



GIG
CYMRU
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WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Date **2026-05-07**
Time **09:30 - 12:30**
Location **Microsoft Teams Meeting; HDD Picton - Dolau Cothi**

Audit & Risk Assurance Committee Meeting (review of draft accounts)

HDD_Audit and Risk Committee
NHS Wales

Agenda - 7 May 2026

1 Introductions

09:30, 0 min

1.1 Apologies

09:30, 0 min

Rhodri Evans (Hywel Dda UHB - Independent Member)

1.2 Declaration of Interests

09:30, 0 min

All

2 Audit Wales

09:30, 0 min

2.1 Audit Wales Update Report

09:30, 5 min

Anne Beegan, Urvisha Perez, David Williams

2.2 Digital Transformation Review

09:35, 20 min

Anne Beegan, Urvisha Perez, Huw Thomas (Hywel Dda UHB - Director of Finance), Anthony Tracey (Hywel Dda UHB - Digital Director)

3 NWSSP – Audit and Assurance Services - Internal Audit

09:55, 0 min

3.1 Internal Audit Plan Progress Report

09:55, 5 min

James Johns (NWSSP - Internal Audit)

3.2 Sickness Management Follow-up (Review)

10:00, 20 min

James Johns (NWSSP - Internal Audit), Lisa Gostling (Hywel Dda UHB - Director of Workforce & OD/Deputy CEO), Heather Hinkin (Hywel Dda UHB - Assistant Director People Management)

3.3 Major Infrastructure Investment Programme (Reasonable Assurance)

10:20, 10 min

James Johns (NWSSP - Internal Audit), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Rob Elliott (Hywel Dda UHB - Programme Director Major Infrastructure Projects)

3.4 Withybush General Hospital – Fire Precautions Works Phase 2 (Reasonable Assurance)

10:30, 10 min

James Johns (NWSSP - Internal Audit), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science), Rob Elliott (Hywel Dda UHB - Programme Director Major Infrastructure Projects)

3.5 Infection Prevention & Control

10:40, 0 min

James Johns (NWSSP - Internal Audit)

3.6 Commissioning Third Sector

10:40, 0 min

James Johns (NWSSP - Internal Audit)

3.7 Wellsky System

10:40, 0 min

James Johns (NWSSP - Internal Audit)

3.8 Decision Making for High Cost Drugs

10:40, 0 min

James Johns (NWSSP - Internal Audit)

3.9 GP Out of Hours

10:40, 0 min

James Johns (NWSSP - Internal Audit)

BREAK

10:40, 10 min

4 Governance

10:50, 0 min

4.1 Report on the Adequacy of Arrangements for Declaring, Registering and Handling of Interests, Gifts, Hospitality, Honoraria and Sponsorship

10:50, 5 min

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

4.2 Draft Audit and Risk Assurance Committee Annual Report 2025/26

10:55, 5 min

Rhodri Evans (Hywel Dda UHB - Independent Member)

4.3 Draft Head of Internal Audit Opinion and Annual Report 2025/26 (Verbal Update)

11:00, 15 min

James Johns (NWSSP - Internal Audit)

4.4 Assurance Report on Board Effectiveness

11:15, 5 min

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

4.5 Audit Enquiries to those Charged with Governance and Management

11:20, 5 min

Huw Thomas (Hywel Dda UHB - Director of Finance)

4.6 Draft Performance Overview

11:25, 5 min

Huw Thomas (Hywel Dda UHB - Director of Finance), Alwena Hughes Moakes (Hywel Dda UHB - Communications and Engagement Director), Fiona Hancock (Hywel Dda UHB - Senior Communications Officer)

4.7 Draft Accountability Report (To Follow)

11:30, 10 min

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

5 Financial Focus

11:40, 0 min

5.1 Financial Grip and Control

11:40, 10 min

Huw Thomas (Hywel Dda UHB - Director of Finance)

5.2 Draft Annual Accounts 2025/26 (To Follow)

11:50, 40 min

Huw Thomas (Hywel Dda UHB - Director of Finance)

6 Any Other Business

12:30, 0 min

All

7 Date and Time of Next Meeting

12:30, 0 min

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1 - Introductions

1.1

09:30, 0 Mins

1.1 - Apologies

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

| For information

1.2

09:30, 0 Mins

1.2 - Declaration of Interests

All

hduhb.nhs.wales/about-us/governance-arrangements/register-of-interests-gifts-sponsorship-and-hospitality/register-of-igsh-documents/register-of-board-members-interests-2026-2027-pdf1/

| For information

2 - Audit Wales

2.1

09:30, 5 Mins

2.1 - Audit Wales Update Report

*Anne Beegan,
Urvisha Perez, David
Williams*

| For assurance

Attachments

[2.1 Audit Wales ARAC Update \(May 2026\).pdf](#)

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

Date issued: May 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 Board's Annual Report and Accounts

- **Executive Lead:** Director of Finance
- **Focus of the work:** To provide an audit opinion on the Health Board's 2025-26 Annual Report and Accounts.
- **Status:** In progress – audit planning and interim testing
- **Expected committee date:** June 2026

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

Structured assessment 2024 - deep dive review of investment in digital systems

- **Executive Lead:** Director of Finance
- **Focus of the work:** This work has examined digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.
- **Status:** Complete – report in today’s papers
- **Expected committee date:** May 2026

Review of radiology services

- **Executive Lead:** Director of Operations
- **Focus of the work:** This work has examined the effectiveness of arrangements to manage current and future demand for the Health Board’s radiology services and will assess the extent of progress made in implementing the recommendations from our 2017 radiology service review.
- **Status:** Report drafting
- **Expected committee date:** June 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 will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose.
- **Status:** Fieldwork underway
- **Expected committee date:** August 2026

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 will focus 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:** Fieldwork underway
- **Expected committee date:** August 2026

Structured Assessment 2026

- **Executive Lead:** Director of Corporate Governance
- **Focus of the work:** The 2026 structured assessment will examine proper arrangements for the efficient, effective, and economical use of resources and track progress against previous audit recommendations. It will also inform our thinking on whether to undertake future work on hosted bodies' governance arrangements, particularly the Joint Commissioning Committee (JCC) and the NHS Wales Shared Services Partnership (NWSSP).
- **Status:** Planning
- **Expected committee date:** December 2026

Review of the management and prevention of diabetes

- **Executive Lead:** Director of Public Health
- **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

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:** To be confirmed

Other relevant publications

Since the last committee update, the Auditor General has not published any other outputs relevant to the NHS.

Since the last committee update, Audit Wales has published the following corporate documents.

[Annual Plan for 2026-27](#)

April 2026

There are no relevant Audit Wales 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](#).



[Data tools](#) to help you better understand public spending trends.



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Audit Wales

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Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

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



2.2

09:35, 20 Mins

2.2 - Digital Transformation Review

*Anne Beegan,
Urvisha Perez, Huw
Thomas (Hywel Dda
UHB - Director of
Finance), Anthony
Tracey (Hywel Dda
UHB - Digital
Director)*

Sections of the report and management response have been redacted to protect cyber security. The full report is being considered during an In-Committee session

| For assurance

Attachments

[2.2 HDUHB Digital Transformation Review \(Final\) Redacted.pdf](#)

[2.2 Management Response Form - HDUHB Digital Transformation Review \(Final\) Redacted.pdf](#)

Digital Transformation

Hywel Dda University Health Board

March 2026

About us

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

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Audit snapshot

What we looked at

- 1 We looked at how Hywel Dda University Health Board's (the Health Board) approach to digital transformation is supporting service improvement. This included the approach to strategy, leadership and skills development. And we considered how the organisation manages risks around digital infrastructure, cyber resilience and artificial intelligence.

Why this is important

- 2 Digital technology is a key enabler to many of the aims of A Healthier Wales. That plan says that new technologies and digital approaches will be an important part of the future whole system approach to health and care.
- 3 However, achieving digital transformation is challenging. It requires investment, the right infrastructure, and staff engagement and training. Systems need to communicate with one another and organisations must manage ever-growing risks around cyber resilience.
- 4 Digital transformation isn't just about technology, it's about culture and leadership. The boards of NHS bodies have a key role in approving and owning the organisation's digital strategy. Boards also need assurance that digital transformation is being managed safely and effectively, and that investment is securing the intended benefits.

What we have found

- 5 The Health Board has a clear and ambitious approach to digital transformation, supported by strong leadership and an established strategic plan. Board oversight of digital transformation is effective, but assurance could be strengthened by consolidating information on the outcomes and impact of engagement across digital projects. While the Health Board is committed to investing in digital transformation, as evidenced through its 10-year strategic partnership with an external specialist, limited funding poses a risk to the delivery of strategic priorities.
- 6 The Health Board is actively progressing a range of local and national projects, with its three-year digital transformation roadmap aiming to improve patient outcomes, staff experience, and drive financial sustainability. The Health Board also has a good approach to evaluating digital projects and tracking their benefits.
- 7 [REDACTED]
- 8 The Health Board is making progress in understanding and improving digital skills through targeted training, a skills pathway, and digital inclusion initiatives. Despite these positive steps, digital confidence varies across the workforce, and the absence of a standalone digital workforce plan is a notable weakness as digital transformation accelerates.
- 9 The organisation shows strong commitment to digital inclusion and partnership working, contributing actively to national and regional programmes. Engagement with staff and service users is improving through clinical informatics leads, digital champions, and design workshops.

