is being produced for the Committee to review and seek assurance that the Post Payment Verification cycle is being managed appropriately.

The purpose of the PPV process is to provide assurance to Health Boards that the claims for payment made by primary care contractors are appropriate and that the delivery of the service is as defined by NHS service specification and relevant legislation.

Asesiad / Assessment

The following key points should be noted:

General Medical Services (GMS)

Progress against the 2026/27 GMS visit programme is progressing well. During the first quarter, all PPV teams focused on undertaking routine GMS revisits alongside routine visits where required. As the backlog of work has now been addressed, the team is undertaking practice revisits arising from previous findings, routine visits that have become due, and any ad hoc requests received from Health Boards.

A proportion of vaccination claims are now processed through the Welsh Immunisation System (WIS). Following issues identified by PPV during verification activities, new internal control processes have been implemented to prevent duplicate vaccination payments prior to payment being made, rather than relying on post-payment recovery processes.

General Ophthalmic Services (GOS)

The GOS visit programme for 2026/27 is progressing more effectively than in recent years. This improvement is primarily due to the increased number of contractors who have adopted electronic patient records, enabling PPV to undertake a greater proportion of verification activities remotely.

However, elements of physical visits remain necessary, as not all contractors currently operate electronic record systems.

General Pharmacy Services (GPS)

During 2026/27, the PPV team continues to undertake verification of the Collaborative Working Scheme and the Quality and Safety Scheme. These reviews are conducted remotely, with data held by PPV being verified against supporting evidence requested from contractors.

In addition, PPV successfully conducted a pilot review of the Winter Incentive Scheme for one Health Board. The pilot produced positive outcomes, and the approach is now being rolled out nationally. The results will be incorporated into the year-end report.

Additional Services

Quarterly dispensing data checks continue to be undertaken, with ongoing enhancements being made to strengthen and streamline the process, ensuring a robust service moving forward. Results relating to the five dispensing practices within HDdUHB have been incorporated into PPV reporting.

Waste Management and Stakeholder Engagement

The PPV team continues to manage the Waste Management Audit Programme on behalf of Health Boards, providing advice and support to General Practitioners and Community

Pharmacies regarding waste management requirements. This includes overseeing the clinical waste self-assessment process, which contractors are required to complete every three years. During this financial year, GOS contractors will also be incorporated into the clinical waste assurance process.

Regular meetings are held with Health Board Primary Care Teams and Counter Fraud Teams to review progress, discuss emerging themes, recommendations and identified risks. In addition, the team facilitates quarterly national GMS and GOS Working Group meetings with Primary Care Managers and PPV representatives to support discussion and agreement on matters relating to the consistent national application of the programme. These meetings continue to provide valuable opportunities for collaboration and shared learning.

Training and Development

PPV training continues to be delivered to Health Boards and contractors as required. The team also provides tailored one-to-one support where requested, particularly for new practice staff working within primary care settings.

Data and Reporting

PPV data analysts are currently developing a suite of dashboards to enhance management information and reporting. These dashboards will provide additional insight and are intended to support future committee reporting requirements.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to:

- **NOTE** the contents of the Post Payment Verification Mid-Year Report 2026/27
- **TAKE ASSURANCE** from the contents of the report

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.14 Receive an assurance on Post Payment Verification Audits through bi-annual reporting to the Committee.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality:	Not Applicable

Quality and Engagement Act (sharepoint.com)	
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	Not Applicable
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	8. Develop initiatives that build social connections and promote culture and the Welsh language as assets to support people's overall wellbeing
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (<i>complete for strategic change and/or significant service changes</i>)	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Evidence is collated based on claims submitted by contractors of a specific sample period.
Rhestr Termau: Glossary of Terms:	Not Applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	To promote value for money by deterring and preventing fraud and loss.
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable

Gweithlu: Workforce:	Not Applicable
Tegwch Iechyd: Health Equity:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

