Regional Joint Committee Governance Arrangements

Final Advisory Report

2025/26

Swansea Bay University Health Board
Hywel Dda University Health Board

Contents

Review Reference	SBU-2526-03 / HDU-2526-01
Fieldwork	March 2026 – May 2026
Executive Sign Off	11 June 2026
Audit Committee	23 June 2026 (HDdU) / 16 July 2026 (SBU)
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Executive Summary

Purpose

In March 2024, Welsh Government directed Swansea Bay University Health Board (SBUHB) and Hywel Dda University Health Board (HDdUHB) to establish a Regional Joint Committee (RJC) to strengthen collaboration in the planning and delivery of services in response to shared clinical, financial and population health challenges. This direction recognised the need for a coordinated regional approach to support the long-term safety, quality and sustainability of key services.

This advisory review assessed the governance arrangements in place to support effective partnership working between SBUHB and HDdUHB through the RJC. The review focused on the design, clarity, and coherence of the governance framework established to support the RJC and its subgroups. An assessment of the operational effectiveness of these arrangements will be undertaken as part of a subsequent review within both Health Boards' 2026/2027 internal audit plans.

Overview

The review identified a number of established and effective elements within the RJC governance framework. In particular, there is a clearly defined governance structure supported by approved Terms of Reference, subgroups operating in line with their intended strategic oversight role, developing work programmes aligned to regional priorities, and consistent and reliable reporting arrangements to both Health Boards through the AAA framework. These arrangements provide a strong foundation for regional partnership working, collective oversight and informed Board-level assurance.

The RJC has made clear progress in establishing its operating model and defining regional priorities. Governance arrangements are functioning as intended at a structural level, with evidence of Board scrutiny, effective escalation processes, and flexible decision-making where required, including for time-critical regional decisions.

As the committee transitions from establishment to delivery, there is an opportunity to further strengthen consistency and maturity across the governance landscape. Variation in maturity across subgroups reflects, in part, the transition from legacy ARCH[1] arrangements and differing stages of programme development. This variation is particularly evident in the consistency and completeness of governance documentation, the clarity and alignment of subgroup objectives and Terms of Reference, the articulation of outputs, outcomes and success measures within work programmes, and the ability to demonstrate progress, interdependencies and impact at a whole-programme level. In particular:

- Subgroup governance arrangements continue to evolve, with some inconsistency in the development, approval and alignment of Terms of Reference and supporting documentation.
- Work programmes are in place across subgroups but vary in coverage and maturity. While more developed areas (e.g. CSP) demonstrate structured, delivery-focused approaches, others remain more indicative in nature, with less consistent defining of outputs, milestones and outcomes. In some cases (e.g. Finance and Contracting), supporting documentation was not available for review, limiting visibility of delivery expectations and contribution to regional objectives.
- There is an intention to develop an RJC strategic risk register and this could be strengthened by a programme-wide approach to risk management, to ensure delivery risks at subgroup and workstream level are consistently identified, recorded and managed.

Notwithstanding these areas for development, governance arrangements are operating effectively in supporting oversight, reporting and decision-making across both Health Boards.

Addressing the areas identified will support the RJC in transitioning from a developing governance model to a more mature, consistently applied framework, capable of demonstrating clear delivery, effective oversight, and measurable impact across its full remit.

[1] A Regional Collaboration for Health (ARCH) was a long-term, tri-partite partnership between Swansea Bay University Health Board, Hywel Dda University Health Board and Swansea University.

Scope & Actions Summary

Objectives		Related Actions
1	The Regional Joint Committee has a clearly defined and approved governance structure, supported by terms of reference and work programmes aligned to its purpose and objectives.	1, 2, 3
2	Regional Joint Committee subgroups are established with clear roles, responsibilities and reporting arrangements to support the effective delivery of regional outputs.	3
3	The Health Boards receive sufficient information to enable effective oversight, decision-making and escalation of key risks and issues.	4

Management Actions

4

Themes

Risk Types

Public Perception & Reputational Risk

Choose an item.

Choose an item.

Choose an item.

Findings & Agreed Actions

Objective 1: The Regional Joint Committee has a clearly defined and approved governance structure, supported by terms of reference and work programmes aligned to its purpose and objectives.