What we recommend

10 We have made five recommendations to the Health Board focusing on:

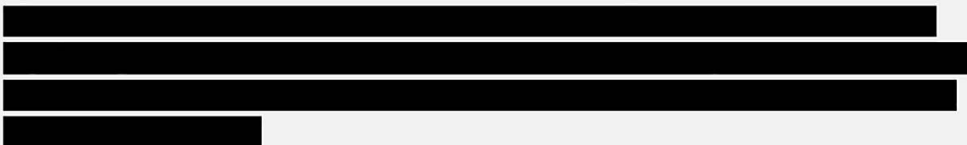
- Providing a more streamlined overview of digital initiatives to the Digital, Data and Innovation Committee,
- [REDACTED]
- Developing a digital workforce plan to support delivery of the strategic digital plan,
- Capturing a consolidated view of outcomes and impact from digital project engagement activities, and
- Strengthen Board level reporting on national digital peer groups.

Key facts and figures

Of the Health Boards workforce, approximately 13,000 staff, only 209 have completed the HEIW (Health Education and Improvement Wales) interactive self-evaluation tool as part of the Digital Capability Framework.

The Health Board has achieved accreditation under the Digital Inclusion Charter¹ in recognition of its Digital Inclusion Programme.

During 2024-25, 499 members of staff attended digital inclusion sessions.



From 2021-22 to 2024-25, the Health Board invested approximately £68 million in digital revenue and £13 million in capital.

¹ The Digital Inclusion Charter for Wales is a framework which helps organisations to reduce digital exclusion.

Our findings

Strategy, planning and leadership

The Health Board has a clear digital strategy, strong digital leadership, and has invested in specialist external support to speed up its digital transformation

Digital strategy and plans

- 11 The Health Board has recently updated its long-term strategy, A Healthier Mid and West Wales, where digital transformation is a key part of achieving future ambitions. The strategy's 'digital first' goal aims to harness digital and AI innovations, create seamless pathways between care and home settings, and support staff with effective tools. It aims to achieve this by delivering its Digital Strategic Plan, Our Digital Response 2020-25, which it is currently updating.
- 12 The plan was launched during the pandemic. This meant the Health Board had to pause or reprioritise some projects, for example, quickly rolling out Microsoft Office 365. Since then, technology has advanced significantly and the Health Board is updating the plan to make sure it is still relevant and responds to current needs. The clear vision and priorities set out in 2020 are mainly unchanged. These aim to help patients manage their own care, make it easier for staff to access shared records, use data to improve care locally and regionally, and improve digital infrastructure.
- 13 The Health Board expects to launch the updated Digital Strategic Plan in summer 2026, following engagement with staff and the public to make sure it reflects their needs. Feedback from the recent long-term strategy engagement has already informed key priorities for digital healthcare. The updated plan will also need to align with other key Health Board strategies, including the People Plan and the Clinical Services Plan.

- 14 While the Digital Strategic Plan is being updated, the Health Board has a clear way forward and focus on delivery. The Health Board's 2025-26 Annual Plan² and Digital Operational Plan set out clear short-term digital priorities, actions, and milestones. It has also created a high-level three-year Digital Transformation Roadmap, which focuses on ten key programmes. Progress on digital projects and priorities are regularly reported to the Digital, Data and Innovation (DDI) Committee.
- 15 In 2025, the Health Board entered a 10-year strategic partnership with CGI, a digital health organisation, to accelerate its digital transformation. This unique partnership is designed to expand the Health Board's digital capacity, strengthen skills, and support knowledge transfer. CGI is currently working with the Health Board on several key areas, including programme management of national system implementations, reviews of artificial intelligence, and migration to cloud-based systems. Although the partnership has not yet been formally evaluated, initial feedback has been positive.
- 16 The Health Board recognises that it needs to improve its digital maturity. Its existing plan was based on an assessment using the Healthcare Information and Management Systems Society (HIMSS) framework, which rated the Health Board at Level 1. This assessment helped the Health Board understand the scale of its digital challenges and set goals to reach HIMSS Level 3 within two years and Level 6 within five years. The Health Board plans to carry out another assessment in 18 months, after implementing several key digital programmes.

² The 2025-26 Annual Plan has 10 planning objectives, objective 9 focuses on digital plans.

Board ownership of digital transformation

- 17 The Board shows strong ownership of digital transformation. Over the past three years, understanding and engagement have increased, supported by regular updates on individual digital projects and wider transformation plans through the DDI Committee, Board meetings, and Board Development Sessions. The Board sees digital as essential to delivering change, reinforced in November 2024 when it approved a 10-year strategic digital partnership to accelerate progress.
- 18 There is clear digital leadership and expertise at Board level. The Board has an Independent Member for Information Technology, who chairs the new DDI Committee.

Roles, responsibilities and accountability

- 19 The Board has good oversight of its Digital Strategic Plan, which it strengthened by establishing the DDI Committee ³ in April 2025.
- 20 Chaired by the Independent Member for Information Technology, the DDI Committee operates effectively, with open discussion and good scrutiny. It has good oversight of digital plans, projects and risks, regularly receiving updates on the Digital Strategic Plan, the strategic digital partnership, business cases and the 2025-26 Annual Plan digital objective. While these reports are clear, they often duplicate information, with each one providing updates on the same projects, such as the Electronic Prescribing and Medicines Administration (ePMA) Project, from a different perspective and with varying levels of detail. There is an opportunity, therefore, for the Health Board to review committee reporting to reduce overlap and present a more streamlined, consolidated view of digital work.

³ The Sustainable Resources Committee, which previously oversaw digital work, was stood down in March 2025.

- 21 There are clear executive and operational arrangements for overseeing digital work. The Director of Digital reports to the Executive Director of Finance, who is the executive lead for digital. Both sit on the DDI Committee and regularly attend Board meetings to update members on digital work. Having digital overseen by the Executive Director of Finance helps ensure strong links to investment decisions and a focus on value for money and return on investment.
- 22 The Executive Director of Finance has an annual objective to progress actions related to digital, technology and AI with progress and risks regularly reported to the DDI Committee. Several operational groups also support delivery, including Performance Group meetings, the Change Advisory Board, and Senior Digital Team meetings. These groups report into the Healthier Mid and West Wales Group, which is a sub-group of the Executive Team.
- 23 The Health Board is actively working to strengthen clinical digital leadership. It already has a Chief Clinical Information Officer who meets regularly with the Director of Digital. To broaden this leadership, the Health Board plans to recruit Chief Information Officers for Nursing and Allied Health Professions. These roles will serve as vital links between clinical and digital teams, ensuring a strong clinical perspective in decision-making. It also plans to set up a group of interested clinicians to address topics such as clinical safety, but this is still in its early stages.

Identifying and managing risks

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Digital skills

The Health Board has a positive approach to assessing and developing digital skills, which it could strengthen by developing a digital workforce plan

Assessing digital skills

- 35 The Health Board has a basic understanding of workforce digital skills and capability, with only 209 staff completing the HEIW's Digital Competency Framework self-assessment tool. However, the results were still useful, highlighting that almost half of those who took part (45%) said they were still learning or not confident in their digital skills.
- 36 This understanding has helped the Health Board design digital skills training that fits the different needs of staff in various roles. It has created a Digital Skills and Confidence Development Pathway to encourage ongoing learning and to make it easier for staff and managers to find useful training resources. The pathway, which the Health Board has started to roll out, aims to develop basic and more advanced skills, with an internal skills audit and HEIW's Digital Competency Framework as tools to support learning and self-evaluation. The Health Board also plans to include digital skills discussions into staff Personal Appraisal and Development Reviews (PADR).
- 37 When implementing new digital projects, the Health Board adopts a positive 'no one left behind' approach by working with staff to build their digital skills and confidence before new systems are rolled out. For example, digital skills and digital inclusion are key considerations in the Outline Business Case for the Patient Service Centre, which was presented to the DDI Committee in January 2026.

Developing digital skills

- 38 The Health Board does not have a standalone digital workforce plan. The refresh of its digital strategic plan offers an opportunity to identify gaps in digital skills and capacity and outline the resources needed to address them in the short-, medium-, and longer-term.
- 39 Despite this, the Health Board recognises the need to upskill its workforce to support digital transformation, with its Digital Inclusion Programme (see **paragraph 42**) covering staff and the wider community. A dedicated workstream within this programme aims to strengthen digital skills and confidence by improving access to digital-inclusion resources and motivating staff to engage with digital change. To support this, the Health Board is using and developing a range of tools, including digital inclusion champions, online training, managerial and team checklists, roadshows, and tailored support from the Digital Inclusion Team.
- 40 During 2024-25, 499 staff engaged with digital inclusion activities. While participation is low compared to the size of the workforce, those attending report increased confidence and skills. The Health Board is aware of the key challenges, such as staff resistance to digital change, limited time available for training, inconsistent digital infrastructure and varying levels of manager engagement with the self-assessment tool.
- 41 The Digital Directorate comprises 227 Whole Time Equivalent (WTE) staff across a variety of roles. The Health Board reported that recruiting digital staff is challenging, but retention is not a problem. Its partnership with CGI has increased digital capacity and helped the team progress transformation projects previously delayed due to operational pressures. CGI also supports knowledge transfer and upskilling, which is harder to achieve through short-term contracts. As a global organisation, CGI brings wider experience and broader perspectives to the Health Board.