Audit Report - April to September 2026 = Hywel Dda University Health Board

General Medical Services (GMS)	H DUHB							ALL WALES				
	Visit Type	HB Annual Visits Due	No. In progress	No. Recoveries	Value of recoveries	Value of Duplicate Recoveries	Total Recoveries	All Wales Visits Due	All Wales No. in progress	All Wales Value of Recoveries	All Wales Value of Duplicate Recoveries	All Wales Total Recoveries
GMS 2025 - 2026	Combined		15				£19,324.75		156			£228,801.68
GMS 2026-2027	Routine	14	8	14	£153.21	£378.50	£531.71	95	63	£15,071.29	£15,939.72	£31,011.01
	Revisit	20	8	86	£1,412.91	£0.00	£1,412.91	169	65	£74,722.65	£683.20	£75,405.85
	TOTAL	34	16	100	£1,566.12	£378.50	£1,944.62	264	128	£89,793.94	£16,622.92	£106,416.86

General Ophthalmic Services (GOS)	H DUHB					ALL WALES		
	Visit Type	Annual Visits Planned	No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	All Wales Value of Recoveries
GOS 2025-2026	Combined		19		£3,437.92		138	£20,003.35
GOS 2026-2027	Routine	18	9	24	£738.38	145	104	£3,188.45
	Revisit	10	4	7	£84.98	64	13	£1,732.86
	TOTAL	28	13	31	£823.36	209	117	£4,921.31

General Pharmacy Services (GPS)	H DUHB					ALL WALES			
	Visit Type	Annual Visits Planned	No. In progress	No. Recoveries	Value of recoveries	All Wales visits due	All Wales No. in progress	No. Recoveries	All Wales Value of Recoveries
GPS 2025 - 2026	Combined		31		£2,219.84		232		£44,803.70
GPS 2026 - 2027	Routine	37		0	£0.00	281	0	0	£0.00
Due to commence in Quarter 3 of 2026/27	TOTAL	37							

New Recovery process					
	Quarter Period	Amount of Dispensing GP Practices	Value of Recoveries	All Wales Dispensing GP Practices	All Wales Value of Recoveries
DISPENSING 2025-2026	Quarter 1 & 2 2025/26 (Apr to Sep 2025)	5	£237.13	61	£42,478.77
Dispensing GP practices should not dispense to patients who live within 1.6 kms / 1 mile from a Local Community Pharmacy					

GMS Summary								
PRACTICE	Routine or Revisit	Overall Sample size	Claim errors	Error % recovery	Value of recovery	Value of Duplicate recovery	Total recovery	Breakdown of Recoveries and individual services with 10% or more error rate
Practice 1	Revisit							In progress
Practice 2	Routine							In progress
Practice 3	Revisit							In progress
Practice 4	Routine							In progress
Practice 5	Revisit	993	84	8.46%	£1,235.73	£0.00	£1,235.73	Immunisations and NPT
Practice 6	Routine	226	7	3.10%	£90.35	£158.50	£248.85	Gonadorelin and Immunisations. Duplicate recoveries on Covid, Flu, Gonadorelin, Immunisations and RSV.
Practice 7	Revisit	6	2	33.33%	£177.18	£0.00	£177.18	Minor Surgery
Practice 8	Routine	478	7	1.46%	£62.86	£220.00	£282.86	Immunisations, Insulin and RSV. Duplicate recoveries on Covid, Gonadorelin, Flu, Immunisations and RSV
Practice 9	Revisit							In progress
Practice 10	Routine							In progress
Practice 11	Revisit							In progress
Practice 12	Routine							In progress
Practice 13	Revisit							In progress
Practice 14	Routine							In progress
Practice 15	Revisit							In progress
Practice 16	Routine							In progress