Terms of Reference

The RJC has been formally established in line with ministerial direction issued in March 2024 and is intended to operate at a level equivalent to a Board Assurance Committee within both Health Boards. Its first meeting was held in January 2025. The Committee operates with a clearly articulated purpose and scope, supported by approved Terms of Reference (ToR), which set out its objectives, membership, quorum, meeting arrangements, and reporting lines.

The RJC ToR were approved by the respective Health Boards in May 2025, and have been subsequently reviewed in April 2026, which included strengthening self-assessment arrangements, clarifying the Committee's system-wide oversight role, and reinforcing reporting expectations to Welsh Government. Review of the RJC Terms of Reference identified varying levels of maturity across the RJC's supporting subgroups[2], with the objectives of the Clinical Services Planning (CSP) and Regional Health Economy (RHE) subgroups being the most clearly articulated. We note that this variation was acknowledged in the April 2026 review of ToR, with the RJC agreeing that further work was required to develop and align objectives of the Finance and Contracting, and Workforce and Organisational Development (WOD) subgroups to improve consistency.

Review of RJC papers (January 2025 to April 2026) confirms that meetings have consistently achieved quorum. While the expectation is for quarterly meetings, the planned October 2025 meeting was stood down to allow greater focus on subgroup development, including clarifying ambition, scope, and delivery expectations. An extraordinary meeting was convened in February 2026, aligned to Health Board reporting cycles, to enable timely consideration, endorsement, and submission of the Regional Cellular Pathology business case to Welsh Government.

Although the RJC has received updates on the development of subgroup ToR, formal approval has not been consistently undertaken beyond that of the Research Innovation and Excellence (RIE) subgroup (see **Action 1**). Our review of subgroup and workstream ToR (see objective 2) identified that there could be greater consistency and alignment with the overarching RJC ToR (see **Action 1 & 3**).

Work Programme

The RJC work programme has evolved from an initial consolidation of legacy ARCH arrangements into a more structured articulation of regional priorities aligned to its core objectives. Comparison of the 2026/27 work programme with both Health Boards' Annual Plans confirms alignment between regional priorities and organisational commitments, providing a clear line of sight between regional planning and local delivery.

Earlier iterations of the work programme incorporated a subgroup maturity assessment (see **Appendix A**), providing a structured view of relative development across the RJC portfolio. This enabled clearer differentiation between established delivery areas and those still in scoping or development phases, supporting more informed oversight by the RJC. We have prepared an updated maturity assessment (see **Appendix B**), based on a review of supporting documentation for each subgroup, which provides a current view of their development.

[2] Regional Health Economy Subgroup, Regional Clinical Services Planning Subgroup, Regional Workforce & OD Subgroup, Regional Digital & Data Subgroup, Regional Finance and Contracting Subgroup, Regional Research Innovation & Excellence Subgroup.

Review of the RJC work programme, delivered through its constituent sub-groups, demonstrates clear progression since establishment, with increasing clarity around intended outputs and areas of focus. This is most evident within the CSP subgroup, where outputs and priorities are articulated in a more structured and delivery-focused manner, reflecting a more mature programme of work.

In contrast, other subgroups remain at an earlier stage of development, with plans articulated more at the level of intention or direction. There is less consistent sequencing of activities and articulation of corresponding deliverables, timescales and outcome measures. While this is consistent with their stage of development, it could contribute to variation in how activity, outputs, and outcomes are monitored (see **Action 2**).

Similarly, this was recognised by the RJC through its self-assessment of its first year of operation, which identified a need for clearer measurement of effectiveness and impact. An action plan has been developed to address this, which includes expanding reporting to provide clearer outline of timescales, outputs, and outcomes rather than activity alone.

Action 1: RJC

Improving consistency across subgroup and respective workstream Terms of Reference would support clearer roles, defined responsibilities, and more robust governance accountability.

Action 2: RJC Work Programme

Further development of the RJC work programme would support consistent articulation of expected outputs and delivery contributions across all subgroups. This could be strengthened through periodic use of a subgroup maturity assessment or view to inform Committee-level oversight and self-assessment.

Objective 2: Regional Joint Committee subgroups are established with clear roles, responsibilities and reporting arrangements to support the effective delivery of regional outputs.

Work programmes are in place across the RJC substructure and are broadly aligned at a strategic level to RJC objectives. Acknowledging there are differing levels of maturity across these programmes, there is variation in both the level of detail and the way in which they are articulated and reported to the RJC.