Collaboration and involvement

The Health Board demonstrates strong commitment to digital inclusion and partnership engagement, while its approach to service user involvement is evolving

Reducing digital exclusion

42 The Health Board is strongly committed to digital inclusion. It set up the Digital Inclusion Support Service in May 2023, which includes a Digital Inclusion Manager and two Digital Inclusion Advisors. This team runs a clear Digital Inclusion Programme that supports both staff and the wider community. The programme is built around eight main areas which focus on:

- improving digital access and skills,
- co-designing services,
- increasing digital health literacy,
- developing digital health hubs,
- strengthening engagement with underserved groups,
- enhancing the digital capability of the workforce, and
- embedding digital inclusion across health and wellbeing strategies.

43 Demonstrating its commitment, the Health Board achieved Digital Inclusion Charter status in September 2022. In addition, the Digital Director sits on the Digital Inclusion Alliance Wales⁵ Steering Group, and the Independent Member for Information Technology chairs the Regional Digital Inclusion

⁵ The Digital Inclusion Alliance for Wales (DIAW) is a group of organisations working together to advance digital inclusion across Wales.

Steering Group⁶. These roles create valuable opportunities for information sharing and collaborative working.

- 44 The Health Board acknowledges that its work on digital inclusion is further ahead for staff than for the community and **paragraph 39** outlines the range of support to develop workforce skills. In addition, the programme includes a laptop-loan scheme to support staff with training, as well as a 'databank' initiative that helps staff purchase mobile data. However, it is working with partners to improve community digital inclusion. This includes:
- working with Ceredigion County Council's Independent Living Hub to build service user's digital confidence,
 - setting up a Digital Inclusion Alliance Group to coordinate local opportunities,
 - advising Pembrokeshire County Council on including digital access within its new Independent Living Centre, and
 - identifying and signposting patients who may benefit from community digital support.
- 45 The DDI Committee receives routine updates on digital inclusion activities across the eight areas of the programme. However, these reports do not include milestones or participation data, making it difficult to assess progress or impact. Although the annual benefit realisation report includes some digital inclusion metrics, these focus on staff initiatives only. The Health Board recognises these gaps, especially measuring soft-skills and longer-term outcomes.

Staff and service user involvement

- 46 The Health Board is committed to involving staff, patients, and service users in shaping its digital programmes. Engagement is now a routine part of major projects and will be an important part of updating the Strategic Digital Plan.

⁶ The Regional Digital Inclusion Steering Group brings partners in West Wales together to improve digital inclusion.

- 47 Staff involvement is supported through mechanisms such as clinical informatics leads, digital champions, and multidisciplinary design workshops. This helps ensure digital solutions reflect frontline needs and operational practice. To strengthen clinical input, the Health Board is creating a Clinical Informatics model which brings together roles like the Chief Clinical Information Officer, Nursing Informatics Leads, and Digital Pharmacists into a single, coordinated structure, helping to ensure all professions are represented in digital decision-making.
- 48 The Health Board is also improving how it engages with patients and the public through user testing, feedback surveys, and targeted outreach to people at risk of digital exclusion. It is also increasingly placing more focus on digital inclusion and co-design, particularly for virtual care pathways and patient-facing technologies.
- 49 While the Board receives assurance about stakeholder involvement in digital transformation on a project-by-project basis, this information is not brought together to show the overall impact, and outcome measures are unclear. This makes it difficult to gauge progress. Pulling this information together would help the Health Board identify gaps in engagement and strengthen involvement across all groups, including those that are seldom heard.

Partnership working

- 50 The Health Board works well with its national and regional partners, including DHCW, Welsh Government, and Swansea Bay University Health Board. It has a strong working relationship with DHCW, supported by regular leadership-level meetings that help with joint planning and problem-solving. DHCW was also directly involved in the CGI procurement, and Welsh Government approved the investment.

- 51 Digital leaders in the Health Board are actively involved in national digital groups and peer networks. For example, the Director of Digital chairs the Digital Directors' Peer Group and is a member of the AI Commission for Health and Social Care. The Executive Director of Finance chairs the Digital Services for Patients and the Public Group, and the Independent Member for IT chairs the Digital IMs Peer Group. This national involvement helps the Health Board influence wider digital policy and stay aligned with national priorities.
- 52 The Board receives regular reports on the strategic digital partnership and the work of the regional joint committee. However, it receives limited information about other important digital partnerships and national digital groups. As a result, the Board has less visibility of what these partnerships are delivering, how they support local digital plans, and whether any risks or gaps need attention.

Using digital developments to support service transformation

The Health Board is committed to adopting national digital systems and has a strong approach to benefits realisation. While committed to digital investment, limited funding poses a risk to delivery

Investment in digital transformation

- 53 The Health Board's financial position is challenging, with a forecast year-end deficit for 2025-26. Despite this, the Board has shown a strong commitment to investing in digital transformation, notably by entering a 10-year strategic partnership with CGI worth £75 million⁷. However, there is no dedicated funding for the contract, so each project still needs an approved business case and must rely on funding from sources like Welsh Government, end of year funding, or discretionary capital. This uncertainty risks delivery of the Strategic Digital Plan. However, to give both parties flexibility, CGI's contract was agreed on a 'zero-commitment' basis.
- 54 Given these financial pressures, the Health Board is realistic and uses the MoSCoW⁸ method to prioritise digital projects. This method helps identify what must be funded now and what can be delayed, making sure resources are focused on critical projects and those that deliver the greatest value. This structured approach supports clear decision-making, reduces waste and helps keep projects achievable. The prioritised projects form the basis for the annual Digital Operational Plan.

⁷ The contract value of £75 million over 10 years is based on anticipated costs of future digital projects and the Health Board's typical spend on digital transformation.

⁸ The MoSCoW method is a prioritisation tool that groups requirements into four categories: Must have, Should have, Could have, and Won't have.

55 **Exhibit 1** shows that capital and revenue spending on digital services has fluctuated over recent years, with an average combined annual spend of around £20 million. While **Exhibit 2** shows that the Health Board intends to increase its revenue digital investment from 2025-26 onwards, there is a risk this might not happen if wider financial challenges continue. This will likely impact the pace of digital transformation, and the Health Board will need to make sure it has contingency plans in place.

Exhibit 1: Annual capital and revenue investment in digital (2021–22 to 2024–25)

Financial Year	Capital £m	Revenue £m
2021-22	4.8	19.5
2022-23	1.2	16.0
2023-24	2.8	18.9
2024-25	3.7	14.0

Exhibit 2: Planned levels of capital and revenue investment in digital (2025-26 to 2027–28)

Financial Year	Capital ⁹ £m	Revenue £m
2025-26	1.0	24.5
2026-27	1.0	31.4 ¹⁰
2027-28	1.0	34.1
2028-29	1.0	37.0

Source: Health Board supplied data

⁹ This is subject to confirmation.

¹⁰ This figure includes Corporate and Health Records, which will fall under the Digital Directorate's responsibility.

Local and regional digital projects

- 56 The Health Board is actively progressing a range of local projects. Its three-year digital transformation roadmap sets out ten key programmes that aim to improve patient outcomes, staff experience, and drive financial sustainability. These programmes include both national and local solutions such as the Laboratory Information Management System replacement, electronic observation systems, and developing a patient service centre and patient relationship management tool.
- 57 The Health Board is also working on regional digital solutions with Swansea Bay University Health Board. A regional Joint Committee has been in place since January 2025, and has five shared regional objectives, including improving digital collaboration and efficiency. Both organisations have committed to working together on digital initiatives and have established joint working groups covering data and intelligence, infrastructure, digital inclusion, and clinical systems, alongside a regional digital forum. The two Health Boards also plan to develop a shared digital roadmap and, as noted earlier, a joint AI strategy and governance framework by early 2026.
- 58 In addition, the Health Board works with local universities, including Aberystwyth and Swansea Universities, through joint roles and sponsored PhDs. These partnerships help with data projects that support planning and forecasting.

Adopting national digital systems

- 59 The Health Board is rolling out national digital systems, like the ophthalmology electronic patient record (OpenEyes) and digital maternity records (BadgerNet), to improve access, quality, and efficiency.

- 60 While committed to Once for Wales solutions, the Health Board also takes a pragmatic approach, accelerating local digital developments where necessary. It has communicated to both DHCW and Welsh Government that it will move ahead at pace when required, with the intention of migrating to national solutions once they are available. For example, the Health Board is exploring the development of a Patient Service Centre but is clear that it must integrate with existing national systems such as the NHS Wales App and Patient Knows Best.
- 61 However, local solutions are not always feasible, and reports to the DDI Committee highlight significant delays to some key national projects such as LIMS, OpenEyes, and BadgerNet. Although many of these delays are outside the Health Board's control, they could seriously affect service delivery and hinder progress toward digital transformation. The Health Board noted that, while relationships with DHCW and Welsh Government are positive, the role of Welsh Government appears less clearly defined than that of DHCW.

Evaluating digital solutions

- 62 The Health Board has a strong approach to benefits realisation. In September 2024, Internal Audit gave the Health Board a substantial assurance rating for its Digital Benefits Realisation work. The review found that the Health Board uses a clear framework to track outcomes of digital projects, making sure they support strategic objectives and provide value. Business cases clearly set out expected benefits, and established processes are in place to monitor progress, spot any under-performance, and take corrective action.
- 63 The Board receives sufficient assurance about how digital solutions are being evaluated. In October 2025, the DDI Committee received the 2024-25 Digital Innovation and Transformation Benefits Realisation Report. This report explains the benefits process and highlights key financial and non-financial benefits from the past year. Examples include:
- Hybrid Print and Post project – Moved 64% of appointment letters to digital, cut first class mail by 20% saving £91,567, and offered up 2.5 hours per day in the Contact Centre for other tasks.