Advisory Notes
• The planned visits were sent to the HB for 2026/27 Visit Plan. These are subject to change due to ad hoc visits or closures/mergers. • All closed visit files have been authorised by the Health Board GMS team with any concerns/issues being addressed. • The duplicate amount of recovery is due to the practice submitting certain additional claims for the same patient more than once. This is a new audit check by PPV and feedback and lessons learnt are being shared to reduce these errors. • The Health Board have been advised of each recovery made in a detailed report and where necessary the Health Board will follow up directly with the practice/Local Counter Fraud regarding any concerns. • PPV work collaboratively with Health Board managers and Local Counter Fraud to assist with any concerns that may arise. • Training/support is given to practices by PPV after their visit when requested. • Revisits are taking longer than expected due to 100% check of claims, which is expected to have higher claim error rates when checking 100% of claims. • Revisits are triggered when the claim error % is 10% or over on any individual service in the routine visit sample, it is not based off the % recovery as a whole. • Recovery % is based off the sample total and the claim errors made. The recovery % may look higher due to a smaller amount of claims being sampled.

GOS Summary										
PRACTICE	Routine or Revisit	Overall Sample size	Claim errors	Error % recovery	Value of recovery				Breakdown of Recoveries and individual services with 10% or more error rate	Advisory Notes • The planned visits were sent to the HB for 2026/27 Visit Plan. Numbers are subject to change due to ad hoc visits or closures/mergers. • As contractors are transitioning to electronic records, remote access and physical visits are progressing well
Practice 1	Routine	103	12	11.65%	£328.44				GOS 4 and WGOS 5 claims	
Practice 2	Routine	103	1	9.97%	£54.23				Claim recovery under 10% per service	
Practice 3	Routine	103	3	2.91%	£24.56				Claim recovery under 10% per service	
Practice 4	Revisit								In progress	
Practice 5	Routine	103	1	0.97%	£46.27				Claim recovery under 10% per service	
Practice 6	Routine	103	0	0.00%	£0.00				All claims verified	
Practice 7	Routine	103	0	0.00%	£0.00				All claims verified	
Practice 8	Routine	103	4	3.88%	£130.61				Claim recovery under 10% per service	
Practice 9	Routine	103	3	2.91%	£154.27				EHEW claims	
Practice 10	Revisit								In progress	
Practice 11	Routine	103	0	0.00%	£0.00				All claims verified	
Practice 12	Revisit	8	2	25.00%	£46.52				GOS 4 claims	
Practice 13	Revisit	300	5	1.67%	£38.46				Claim recovery under 10% per service	

9 - For Information

9.1

12:30 PM, 0 Mins

9.1 - ARAC Workplan 2026/27

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

| For information

Attachments

[Audit Work Programme 2026-27 v2.pdf](#)

HYWEL DDA UNIVERSITY HEALTH BOARD – AUDIT & RISK ASSURANCE COMMITTEE DRAFT ANNUAL WORK PLAN 2026/27

The proposed work programme is aligned to the requirements of the 2012 Revised NHS Wales Audit Committee Handbook, Draft Terms of Reference and example agenda and timetable.

AGENDA ITEM/ISSUE	LEAD	PURPOSE	14 April 2026	7 May 2026	23 June 2026	13 Aug 2026	15 Oct 2026	10 Dec 2026	11 Feb 2027	April 2027
INTRODUCTIONS										
Apologies	Chair	Information	✓	✓	✓	✓	✓	✓	✓	✓
Declaration of Interests	All	Information	✓	✓	✓	✓	✓	✓	✓	✓
GOVERNANCE										
Minutes from previous meeting	Chair	Approval	✓		✓	✓	✓	✓	✓	✓
Matters Arising & Table of Actions	Chair	Assurance	✓		✓	✓	✓	✓	✓	✓
Matters Arising not on agenda	Chair	Discussion	✓		✓	✓	✓	✓	✓	✓
Self-Assessment of Committee's effectiveness	JW	Assurance			✓			✓		
Escalation Status Update	PK/LD/SA	Assurance	✓		✓	✓	✓	✓	✓	✓
Review and report upon the adequacy of arrangements for declaring, registering and handling interests	JW	Assurance		✓						
Receive full report of all offers of gifts and hospitality	JW	Assurance		✓						
Review ARAC Annual Report	Chair	Approval		✓						
Review Board Effectiveness Report	JW	Assurance		✓						
Review Accountability Report, incl Annual Governance Statement	JW	Approval		✓ (Draft)	✓ (Final)					
Review Head of Internal Audit Opinion and Annual Report (incl Capital/PFI)	JJ	Assurance		✓ (Draft)	✓ (Final)					
Internal Audit: Annual Governance Statement Review	JJ	Assurance		✓	✓					
Review, agree and recommend to the Board the audited accounts & financial statements	HT	Approval		✓ (Draft)	✓ (Final)					
Audit Enquiries to those charged with Governance and Management	HT	Approval		✓						