The CSP subgroup has a more developed portfolio approach, supported by structured AAA and highlight reporting, with a clear linkage between programme activity, risk, prioritisation and executive decision-making. This includes decisions taken to pause specific workstreams, such as Urgent and Emergency Care, in recognition of programme resource constraints. While evidence was available to support the decision-making process at the point of pause, including consideration of capacity and prioritisation of resources, limited supporting documentation was available to demonstrate the progress of this workstream prior to this decision.

In contrast, other subgroups are at earlier stages of development, with variation in maturity reflecting the transition from legacy ARCH arrangements to newer RJC-established structures. The RHE subgroup reports progress using narrative-based highlight summaries, with a strong emphasis on partnership working and activity; however, this is not consistently supported by clearly defined outputs or success criteria. This has been recognised by management and is a key focus within the Health Intelligence and Health Inequalities workstreams as the subgroup develops its longer-term strategic plan.

The REI subgroup structure has established short-term milestones and supporting documentation; however, given its delayed implementation, longer-term outcomes and benefits realisation remain under development. Similarly, the WOD subgroup has made positive progress through the introduction of "plan on a page" documentation; however, this approach is not yet been consistently applied across all workstreams.

A more structured approach is evident within the Data and Digital subgroup, where a defined delivery plan was presented to the RJC in April 2026, incorporating clearly articulated workstreams, milestones, outputs and intended benefits. This reflects a response to challenge from RJC members for greater clarity on near-term priorities and delivery expectations.

In contrast, while the Finance and Contracting Subgroup is referenced within the RJC structure and work programme, no supporting documentation or defined work programme was available for review. This restricts visibility of its role, delivery expectations and contribution to wider regional objectives (see **Action 3**).

Structured reporting is undertaken to the RJC, primarily through the Alert, Advise and Assure (AAA) framework, which supports visibility of key activity and provides an established mechanism to escalate issues.

In addition to formal subgroups, the Regional Drive and Delivery Group (RDDG) operates as an Executive-level operational and steering forum. Chaired jointly by the Chief Executives and comprising senior executive representation from both Health Boards, the RDDG provides coordination and oversight of delivery across the RJC portfolio. Meeting cycles are aligned with those of the RJC, enabling the group to review progress, coordinate inputs and monitor actions in advance of and following formal RJC reporting.

Evidence from action logs and meeting notes indicates that the RDDG is actively tracking and progressing RJC actions across subgroup workstreams, such as the Orthopaedics programme within CSP. The decision to step down the October RJC meeting provided additional operational focus at RDDG level, enabling subgroups to refine their plans, clarify intended outputs and outcomes, and consider key risks and dependencies ahead of subsequent RJC reporting.

Variation in maturity and coverage of work programmes is, in part, reflective of wider programme capacity and resource constraints. Evidence from CSP and RDDG indicates that conscious decisions are being made to focus available programme management and operational resource on areas of greatest strategic importance and readiness.

The RJC Programme Management Office (PMO) capacity is directed towards the CSP and RHE portfolios and delivered through a small core team. Engagement with national programmes is ongoing to identify additional resources to support its operation.

Action 3: Strengthen formal governance and documentation discipline

Formalising and standardising governance arrangements across all subgroups would strengthen documentation discipline. This includes ensuring Terms of Reference are approved, documentation is maintained and up to date, and consistent standards (such as version control and clear articulation of purpose, outputs and responsibilities) are applied.

This is particularly relevant where documentation is limited or not fully developed, for example within the Finance and Contracting sub-group, where work programme documentation does not consistently set out defined outputs, milestones or delivery timescales. This could also include updating legacy references (e.g. ARCH within CSP documentation) and ensuring governance documentation accurately reflects current operating arrangements.

Objective 3: The Health Boards receive sufficient information to enable effective oversight, decision-making and escalation of key risks and issues.

Review of RJC meeting papers (January, May and August 2025; and January 2026), minutes, and corresponding AAA subgroup reports confirmed that Board papers accurately reflect the content, decisions, assurances, and matters requiring escalation arising from RJC meetings across all periods tested. Where AAA reports indicated "no alerts" or "no risks", this was fully consistent with the underlying RJC documentation.

Comparison of reporting across both Health Boards confirms consistency in the format, structure and content of information presented. The same AAA reports, containing identical core assurance content, including decisions and risks, were submitted to both Boards at the next scheduled Board meeting following each RJC meeting.