- Digital Health Records – 532 users viewed over 42,000 records and nearly 49,000 documents. This made information easier to access and helped save time.
- Radiology Test Requesting – 25,286 electronic requests were made (10% of total requests), saving about 290 hours of transcription time. It is now being tested in primary care before wider rollout.

64 While the report clearly sets out achievements, it also highlights the challenges to realising intended benefits and action planned for the next 12 months. The Health Board understands that change can bring positive and negative effects and measuring these is part of its evaluation process.

Recommendations

The following table details the recommendations arising from our work.

R1 The Health Board should review the digital reports received by the Digital, Data and Innovation Committee to reduce duplication and provide a more streamlined overview of digital initiatives. **(paragraph 20)**

R2 [Redacted]

R3 The Health Board should produce a Digital Workforce Plan to support its updated Strategic Digital Plan. This will enable it to understand digital skills gaps and allocate the resources needed for workforce development. **(paragraph 38)**

R4 The Health Board should introduce a process to summarise and track the outcomes and impact of engagement activities across digital projects, to improve assurance. **(paragraph 49)**

R5 The Health Board should strengthen Board-level reporting on national digital groups and digital partnerships, to give the Board better oversight of national developments and how they affect local digital plans. (**paragraph 52**)

Appendices

1 About our work

Scope of the audit

The goal of this audit is to find out if the Health Board is using digital technology to support service modernisation and efficiency. This included the approach to strategy, leadership and skills development for digital transformation, and how risks around digital infrastructure, cyber resilience and artificial intelligence are being managed.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the Health Board have a well-led and appropriately resourced approach to digital transformation?
- Is the Health Board developing the digital skills, capacity, and capability of its workforce?
- Does the Health Board have a clear plan for managing its cyber resilience arrangements and digital infrastructure and how they will need to change to support its digital transformation ambitions?
- Does the Health Board engage effectively with staff, partners, patients / service users to deliver its digital transformation ambitions and minimise digital exclusion risks?
- Is the Health Board actively utilising new digital technology and data solutions to enhance the accessibility, quality, efficiency, and productivity of its services?

Criteria

Our audit questions were shaped by:

- External reference input from the Welsh Government, all-Wales NHS Directors of Digital, and Digital Health & Care Wales.
- Relevant Welsh Government strategies and plans.
- Relevant NHS Digital Transformation review reports completed by the National Audit Office and House of Commons Health and Social Care Committee.
- NHS England Department of Health & Social Care: A plan for digital health and social care policy paper.
- NHS England Transformation Directorate: What good looks like framework.

Methods

We asked Hywel Dda University Health Board to:

- Complete a self-assessment to help us understand how the organisation is undertaking digital transformation.
- Give us facts and figures about its spending on digital technology, staff digital skills, cyber resilience, and how it involves people in digital transformation.

We reviewed a range of documents, including:

- Board and committee papers and minutes.
- Key governance documents, including Digital, Data and Innovation Committee Terms of Reference.
- Key strategies and plans, including the Digital Strategic Plan and Annual Plan.
- Key risk management documents, including the Board Assurance Framework.
- Relevant policies and procedures.
- Reports prepared by other relevant external bodies.

We interviewed the following key stakeholders:

- Chief Executive
- Executive Director of Finance
- Director of Digital

- Independent Member – Information Technology

We observed Board meetings as well as meetings of the following committees:

- Digital, Data and Innovation Committee

2 Key terms in this report

Term	Description
Strategic Risk Register	The Strategic Risk Register sets out the risks linked to the organisation’s strategic objectives, and the controls and assurances in place to manage those risks.
Corporate Risk Register	A Corporate Risk Register sets out the organisation’s significant risks (either those with high scores or organisation-wide impact) and the actions in place to manage them.
Shadow IT	Shadow IT refers to any software, hardware, or technology service used within an organisation without the knowledge, approval, or oversight of the IT department
Once For Wales	National approach in NHS Wales where a digital system, process or standard is designed, procured and implemented once at a national level, rather than each Health Board creating its own version.
HEIW’s Digital Capability Framework	A national model outlining the digital skills, behaviours and confidence health and care staff need, organised into six capability domains with a self-assessment tool for development
Digital Inclusion Charter	The Digital Inclusion Charter for Wales is a national set of commitments that organisations sign up to in order to actively support and promote digital inclusion across Wales.

Electronic Prescribing and medicines administration (ePMA)

A system in its hospitals, designed to improve patient safety through better documentation, streamlined workflows, and more efficient access to medication records as part of NHS Wales' Digital Medicines Programme

OpenEyes

Electronic patient record (EPR) system designed specifically for ophthalmology services.

BadgerNet maternity

A digital system for recording maternity care.

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.

The Auditor General carries out his work with the help of staff and other resources from the Wales Audit Office, which is a body set up to support, advise and monitor the Auditor General's work.

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.



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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

Audited body	Hywel Dda University Health Board
Audit name	Digital Transformation Review
Response received	27 April 2026

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	The Health Board should review the digital reports received by the Digital, Data and Innovation Committee to reduce duplication and provide a more streamlined overview of digital initiatives. (paragraph 20)	The Health Board agrees with this recommendation. A review of the digital reports submitted to the Digital, Data and Innovation Committee will be undertaken to reduce duplication and improve clarity. This will include rationalising overlapping reports, aligning content to the Committee's core assurance requirements, and introducing a more structured, consolidated reporting approach. The aim is to provide a streamlined, high-level overview of digital initiatives, delivery progress, benefits realisation and key risks, while retaining the ability to undertake deeper dives where required. This will support clearer line of sight for the Committee and more effective use of agenda time.	30 September 2026	Digital Director

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R2	[Redacted]	[Redacted]	[Redacted]	[Redacted]

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R3	<p>The Health Board should produce a Digital Workforce Plan to support its updated Strategic Digital Plan. This will enable it to understand digital skills gaps and allocate the resources needed for workforce development. (paragraph 38)</p>	<p>The Health Board agrees with this recommendation. A dedicated Digital Workforce Plan will be developed to support delivery of the updated Strategic Digital Plan and to ensure the sustainability of digital transformation over the medium to long term. The plan will assess current digital capacity and capability across the organisation, identify key digital skills gaps, and define the workforce investments required to support priority digital programmes and business-as-usual services.</p> <p>The Digital Workforce Plan will align with the Health Board's Digital Strategic Plan, wider workforce strategy and national NHS Wales expectations. It will consider the skills required to support core digital services, emerging technologies (including data, analytics and AI), clinical informatics, change and adoption, and cyber and information governance. The output will provide a clear basis for workforce development, succession planning, training priorities and funding decisions, and will support more informed resource allocation as digital delivery scales.</p>	31 December 2026	Digital Director

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R4	<p>The Health Board should introduce a process to summarise and track the outcomes and impact of engagement activities across digital projects to improve assurance. (paragraph 49)</p>	<p>The Health Board agrees with this recommendation. A more consistent and structured approach will be introduced to summarise, track and report the outcomes and impact of engagement activities undertaken across digital programmes and projects. This will improve assurance that stakeholder, workforce and patient engagement is purposeful, proportionate and informing delivery decisions.</p> <p>The approach will build on existing engagement activity already taking place through digital programmes, including service engagement, digital inclusion activity and adoption support, and will introduce a light-touch mechanism to capture key engagement themes, actions taken in response, and the resulting impact on delivery, adoption or user experience. This information will be aggregated at portfolio level and reported through existing digital governance and assurance forums, providing clearer line of sight between engagement activity and programme outcomes.</p>	31 March 2027	Digital Director

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		<p>The process will be aligned to the Health Board’s digital delivery and assurance reporting approach, enabling engagement insights to be reflected alongside progress, risks and benefits, without creating unnecessary reporting burden.</p>		
R5	<p>The Health Board should strengthen Board-level reporting on national digital groups and digital partnerships, to give the Board better oversight of national developments and how they affect local digital plans. (paragraph 52)</p>	<p>The Health Board agrees with this recommendation. Board-level reporting will be strengthened to provide clearer and more consistent oversight of national digital groups, programmes and strategic digital partnerships, and the implications these have for local digital priorities, affordability and delivery plans.</p> <p>This will be achieved by rationalising and standardising the way national and regional digital developments are summarised and escalated from the Digital, Data and Innovation Committee to the Board. A clearer narrative will be provided on key national programmes, emerging policy direction, and strategic partnerships, with explicit articulation of opportunities, constraints, dependencies and required local action. This will</p>	30 September 2026	Digital Director

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
		<p>enable the Board to better understand how national initiatives impact the Health Board's Digital Strategic Plan, delivery sequencing and investment decisions.</p> <p>The approach will build on existing DDIC papers covering the national and regional digital landscape and digital partnerships, and will ensure that Board updates focus on what has changed, why it matters, and what decisions or awareness are required, rather than duplicating operational detail.</p>		

3 - NWSSP – Audit and Assurance Services -
Internal Audit

3.1

09:55, 5 Mins

3.1 - Internal Audit Plan Progress Report

James Johns
(NWSSP - Internal
Audit)

| For assurance

Attachments

[3.1 SBAR IA Plan Progress Report May 2026.pdf](#)

[3.1 IA Plan Progress Report May 2026.pdf](#)



**PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	07 May 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit & Assurance Services Progress Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Head of Internal Audit
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Internal Audit

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

The Audit & Assurance Services progress report provides the Audit & Risk Assurance Committee (ARAC) with an update in relation to the delivery of the approved Internal Audit Plan for 2025/26, 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 & Risk Assurance Committee is asked to take assurance with regard to the delivery of the Internal Audit plan and from the outcomes of the finalised audit reports.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	<p>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.</p> <p>3.17 This will be achieved by:</p> <p>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;</p> <p>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;</p> <p>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;</p> <p>3.17.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation; and</p> <p>3.17.5 annual review of the effectiveness of internal audit.</p>
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Internal Audit reports cover a range of organisational risks.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable
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Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Internal Audit Plan & Charter. Individual Internal Audit reports. Evidence gathered from the Health Board as part of the delivery of audit assignments. Health Board Risk Registers. Board and Committee Papers.
Rhestr Termiau: Glossary of Terms:	Contained within the reports.
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Director of Corporate Governance Executive Directors and Senior Managers relevant to the individual audits.