AGENDA ITEM/ISSUE	LEAD	PURPOSE	14 April 2026	7 May 2026	23 June 2026	13 Aug 2026	15 Oct 2026	10 Dec 2026	11 Feb 2027	April 2027
Audit Wales ISA 260 incl Letter of Representation	Audit Wales	Assurance			✓					
Review the Health Board's Annual Report (Overview & Perf Section)	HT	Approval		✓ (Draft)	✓ (Final)					
Review changes to Standing Orders & Standing Financial Instructions*	JW	Approval	✓							
Annual Review of Standing Orders and Standing Financial Instructions	JW	Approval	✓							✓
Scheme of Delegation	JW	Approval					✓			
Annual Review of Terms of Reference	Chair/JW	Approval			✓					
All Wales NHS Audit Committee Chairs' Meeting Update	Chair	Information			✓		✓	✓	✓	✓
Review of any other sources of external assurance to ensure approp planning & coordination and that the Board is informed accordingly of any issues relating to compliance, risks of non-compliance & recommendations	All	Assurance	✓	✓	✓	✓	✓	✓	✓	✓
Provide assurances where a significant activity is shared with another organisation (eg NWSSP/JCC)	HT	Assurance	✓	✓	✓	✓	✓	✓	✓	✓
Receive assurances from internal audit performed at these organisations that risks in the services provided to them are adequately managed and mitigated with appropriate controls	JJ	Assurance	✓	✓	✓	✓	✓	✓	✓	✓
Review of Capital & PFI Audit Reports including results & the adequacy of executive & management responses to any issues identified and ensuring that they are acted upon	MG	Assurance	✓	✓	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ISSUE	LEAD	PURPOSE	14 April 2026	7 May 2026	23 June 2026	13 Aug 2026	15 Oct 2026	10 Dec 2026	11 Feb 2027	April 2027
AUDIT WALES										
Review External Audit Plan via update reports	Audit Wales	Assurance	✓	✓	✓	✓	✓	✓	✓	✓
Approve External Audit Strategy & Annual Audit Plan (designed to implement the strategy) & assoc fees	Audit Wales	Approval	✓							✓
Review of External Audit Reports including results & the adequacy of executive & mgmt responses to any issues identified and ensure that the other Cttees monitor & report back	Audit Wales	Assurance	✓		✓	✓	✓	✓	✓	✓
Consider any Audit Wales National Value for Money Examinations & Performance Reports	Audit Wales	Assurance	✓		✓	✓	✓	✓	✓	✓
Receive the Auditor's General report to those charged with governance (Year-end)	Audit Wales	Assurance		✓						
Structured Assessment 2024 Management Response Update	Audit Wales/JW	Assurance	✓							
Structured Assessment 2025	Audit Wales	Assurance	✓							
Structured Assessment 2026	Audit Wales	Assurance						✓		✓
Review of the Management of Outpatients	Audit Wales/AC	Assurance	✓							
Digital Transformation Review (also IC)	Audit Wales/HT	Assurance	D	✓						
Review of Radiology Services	Audit Wales/AC	Assurance	D		✓					
Deep Dive - Review of the Arrangements to Manage Estates	Audit Wales/JS	Assurance	D			D	✓			
Review of Cancer Services	Audit Wales/AC	Assurance	D			D	✓			
Review of Eye Care Services	Audit Wales/AC	Assurance							✓	