One instance of variation was identified in March 2025, where additional narrative context relating to the developing governance architecture of the RJC was provided to Hywel Dda but not to Swansea Bay. However, this did not affect the consistency of assurance or decision-making information and has not recurred in subsequent reporting cycles.

Evidence of Board scrutiny and challenge when receiving RJC AAA reports was evident, particularly in relation to complex or high-impact matters such as the progression of the Regional Cellular Pathology business case. We did not identify any instances where issues were formally referred back to the RJC.

Where RJC and Board meeting cycles did not fully align, appropriate flexibility was applied to ensure that Boards received complete and accurate updates at the earliest available opportunity. The use of extraordinary RJC meetings and Special Board meetings, particularly in relation to significant regional clinical decisions, demonstrates that governance arrangements are sufficiently flexible to respond to time-critical requirements.

The RJC does not maintain a standalone risk register, although subgroup reporting includes references to a range of workstream and project risks. As part of this review, a mapping exercise against Health Board risk registers confirmed that regional and RJC-relevant risks are appropriately captured. This includes recognition of cross-organisational and system-wide dependencies, particularly in areas such as workforce sustainability, diagnostics and cancer pathways, digital resilience, financial sustainability, and the delivery of regional clinical services.

At its April 2026 meeting, the RJC considered its approach to identifying and managing system-wide risks arising from regional working. An action was agreed for the Directors of Corporate Governance of both Health Boards to jointly develop and present a proportionate and pragmatic RJC strategic risk register, identifying system-wide risks aligned to RJC objectives, an initial high-level outline is to be presented to the RJC in July 2026.

Review of subgroup agendas identified that risks are routinely referenced within highlight reports, with some evidence of workstream or project-level risk registers (for example, within the CSP subgroup at individual project level). However, there is no clearly defined programme-wide approach to risk management to ensure that delivery risks are identified, recorded and managed consistently across subgroups and workstreams. (see **Action 4**).

Action 4: Programme Risk Management

Completion of the strategic risk register should be followed by the definition and implementation of a programme-wide approach to risk management, to ensure delivery risks are consistently identified, recorded and escalated across all subgroups and workstreams.

Appendix A: RJC Work Programme Status (August 2025)

The following summary was presented at the Regional Joint Committee meeting (18 August 2025)

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Work Programme Progress Summary

Subgroup	ToRs agreed by Sub-Group	Programme Defined	Ambition Agreed	Agreed Subgroup Work programme	Objectives/ Outcomes Agreed	Resources Agreed	Risks Understood	Dependencies Understood	Key Milestones	Detailed Plans
Regional Health Economy	✗	✓	✓	✓	✗	✗	✓	✗	✓	✗
Clinical Services Planning	✓	✓	✓	✓	✓	✗	✓	✗	✓	✗
Workforce & OD	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Data and Digital	✗	✓	✓	✓	✗	✗	✗	✗	✓	✗
Finance and Contracting	✗	✓	✓	✗	✗	✗	✗	✗	✗	✗
Research, Innovation & Excellence	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗

Appendix B: RJC Work Programme Status (May 2026)

This programme status was developed as part of an exercise undertaken by Audit & Assurance, based on a review of supporting documentation for each of the sub-groups:

Subgroup	ToR's agreed by Sub-group	Programme Defined	Ambition Agreed	Agreed Sub-group Work Programme	Objectives/ Outcomes agreed	Resources agreed	Risks Understood	Dependencies Understood	Key Milestones	Detailed Plans
Regional Health Economy	✓	In progress	✓	✓	✓	In progress	In progress	In progress	In progress	In progress
Clinical Services Planning	✓	✓	✓	✓	✓	In progress	✓	In progress	✓	✓
Workforce & OD	No	✓	✓	Partial	✓	✓	✓	In progress	In progress	In progress
Data & Digital	No	✓	✓	✓	✓	✓	✓	In progress	✓	✓
Finance & Contracting	No	In progress	In progress	In progress	In progress	In progress	Unclear	Unclear	Unclear	Unclear
Research, Innovation & Excellence	✓	✓	✓	✓	✓	In progress	In progress	In progress	In progress	In progress

Appendix C: Assurance Opinion & Prioritisation of Findings

Assurance Opinion

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

Prioritisation of Findings

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

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