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

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

Hywel Dda University Health Board Audit & Risk Assurance Committee

May 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 2025/26 Internal Audit Plan. The report also includes details of the progress with the delivery of individual audits, outcomes from finalised audits and any updates required to the plan.

2. Outcomes from Finalised Audits

2.1 The Internal Audit Reports finalised since the previous meeting of the Committee are highlighted in the table below along with the allocated assurance ratings, where applicable. The full versions of these reports are included on the agenda as separate items.

ASSIGNMENT	ASSURANCE RATING
Major Infrastructure Investment Programme	 Reasonable
Withybush Fire Precautions Phase 2	 Reasonable
Sickness Management Follow up	n/a

3. Planning and Delivery Update

3.1 The assignment status schedule highlighting progress with the delivery of the 2025/26 plan is set out at Appendix A.

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

Audit	Current status	Current Position / comments
Infection, Prevention and Control	Draft	Additional work required to resolve queries, which was required to determine assurance rating provided.
Wellsky System	Initial draft	Field work took slightly longer than planned.
Third Sector Commissioning	Draft	Additional work required, including to resolve queries.

3.3 All remaining audit work will be completed prior to the finalisation of the annual report and opinion in advance on the June ARAC meeting. The annual opinion is still being determined, as with the previous two years, it has been a close call. The final opinion will be communicated as soon as possible.

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 and some Committees and board meetings have been observed in the period since the last meeting of the committee. Ongoing liaison meetings with Counter Fraud, Audit Wales and Health Inspectorate Wales have also continued.

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

Audit Output	Planned start	Planned ARAC	Executive Lead/Responsible Director	Progress Status	Assurance	H	M
Joint Committee with SBUHB	Q3/4	Apr	Corporate Governance	wip			
Operational Governance Arrangements	Q2/3	Dec	Chief Operating Officer	FINAL	Limited	4	-
Escalation Governance	Q3/4	Feb	Corporate Governance /CEO	Final	Substantial	-	-
Level Three / Four Directorates	Q2/3	Dec	Chief Operating Officer	FINAL	Limited	3	4
Nursing Management	Q1/2	Aug	Nursing, Quality Safety & Experience	FINAL	Limited	1	2
Medical Workforce Stabilisation	Q3/4	April	Medical	wip			
Validation of Emergency Departments performance and waiting time data	Q1/2	Oct	Chief Operating Officer	Final	Limited	2	4
Staff Sickness Management	Q1/2	Aug	Workforce & OD	Final	Limited	1	2
Commissioning– Long Term Agreement	Q2	Oct	Strategy & Planning	Final	Reasonable	1	-
Commissioning – Third Sector	Q3/4	May	Chief Operating Officer	Draft			
Decision making for high-cost drugs	Q2/3	Feb	Finance	wip			

Audit & Risk Assurance Committee Progress Report

GP Out of Hours	Q3/4	Apr	Chief Operating Officer	planning				
Corporate Risk Ophthalmology	Q1/2	Aug	Chief Operating Officer	Final	Reasonable	-	2	
Vaccination & Immunisation	Q1/2	Oct	Public Health	Final	Limited	5	4	
Patient Experience	Q3/4	Feb	Nursing, Quality Safety & Experience	Final	Reasonable	1	4	
Infection Prevention & Control	Q3/4	Apr/may	Nursing, Quality Safety & Experience	Draft				
Human Tissue Authority	Q2	Oct	Allied Health Professionals & Health Science	Final	Limited	2	4	
Medical Devices Regulations	Q2/3	Dec	Chief Operating Officer	Final	Substantial		1	
Managed Practices	Q1/2	Dec	Chief Operating Officer	Final	Reasonable	2	4	
Follow up and agreed Action Implementation Tracking -			Corporate Governance	wip				
Human Tissue Authority – recommendation follow up	Q4	Apr	Allied Health Professionals & Health Science	FINAL	n/a	-	-	
Sickness Management - recommendation follow up	Q4		Nursing/Workforce	FINAL	n/a	-	-	
Wellsky System			Finance	Initial draft				
Cyber Security	Q2/3	Dec	Finance	FINAL	Substantial		1	
Departmental /Shadow IT systems management	Q3	Feb	Finance	FINAL	Reasonable	2	1	

Estates Assurance - Space Utilisation	Q2/3	Feb	Strategy & Planning	FINAL	Advisory		
Major Infrastructure Investment Plan (MIIP)	Q3/4	April	Strategy & Planning	FINAL	Reasonable	1	9
Control of Contractors	Q1/2	Oct	Chief Operating Officer	Final	Advisory	-	-
Capital Governance	Q1	Oct	Strategy & Planning	Final	Advisory	-	-
Integrated Audit & Assurance Plans (SSU)- Withybush General Hospital Fire – Phase 2.	IAAPs		Strategy & Planning	Final	Reasonable	1	7



Office details: [Audit & Assurance Services West Team](#)

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

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

3.2

10:00, 20 Mins

3.2 - Sickness Management Follow-up
(Review)

*James Johns
(NWSSP - Internal
Audit), Lisa Gostling
(Hywel Dda UHB -
Director of
Workforce &
OD/Deputy CEO),
Heather Hinkin
(Hywel Dda UHB -
Assistant Director
People Management)*

| For assurance

Attachments

[3.2 Sickness Management Follow-up Final IA Report.pdf](#)

Staff Sickness Management (Follow Up)

Final Internal Audit Report

2025/26

Hywel Dda University Health Board

Contents

Executive Summary1
Status of Previously Agreed Management Actions2
Appendix A5

Review Reference	HDU-2526-20
Fieldwork	February - April 2026
Executive Sign Off	28 April 2026
Audit Committee	May 2026
Executive Lead	Lisa Gostling, Director of Workforce & OD Sharon Daniel, Director of Nursing Quality & Patient Experience
Audit Team	James Johns, Head of Internal Audit Sophie Corbett, Deputy Head of Internal Audit



Executive Summary

Purpose

The overall objective of this audit is to assess progress in implementing the actions agreed with management to address findings identified in the previous audit of Sickness Management (HDU-2526-08) and the sickness elements of the Nursing Management review (HDU-2526-04).

Overview

The agreed management actions raised in the original Staff Sickness Management and Nurse Management report were reviewed and a summary of their status is noted in the table below:

Ref.	Report	Matter Arising	Priority Rating	Implemented	Partially Implemented	Not Implemented
1	HDU-2526-08 Staff Sickness Management	Planned Programme of Sickness Reviews	High		✓	
2		Staff Training	Medium	✓		
3	HDU-2526-04 Nursing Management	Good Practice Guidance/ Planned Programme of Sickness Reviews	High		✓	

A review of the supporting documentation and additional testing confirmed the implementation of sickness management training across the organisation (Finding 2).

Findings 1 & 3 relate to common issues and related actions across both audit reports. Action has been taken separately by the Workforce & OD and nursing management teams in the development of templates to aid sickness absence reviews, although the nurse management template has not yet been implemented. Planned programmes of reviews have not been developed, further work is required to adopt a consistent approach to the review templates and wider dissemination of the good practice guidance developed by nurse management and Clinical Care Groups (CCGs)/ functions need to take accountability for ensuring that sickness reviews are undertaken within their respective areas. Where reviews have been undertaken by identified leads, testing during this audit identified inaccuracies in the returned figures and inconsistencies in the length of testing periods and sample sizes.

The mitigation of the risks and matters arising from the original reports will contribute to the controls in place to reduce the Health Board’s current sickness absence rate. Failure to address these issues impacts the wellbeing of staff and the organisation’s financial position.