AGENDA ITEM/ISSUE	LEAD	PURPOSE	14 April 2026	7 May 2026	23 June 2026	13 Aug 2026	15 Oct 2026	10 Dec 2026	11 Feb 2027	April 2027
Review of Management & Prevention of Diabetes	Audit Wales/AG	Assurance								✓
Progress Update: Audit Wales Radiology Review	AC	Assurance						✓		
INTERNAL AUDIT										
Internal Audit: Audit Plan Progress Report	JJ	Assurance	✓	✓	✓	✓	✓	✓	✓	✓
Review and approve Annual Internal Audit Plan	JJ	Approval	✓							✓
Review of Internal Audit Reports including results & the adequacy of executive & management responses to any issues identified and ensuring that they are acted upon	JJ	Assurance	✓	✓	✓	✓	✓	✓	✓	✓
Review and approve Internal Audit terms of reference (charter) and the effectiveness of internal audit	JJ	Approval	✓							✓
Correspondence Regarding Audit Participation and Implementation of Recommendations	Chair/EM/JW	Discussion				✓				
Operational Governance Arrangements (Limited Assurance)	JJ/AC	Assurance	✓							
Level 3 / 4 Directorates (Limited Assurance)	JJ/HT	Assurance	✓							
Estates Assurance – Space Utilisation (Advisory Report)	JJ/LD	Assurance	✓							
Human Tissue Authority Follow-up (Review)	JJ/JS	Assurance	✓							
Shadow IT (Reasonable Assur) (IC)	JJ/HT	Assurance	✓							
Sickness Management Follow-up (Review)	JJ/LG	Assurance		✓						
Major Infrastructure Investment Plan (Reasonable Assurance)	JJ/LD	Assurance	D	✓						
WGH Fire Precaution Works Phase 2 (Reasonable Assurance)	MG/LD	Assurance		✓						

AGENDA ITEM/ISSUE	LEAD	PURPOSE	14 April 2026	7 May 2026	23 June 2026	13 Aug 2026	15 Oct 2026	10 Dec 2026	11 Feb 2027	April 2027
GP Out of Hours (Limited Assurance)	JJ/AC	Assurance	D		✓					
Commissioning – Third Sector (Reasonable Assurance)	JJ/AC	Assurance			✓					
Regional Joint Cttee Governance Arrangements (Advisory Report)	JJ/JW	Assurance	D		✓					
Infection Prevention & Control (Limited Assurance)	JJ/SD	Assurance	D		✓					
Medical Workforce Stabilisation (Reasonable Assurance)	JJ/MH	Assurance	D		✓					
High Cost Drugs (Limited Assurance)	JJ/MH/HT	Assurance	D		✓					
WellSky System (Advisory Report)	JJ/HT	Assurance	D		✓					
Follow-up and Action Implementation Review (Reasonable Assurance)	JJ/JW	Assurance			✓					
Capital Equipping (Limited Assurance)	JJ/LD	Assurance				✓				
Organisational Change Process - Operational Structure (Advisory)	JJ/AC	Assurance					D	✓		
Pathways of Care Delays (Reasonable Assurance)	JJ/AC	Assurance					✓			
Workforce Planning (Reasonable Assurance)	JJ/LG	Assurance					✓			
Staff Experience and Wellbeing (Reasonable Assurance)	JJ/LG	Assurance					✓			
Financial Management - Grip and Control	JJ/HT	Assurance					D	✓		
Radiology Informatics System Programme	JJ/HT	Assurance					D	✓		
Primary Care Prescribing	JJ/AC	Assurance						✓		
Rostering	JJ/LG	Assurance						✓		
Quality Management System	JJ/SD	Assurance						✓		
Integrated Audit and Assurance Plans - Aseptic Scheme	JJ/LD	Assurance						✓		
Health and Safety	JJ/JS	Assurance						✓		
Cost Management and Savings	JJ/HT	Assurance						✓		