Status of Previously Agreed Management Actions

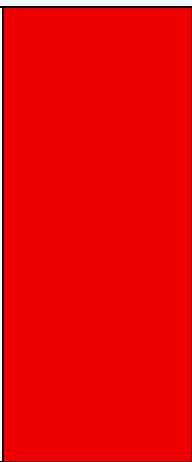
Report: HDU-2526-08 Sickness Management

Ref	Original Agreed Action	Original Responsibility & Timescale	Priority Rating	Status
1	<p>Planned Programme</p> <p>Development of a planned programme of sickness absence reviews, led by service managers with appropriate support from Workforce, to assess compliance with policy requirements and understand and address the root causes of non-compliance.</p> <p>Heads of service will be held accountable for non-compliance. Outcomes of the reviews will be reported via the CCG governance structures to provide assurance over the effectiveness of sickness management arrangements.</p>	<p>Lisa Gostling (Director of Workforce & OD) 30th September 2025</p>	<p>High Priority</p>	<p>Partially Implemented</p> <p>In August 2025, Clinical Care Group (CCG) Service Directors were informed that each CCG will be required to produce a programme of planned sickness absence reviews and submit it to Workforce & OD by 30 September 2025.</p> <p>To aid the CCGs in undertaking the sickness absences reviews, Workforce & OD developed a testing template that was communicated to each Executive Director and Clinical Care Group (CCG) Service Directors in August 2025.</p> <p>However, no evidence was provided to support the development of a planned programme of sickness absence reviews by the CCGs.</p> <p>A review of the sickness absence template identified that the number of absences tested is captured; no individual absence data is recorded. No guidance to aid the services complete the audit template was provided.</p> <p>Testing was undertaken on a sample of 30 service areas (from data uploaded onto the AMAT system) to ensure the sickness absence review had been completed and the captured information accurately reconciled to employee sickness periods. Identified service leads (identified as a 'reviewer') were contacted to request the detail of the sampled sickness absence information with only 13 responding.</p> <p>A reconciliation of the sickness absence periods listed tested in the templates identified the following:</p> <ul style="list-style-type: none"> • Inaccuracies in the information recorded on the audit template against source data such as the number of reviews recorded • Instances where the reviewer was unable to confirm the sickness periods in their review sample • Inconsistencies in the length of testing periods and sample sizes • Listed individuals named as reviewers were unaware of their responsibility to undertake the sickness absence review. <p>No audit or check of the returned sickness absence review was undertaken by Workforce & OD to confirm the accuracy of the recorded information. To date, no Heads of Service have been held accountable for non-compliance due to</p>

Ref	Original Agreed Action	Original Responsibility & Timescale	Priority Rating	Status
				returned audits noting compliance accuracy of 100% (only one review returned 80% compliance).
2	<p>Staff Training</p> <p>Workforce & OD will strengthen the promotion of available sickness absence management training through Viva Engage and Workforce Advisors/Managers, who will work with their respective service areas to identify and address training needs.</p> <p>The Learning and Development Manager will explore the feasibility of recognising completed training as contributing towards Continuing Professional Development (CPD), to encourage uptake.</p>	<p>Heather Hinkin (Assistant Director Workforce & OD) 30th September 2025</p>	Medium Priority	<p>Implemented</p> <p>Communications have been shared with all staff via Viva Engage to promote both the bitesize training modules and the full online training linked to the <i>All-Wales Managing Absence at Work Policy</i>. These promotions will continue routinely with each new bitesize release.</p> <p>The Operational Workforce Team signposting managers to available training on the intranet, whilst reminders also feature in local partnership forum reports and in one-to-one discussions. Training needs continue to be supported through the standard online package.</p> <p>Further bitesize modules are being developed, this process is ongoing due to significant resource requirements and dependencies on multiple support functions. A fuller assessment of future training needs will be possible once each CCG completes its sickness absence reviews.</p>

Report: HDU-2526-04 Nursing Management

Ref	Original Agreed Action	Original Responsibility & Timescale	Priority Rating	Status
3	<p>Good Practice</p> <p>Good practice identified at PPH Ward 9 will be process-mapped into a guidance document and shared with all Heads of Service/ Nursing for implementation within their respective areas.</p> <p>Development of a planned programme of sickness absence reviews, led by service areas with appropriate support from</p>	<p>Sharon Daniel (Director of Nursing, Quality & Patient Experience)</p> <p>Lisa Gostling (Director of Workforce & OD)</p>	High Priority	<p>Partially Implemented</p> <p>Good practice has been mapped into a guidance document and was issued to Heads of Nursing in February 2026.</p> <p>Nursing management have developed a new document designed to support effective sickness management and includes links to key resources and guidance documents. A sickness absence review audit template has been updated and is accompanied by a step-by-step guide to aid the reviewer undertake the audits. However, the sickness absence review audit template is expected to be rollout for use in May 2026, whilst there is no planned programme of sickness absence reviews currently in place.</p>

	<p>Workforce, to assess compliance with policy requirements and understand and address the root causes of non-compliance.</p> <p>Ward/ Department Managers will be held accountable for non-compliance, with overall responsibility escalating through Senior Nurse Managers to Heads of Nursing.</p>	30 th September 2025		
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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](#)



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

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

Public Sector Internal Audit Standards

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



3.3

10:20, 10 Mins

3.3 - Major Infrastructure Investment Programme (Reasonable Assurance)

*James Johns
(NWSSP - Internal Audit), Lee Davies
(Hywel Dda UHB - Executive Director of Strategy and Planning), Rob Elliott
(Hywel Dda UHB - Programme Director Major Infrastructure Projects)*

| For assurance

Attachments

[3.3 Major Infrastructure Investment Programme Final IA Report.pdf](#)

Major Infrastructure Investment Programme

Final Internal Audit Report

2025/26

Hywel Dda University Health Board



Reasonable Assurance

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Executive Summary1

Findings & Agreed Action Plan3

Appendix A14

Review Reference

HDU-SSU-2526-30

Fieldwork

February – March 2026

Executive Sign Off

20th April 2026

Audit Committee

7th May 2026

Executive Lead

Lee Davies, Executive Director of Strategy & Planning

Audit Team

Huw Richards, Deputy Director, SSu
Melanie Goodman, Audit Manager



Executive Summary

Purpose

This audit was commissioned in accordance with the 2025/26 Internal Audit Plan approved by the Audit, Risk and assurance Committee. This was the first audit of the Major Infrastructure Investment Programme. Any future audits will be delivered via an Integrated Audit Plan included within the individual Business Justification Cases, subject to approval by Welsh Government.

Overview

The Major Infrastructure Investment Programme seeks to address the most urgent and unacceptable risks associated with the Health Board's critical infrastructure, and the impact these will have on business continuity and patient safety, whilst also reducing existing backlog maintenance at each acute site.

Programme development commenced in 2018 and has been rationalised over a number of years to reach its current form. Initially, plans were developed to maintain business continuity for a short interim period until the aims of the A Healthier Mid and West Wales (AHMWW) programme (and associated estates reconfiguration) were achieved. Now the AHMWW timeline has been extended, there is a greater need to address the key priorities more urgently. The current programme reflects this through the delivery of ten priority schemes over three phases, with a total investment requirement range of £49-55m. Welsh Government funding of £895k to develop the Business Justification Case for Phase 1 was awarded in December 2025. The Health Board has demonstrated a clear risk assessed, prioritised approach in defining the programme, developed with support from NWSSP: Specialist Estates Service over several years. Recognising the audit took place at the commencement of Phase 1, governance and project management arrangements have to date reflected available resource and the uncertainty over the form and timeline of the programme. We recognise that work was underway during the audit to shift to a more formal, structured approach with the commencement of Phase 1 and provision of formal approval/ funding, including the appointment of the external Project Manager in February 2026.

In recognition that the programme's primary objective is to identify and prioritise high-risk estates compliance issues to support business continuity and ongoing patient safety, an overall assessment of **Reasonable Assurance** has been concluded from this review.

Whilst a robust and compliant procurement process for the appointment of advisers was evidenced, the absence of adviser contracts in place for the completed and ongoing RIBA stages (in breach of the Health Board's Standing Financial Instructions) has limited the assurance at the '*Appointments and Contract*' objective. It is recognised that this matter has been resolved post-issue of the draft report, with all adviser contracts now in place at the time of the final report.

The matters requiring management attention include:

- Governance and project management arrangements should be further aligned with other Health Board capital projects, now Phase 1 has commenced.
- A clear audit trail demonstrating value for money and approvals at the procurement process should be maintained.
- Adviser contracts should be implemented as soon as possible.
- Key Performance Indicators should be maintained as defined in the tender specification.
- Improved controls should be introduced for the management of adviser fee payments.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunity for enhancement has been identified that does not impact the overall opinion and are highlighted for management information:

- Whilst pre-tender estimates were determined prior to tender for the external advisers, procurement reports did not provide narrative to confirm affordability or value for money where the winning bids exceeded these. It should be noted however that following the tender returns an appropriate in-house exercise involving Major Capital and Procurement fully appraised the tender returns against financial and quality criteria.

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	Governance: Assurance that appropriate governance arrangements were in place, including establishing the control environment e.g., allocation of roles and responsibility, effectiveness of the scrutiny arrangements, operation of effective reporting.	1-4	Reasonable
2	Prioritisation and Identification: Assurance that appropriate mechanisms including funding streams (All Wales Capital, Target Estates Fund etc), risk assessments were in place to identify priority areas within the estate. Also to obtain assurance that effective and appropriate stakeholder engagement had occurred e.g. with Welsh Government and its agents during the prioritisation process.	-	Substantial
3	Appointments and Contracts: To obtain assurance that parties contracted to the Health Board have been appropriately appointed e.g. external advisers, other and in accordance with national and local procurement requirements including the timely completion of appropriate contractual documentation.	5-8	Limited
4	Fee Management and Payments: Assess whether fee-management arrangements for the programme are robust and controlled, ensuring fees are accurately calculated, approved, monitored, and paid in line with internal financial procedures and contractual obligation.	9	Reasonable

Management Actions



High Priority



Medium Priority

Themes



- Approvals
- Contractual
- Finance Management & Control
- Governance
- Performance Monitoring
- Reporting

Risk Types

Quality or Safety Issues

Financial Loss

Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Overview / Summary of Observations

The Major Infrastructure Investment Programme benefited from an appropriate allocation of key internal roles, including leadership from the Senior Responsible Officer and Project Director, with scrutiny and control at the Programme Group (chaired by the Project Director and supported by advice from NWSSP: Specialist Estates Service). High level oversight and decision-making also took place at the Capital Sub-Committee and Infrastructure and Estates Sub-Group.

The Programme has been in development for a number of years, with limited funding support, resources or an agreed way forward until recently. The receipt of Welsh Government funding in December 2025 to develop the first Business Justification Case (BJC1), and the appointment of an external Project Manager in February 2026, marks an appropriate juncture at which to introduce more formality over governance and project management arrangements.