AGENDA ITEM/ISSUE	LEAD	PURPOSE	14 April 2026	7 May 2026	23 June 2026	13 Aug 2026	15 Oct 2026	10 Dec 2026	11 Feb 2027	April 2027
Schemes										
Patient Demographic Information	JJ/HT	Assurance						✓		
Digital Partner Contract	JJ/HT	Assurance						✓		
Operational Governance Arrangements Follow-up	JJ/AC	Assurance							✓	
Management of Service Change	JJ/AC	Assurance							✓	
Complaints	JJ/SD	Assurance							✓	
Estates Assurance - Control of Contractors	JJ/LD	Assurance							✓	
Capital Systems - Targeted Estates Funding	JJ/LD	Assurance							✓	
Follow-up and agreed Action Implementation Tracking	JJ/JW	Assurance							✓	
Artificial Intelligence and Robotic Process Automation	JJ/HT	Assurance							✓	
Heath Records Management	JJ/HT	Assurance							✓	
Regional Joint Committee: Work Programme Delivery	JJ/PK	Assurance								✓
Validation of Emergency Departments Performance and Waiting Time Data Follow-up	JJ/AC	Assurance								✓
Business Continuity - Emergency Escalation	JJ/AC	Assurance								✓
Theatre Stock System Implementation	JJ/AC	Assurance								✓
Primary Care Community by Design (CbD)	JJ/AC	Assurance								✓
Cleanliness Standards Follow-up	JJ/JS	Assurance								✓
Vaccination and Immunisation Follow-up	JJ/AG	Assurance								✓
Progress Update: Operational Governance Internal Audit	AC	Assurance			✓					
Progress Update: Major Infrastructure Investment Programme Internal Audit	LD	Assurance				✓				
Progress Update: Human Tissue	JS	Assurance				✓				

AGENDA ITEM/ISSUE	LEAD	PURPOSE	14 April 2026	7 May 2026	23 June 2026	13 Aug 2026	15 Oct 2026	10 Dec 2026	11 Feb 2027	April 2027
Authority Internal Audit										
Progress Update: High Cost Drugs Internal Audit	MH	Assurance						✓		
CLINICAL AUDIT										
Review annual forward clinical audit plan and terms of reference	MH/IB	Assurance	✓				✓			✓
Review the effectiveness of clinical audit – consider recs from the ECPG on suggested areas of activity for review by internal audit	MH/IB	Assurance	✓							✓
FINANCIAL FOCUS										
Review risks and controls around financial management (via Financial Assurance Report)	HT	Assurance	✓		✓	✓	✓	✓	✓	✓
Review Annual Summary of Single Tender Actions (STAs)	HT	Assurance			✓					
Financial Grip and Control	HT	Assurance	D	✓						
Annual statement of financial procedures	HT	Assurance							✓	
Receive Post Payment Verification (PPV) report	HT	Assurance	✓							✓
PPV Mid-Year Update	HT	Assurance					✓			
Receive PPV annual report	HT	Assurance	✓							✓
Receive Primary Care PPV report	AC	Assurance	✓							✓
Review of Schedule of Losses & Compensation*	HT	Assurance								
Receive reports which record the basis of decisions where the HB awards additional funding to contractors outside the terms of the contract *	HT	Assurance								
COUNTER FRAUD										
Review work plan & results from Counter Fraud activities, including anti fraud policies, etc.	CFO	Information	✓		✓	✓	✓	✓	✓	✓