Whilst these arrangements were not yet in place at the time of audit fieldwork, there was a commitment to review and update existing processes and ensure key project management tools are introduced, and work had commenced in some of these areas. We also recognise that the Major Projects team has been particularly impacted by sickness absence during the last year, which has reduced available resource to undertake some of the actions outlined within this report.

Accordingly, we determine that the governance arrangements provided reasonable assurance at the time of review, however they now require prompt strengthening to ensure appropriate arrangements are in place for the new phase.

Key Findings	Risk & Impact	Agreed Management Action
<p>1 Programme (Project(s)) Execution Plan</p> <p>At the time of the current review a formal Programme / Project(s) Execution Plan (PEP) had not been implemented for the programme.</p> <p>It is acknowledged that this was being developed at the time of audit fieldwork, having been requested by the Project Director in the February 2026 Programme Group meeting.</p> <p>The PEP may include, for example:</p> <ul style="list-style-type: none"> • A summary of Programme (project) scope and objectives; • Roles and responsibilities; • Project(s) programme; • Programme/Project(s) budget; • Inter-relationships of associated Programme and constituent projects 	<p>Governance and programme / project management arrangements may not be clearly defined and understood.</p> <p>Arrangements may not operate as intended.</p>	<p>Agreed Action:</p> <p>A Programme Execution Plan is now in place, reviewed at Project Group level and signed off by the Executive Director (SRO).</p>

	<ul style="list-style-type: none"> • Programme (project) management processes, including e.g. risk management, quality management, change control; • Delegated authorities; • Communication plans; • Reporting requirements. 		<p>Expected Evidence of Implementation: N/A</p>
	<p>Theme: Governance</p>	<p>Medium Priority</p> <p>Control Design</p>	<p>Officer: Project Director, Major Infrastructure Projects</p> <p>Target Implementation Date: Actioned since fieldwork</p>
<p>2</p>	<p>Programme Group</p> <p>A review of Programme Group papers and minutes from 2025 and 2026 identified some issues in the effective operation of the Group to date when compared with the requirements defined within the Terms of Reference (ToR), including:</p> <ul style="list-style-type: none"> • The ToR required clarification in respect of defined membership and quoracy (a review of the terms of reference commenced during audit fieldwork and Audit and Assurance have provided feedback to inform this process). • Attendance of some members has not been at the required level, with two meetings recorded as non-quorate (however, see point 1 re clarification of membership and quoracy). • Minutes / action logs were not captured from two meetings. 	<p>There may be an insufficient level of scrutiny and oversight of a major and complex programme.</p> <p>This may impact project performance.</p>	<p>Agreed Action:</p> <ul style="list-style-type: none"> • Actioned since fieldwork - the ToR has been reviewed and updated, with the comments received from Internal Audit reflected in the updated version. • Members will be reminded of the importance of regular attendance and ongoing attendance monitored. • Meetings will be recorded, ensuring a record is maintained where support staff are not available to take minutes during the meeting. <p>Expected Evidence of Implementation:</p> <p>Updated ToR reflecting the points raised by Internal Audit.</p> <p>Ongoing monitoring of attendance at future Project Group meetings.</p> <p>Minutes/actions captured for every Project Group meeting.</p> <p>Medium Priority</p> <p>Officer: Project Director, Major Infrastructure Projects</p> <p>Target Implementation Date: 30th June 2026</p>
<p>3</p>	<p>Reporting</p> <p>Whilst the Programme Group has received a progress report at each meeting, the template was not fully populated and was lacking in key information, including:</p> <ul style="list-style-type: none"> • No financial information has been reported to date, e.g. spend against budget and forecast outturn, and monitoring of spend and forecasts against the 	<p>The Programme Group does not receive sufficient information to exercise appropriate scrutiny and decision making.</p>	<p>Agreed Action:</p> <p>With the external Project Manager now in post (Feb 2026), this will support more detailed reporting against the areas highlighted by Internal Audit, including risks and programme status.</p> <p>The Progress Report template will be fully populated for each Programme Group meeting to ensure information is fully conveyed.</p>

<p>overarching programme cost envelope. It is recognised that financial reporting is intended to be supported by the external Cost Adviser going forward.</p> <ul style="list-style-type: none"> • Whilst key risks were included in the report, it was noted that these had differed from those presented within the highlight reports submitted to the Capital Sub Committee, and have not been taken from a programme risk register (which had yet to be fully developed (see <i>Key Finding 4</i> below). • Contract status information was not populated – see <i>Key Finding 6</i> in relation to the absence of adviser contracts. This highlights the importance of the inclusion of this information to enable appropriate scrutiny and actions. • Whilst programme activities were listed, reporting did not indicate whether planned activities were on track against the defined programme. Reporting should highlight any actual or potential slippage which may impact key milestones (see also <i>Key Finding 4</i>). 		
<p>Theme: Reporting</p>	<p>Medium Priority</p> <p>Control Operation</p>	<p>Expected Evidence of Implementation:</p> <p>A fully populated Progress Report reported to each Programme Group meeting.</p> <p>Officer: Project Director, Major Infrastructure Projects</p> <p>Target Implementation Date: 30th June 2026</p>
<p>4 Programme / Project Management Tools</p> <p>As noted at <i>Key Finding 1</i>, the PEP should define the programme / project management controls to be operated at the programme.</p> <p>At the time of the current review key tools were not in place, e.g. project/programme risk register, detailed programme/management control plan for BJC1 development.</p> <p>It is recognised the recent appointment of the external project manager (who commenced in post on 16th February 2026) will support delivery of these and other formal project management tools.</p> <p>The same should be used to inform reporting to Programme Board and elsewhere.</p>	<p>Management do not operate sufficient project management tools to support effective planning, delivery, monitoring and reporting of project delivery.</p> <p>Medium Priority</p>	<p>Agreed Action:</p> <p>As above, the recently appointed (Feb 2026) external Project Manager will support the project in developing project management tools, including a risk register and detailed programme for BJC1 development.</p> <p>These tools will be used to inform the Progress Report to Programme Board and elsewhere.</p> <p>Expected Evidence of Implementation:</p> <p>Development of project management tools including a risk register and detailed programme for the BJC1 development phase.</p> <p>Officer: Project Director, Major Infrastructure Projects</p> <p>Target Implementation Date: 30th June 2026</p>
<p>Theme: Governance</p>	<p>Control Operation</p>	

Overview / Summary of Observations

As noted in *Objective 1*, the Major Infrastructure Investment Programme has been in development for several years, commencing in 2018/19. The first iteration of the Programme Business Case identified a full project cost of £246m. Following review in 2020/21, the scope was reduced to take account of the ongoing A Healthier Mid and West Wales programme. The Programme Business Case was approved by the Board in 2020 and endorsed by Welsh Government in 2021, in which projects totalling £87m were identified as priority schemes at that time. Subsequently, an ongoing review of risks and priorities saw the cost envelope increase to circa £130m, reflecting risks to service continuity and patient safety.

Recognising affordability issues and the Welsh Government capital prioritisation exercise, more recently, work had focused on the rationalisation of the programme and identification of the most critical projects within which the highest risks could be addressed across the four acute sites. Development activities were supported in July 2024, by £300k funding from Welsh Government which enabled the appointment of external advisers (see *Objective 3*). Funding available from the Estates & Facilities Advisory Board (EFAB) and the Targeted Estates Fund (TEF) has been secured to enable a number of smaller, more urgent schemes to be taken forward outside of the main Programme.

The current Programme has an investment requirement in the range of £49-55m, covering ten priority schemes. The history and current risk and prioritisation / phasing process, along with costed plans, was presented within the Strategic Estates Development Plan in 2025. It has been agreed with Welsh Government that a refresh of the Programme Business Case itself is not required at this time.

We evidenced ongoing engagement with NWSSP: Specialist Estates Services throughout the above timeline, to support participation in site surveys, the identification of risks and prioritisation of an appropriate programme and phasing of works. The Strategic Estates Development Plan demonstrates the extent of engagement with and support from Specialist Estates Services.

The current plans were shared with Welsh Government in September 2025 and received funding support for the first phase (development of BJC 1) in December 2025, in the sum of £895k.

Recognising the extent of work undertaken to date, supported by Specialist Estates Services and Welsh Government, and the clear documentation of risks and priorities for the current proposals in the Strategic Estates Development Plan, substantial assurance has been determined in this area.

Overview / Summary of Observations

The audit reviewed the procurement and contract arrangements for the following external advisers: Architect, Building Services Engineer, Civil Engineer, Cost Adviser, Principal Designer and Project Manager. Although advisers had been engaged informally earlier in the programme, this review focused on the formal appointments made during 2025.

Appointment

Five advisers were appointed in early 2025, with the Project Manager appointed after completion of RIBA Stage 2 activities, following Welsh Government approval for BJC1 development. Advisers tendered for work across the four-year programme, with awards made at tendered prices and a contractual cap of £475,000 set for each adviser to allow for future programme changes.

Procurement was undertaken through mini competitions from national frameworks, managed by NWSSP: Procurement Services, demonstrating compliance with procurement regulations and Standing Financial Instructions. However, gaps were noted in the audit trail relating to approvals and insurance documentation.