AGENDA ITEM/ISSUE	LEAD	PURPOSE	14 April 2026	7 May 2026	23 June 2026	13 Aug 2026	15 Oct 2026	10 Dec 2026	11 Feb 2027	April 2027
To provide an update on the cases highlighted as part of the counter fraud update report (In-Committee)	CFO	Information	✓		✓	✓	✓	✓	✓	✓
Review and approve Counter Fraud Annual Report	CFO	Approval	✓							✓
Review and approve annual forward work plan for Counter Fraud activities	CFO	Approval	✓							✓
NHS CF Authority SRT Return	CFO	Approval	✓							✓
Annual Review of Requisitions (as part of main Counter Fraud update)	CFO	Information							✓	
Review the Health Board's assessment against NHS Protect Qualitative Assessment Reviews*	CFO	Information								
ASSURANCE AND RISK										
External Recommendations and WHC Assurance Report	JW/CW	Assurance			✓		✓		✓	
Risk Assurance Report	JW/CW	Assurance	✓			✓		✓		✓
Scrutiny of Outstanding Improvement Plans - Update on Status of Risks and Audits: • Community and Integrated Medicine CCG	JW/CW AC	Assurance				✓				
DEEP DIVE										
TBC *		Assurance								
FOR INFORMATION										
ARAC Work Programme	Chair	Information	✓		✓	✓	✓	✓	✓	✓
National Internal Audit Reports *		Information								
REVIEW OF THE MEETING										
Matters & Risks for Escalation to the Board	Chair/JW	Discussion	✓		✓	✓	✓	✓	✓	✓

* To be included on agenda as applicable

Initials

AC – Andrew Carruthers AG – Ardiana Gjini CW – Charlotte Wilmshurst CFO – Counter Fraud Officer CSO – Committee Services Officer EDs – Executive Directors HIW – Healthcare Inspectorate Wales	HT – Huw Thomas IB – Ian Bebb IMs – Independent Board Members JJ – James Johns JS – James Severs JW – Joanne Wilson LD – Lee Davies	LG – Lisa Gostling MG – Murray Gard MH – Mark Henwood PK – Philip Kloer SA – Shaun Ayres SD – Sharon Daniel
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Audit Committee Tasks		14 April 2026	7 May 2026	23 June 2026	13 Aug 2026	15 Oct 2026	10 Dec 2026	11 Feb 2027	April 2027
Prepare Schedule of meeting dates	JW/CSO						✓		
Agenda Setting Meeting with Chair & Exec Lead (at least 1m prior to mtg)	Chair/JW	✓	✓	✓	✓	✓	✓	✓	✓
Disseminate agenda & papers 7 days prior to meeting	CSO	✓	✓	✓	✓	✓	✓	✓	✓
Minutes and action log to be circulated within 7 days of the meeting	CSO	✓	✓	✓	✓	✓	✓	✓	✓
Produce ARAC Update Report for Board	Chair/JW/ CSO	✓	✓	✓	✓	✓	✓	✓	✓
Monitor agreed actions from previous meetings	CSO	✓	✓	✓	✓	✓	✓	✓	✓
Develop & monitor annual work plan linked to corporate objectives, assurance framework and Local and national priorities for Audit	Chair/JW	✓	✓	✓	✓	✓	✓	✓	✓
Ongoing Development of IMs (Briefings/Training/Development sessions)	Chair/JW	✓	✓	✓	✓	✓	✓	✓	✓
Annual Report on Committee's activity for onward submission to the Board – timed to support AGS	Chair/JW		✓						
Process for regular and rigorous self assessment of Committee's effectiveness	Chair/JW +IMs			✓			✓		
Annual bi-lateral meeting between Chair & LCFS *	CFO							✓	
Independent Members private discussions with Internal & External Audit, HIW and LCFS *	All IMs							✓	
Assess performance of Internal Audit *	Chair/IMs							✓	
Assess performance of External Audit *	Chair/IMs							✓	

* Separate meeting

10 - Any Other Business

11 - Review of Meeting

11.1

12:30 PM, 0 Mins

11.1 - Matters and Risks for Escalation to the Board

| For discussion

12 - Date and Time of Next Meeting

9.30am, 10 December 2026