Contracts

Although the tender process specified the use of the Joint Contracts Tribunal (JCT) Consultancy Agreement, formal contracts had not been executed. RIBA Stage 2 has concluded and BJC1 development has commenced, yet contractual cover remains outstanding. Whilst purchase orders have been used to instruct discrete work packages, the absence of formal contracts weakens controls over e.g. change management, performance and payment mechanisms. It also represents non-compliance with Standing Financial Instructions, where the original purchase orders raised for the now-completed RIBA Stage 2 work exceeded the £25,000 threshold for formal contracts for all five advisers.

The RIBA Stage 2 element of work followed the initial tender submission (Dec 2024) and was undertaken solely to evaluate and develop the scope of the project and the risks to the UHB estate. This was jointly undertaken with NWSSP-SES following the changes made due to Targeted Estates Funds (TEF) funding and prioritisation.

Re-Negotiated Fees

Following the original appointments, substantial changes were necessary to the works planned within this programme. This related to two key areas:

- A refresh of Welsh Government Targeted Estates Funds (TEF) which removed a number of projects from the original plan.
- Positive engagement with NWSSP-SES to jointly review critical HB risks which identified a substantially increase on work necessary to address concerns.

Advisers submitted revised prices, increasing total costs from £1,067,759 to £1,728,861. The increases at individual appointments varied significantly but were subject to scrutiny and reflected the revised scope. Two advisers exceeded the contractual cap, with appropriate approvals obtained. Contractual Change Notices were issued but remained unsigned due to the absence of original contracts.

Funding to proceed with the revised programme of works and associated business case development was not made available from WG until December 2025.

The lack of formal adviser contracts is a key limitation and requires resolution.

Key Findings	Risk & Impact	Agreed Management Action
<p>5 Procurement Process</p> <p>The procurement processes applied in the appointment of the external advisers were reviewed, informed by review of the files maintained by NWSSP: Procurement Services.</p> <p>Whilst we evidenced a procurement process compliant with Standing Financial Instructions (SFIs) and procurement regulations, we noted some gaps in the audit trail of the processes applied, including:</p> <ul style="list-style-type: none"> Whilst the required level of insurances was defined in the tender documents, the evaluation documents did not record whether insurances had been checked. <p>The UHB should confirm that appropriate insurances are in place (and maintained) for all advisers.</p> <ul style="list-style-type: none"> The Ratification Papers held on file by Procurement Services had not been fully authorised by the required UHB officers (Project Lead and UHB Decision Maker), with the Procurement checklist also indicating signed copies had not been obtained. We identified three of six papers signed by the Project Lead but only one signed by the Decision Maker. The UHB did not locate any additional signed copies during the audit. <p>The UHB should ensure signed copies of all key documents are retained in project files for reference and audit trail if required.</p> <p>Theme: Approvals</p>	<p>The procurement process does not provide a clear audit trail of value for money assessment, compliance with tender requirements or appropriate approvals in line with delegated authorities.</p> <p>Medium Priority</p> <p>Control Operation</p>	<p>Agreed Action:</p> <p>We confirm that evidence of insurances was included within the tender documents.</p> <p>We will ensure at future procurements that evidence of insurances is documented within the tender evaluation.</p> <p>We will ensure that these are updated each year for the duration of the appointment.</p> <p>We will ensure that signed copies are held for all key approval documents.</p> <p>Expected Evidence of Implementation:</p> <p>Fully completed tender evaluations at future procurements.</p> <p>Officer: Project Director, Major Infrastructure Projects</p> <p>Target Implementation Date: At future projects</p>
<p>6 Adviser Contracts</p> <p>Standing Financial Instructions require formal contracts (in addition to purchase orders) for contracts over £25,000 (Table – ‘Goods & Non-Health Services,’ section 11.10.2).</p>	<p>Non-compliance with SFIs.</p> <p>The UHB is not afforded adequate legal protection.</p>	<p>Agreed Action:</p> <p>Actioned since fieldwork.</p> <p>JCT Consultancy contracts have now been issued to and returned by all advisers.</p>

<p>Whilst tender documents stated that the JCT Consultancy Agreement would be utilised at the adviser appointments, formal contracts had not yet been enacted.</p> <p>To date, RIBA Stage 2 activities have been completed without contractual cover, and BJC1 development work had recently commenced. We acknowledge that the nature of the work undertaken during RIBA Stage 2 means there are no design liability risks, as the work was of an advisory basis to inform programme development. However, this remains a breach of SFIs at each of the five appointments.</p> <p>We have also not identified any framework call-off Service Level Agreements, in the absence of the above. The UHB should confirm with Procurement Services if there is any impact to the appointments to date should framework procedures not have been applied in calling-off the advisers.</p> <p>Whilst the Programme Group progress report includes a section on contract status, this had not been completed to date (see <i>Key Finding 3</i>).</p> <p>The above should be resolved as soon as possible with reporting to the Programme Group to provide appropriate assurances and demonstrate appropriate actions.</p>	<p>Reduced control over adviser performance.</p> <p>Recued protection in the event of a dispute over deliverables.</p>	<p>Expected Evidence of Implementation:</p> <p>Fully executed contracts for all appointed advisers.</p> <p>Officer: Project Director, Major Infrastructure Projects</p> <p>Target Implementation Date: N/A Actioned since fieldwork</p>
<p>Theme: Contractual</p>	<p>Control Operation</p>	
<p>7 Contract Choice</p> <p>It was originally intended to apply the JCT suite of contracts for this programme (for both the advisers and the construction works), reflecting the original anticipated nature of the programme comprising of relatively small, discretionary capital-funded schemes. At the time of audit fieldwork, consideration was being given to switching to NEC contracts, reflecting the increased size and complexity of the individual schemes.</p> <p>Noting that the Architect, Building Services Engineer, Civil Engineer, Cost Adviser and Principal Designer tendered based on an anticipated JCT contract (whilst the Project Manager was latterly appointed based on the NEC suite of contracts) any potential impact of the change on the appointments/prices</p>	<p>Costs may increase if a change in contract impacts adviser perception of risk and effort.</p>	<p>Agreed Action:</p> <p>A decision has been made to maintain the intended JCT Consultancy contract approach for the work being undertaken to develop BJC1.</p> <p>Further consideration will be given to switching to NEC Professional Services Contracts, thereafter, should this be determined to better align with the works-contracting approach. Appropriate advice will be obtained to inform the decision.</p> <p>Any potential cost impacts (to the advisers quoted fees) will be appropriately considered and reported.</p>

<p>should be considered, noting the bids may have been priced to reflect the particular risk profile and administrative burden of the specific contract referenced within the issued tender documentation. This would be particularly relevant to the Project Manager and Lead Consultant/Project Administrator roles defined at the respective NEC and JCT contract forms. Any changes in responsibilities would also have an associated impact on fee rates.</p> <p>Professional advice would also need to be sought to ensure compliance with Procurement Regulations and the original market engagement.</p>		<p>Expected Evidence of Implementation:</p> <p>The basis for any future decisions in relation to contract strategy (including supporting advice received) will be documented and reported to a relevant forum e.g. Programme Group.</p>
<p>Theme: Contractual</p>	<p>Medium Priority</p> <p>Control Design</p>	<p>Officer: Project Director, Major Infrastructure Projects</p> <p>Target Implementation Date: 31st December 2026</p>
<p>8 Contractual Changes</p> <p>Whilst recognising that formal change control has been impeded to date by the absence of contracts as above, Contractual Change Notices were issued following the re-negotiation of the adviser's prices but remained unsigned by either party.</p> <p>Going forward, and once contracts are in place, contractual changes should be appropriately documented and signed utilising the applicable contractual change process (e.g. NEC compensation events) along with application of internal controls such as Contractual Change Notices.</p> <p>It was also noted that there had been some (relatively minor) variance in the figures reported to the Programme Group in respect of the re-negotiated tender prices, with additional variations outside the main uplift not included within reported figures.</p>	<p>The UHB is not afforded adequate legal protection.</p> <p>Reduced control over adviser performance.</p> <p>The Programme Group is not fully informed.</p>	<p>Agreed Action:</p> <p>With formal contracts in place, any future contractual changes will be managed via the appropriate contractual route.</p> <p>Cost information reported to Programme Group will be checked for accuracy and updated if required.</p> <p>Expected Evidence of Implementation:</p> <p>Appropriately applied and authorised contractual changes at any future change events.</p>
<p>Theme: Contractual</p>	<p>Medium Priority</p> <p>Control Operation</p>	<p>Officer: Project Director, Major Infrastructure Projects</p> <p>Target Implementation Date: 31st December 2026</p>
<p>9 Key Performance Indicators</p> <p>Tender documents set out the performance monitoring arrangements to be applied to the adviser appointments, including quarterly Key Performance Indicators (KPIs) based on the NHS Building for Wales framework.</p> <p>No KPIs have been completed to date.</p>	<p>Performance issues are not identified, reported and addressed.</p> <p>Advisers may be retained past potential contractual break</p>	<p>Agreed Action:</p> <p>We will review the intended KPI approach as outlined in the tender specification and determine an appropriate level of application for the current stage.</p>

	<p>We recognise however that no performance concerns have been noted to date in project reports or at Programme Group.</p>	<p>points, allowing poor performance to continue to impact the UHB.</p>	<p>Expected Evidence of Implementation: Implementation of KPI monitoring for advisers.</p>
	<p>Theme: Performance Monitoring</p>	<p>Medium Priority</p> <p>Control Operation</p>	<p>Officer: Project Director, Major Infrastructure Projects Target Implementation Date: 31st October 2026</p>

Overview / Summary of Observations

Adviser activities to date have focused on RIBA Stage 2 development, with fees met from a £300k budget funded by Welsh Government in 2024. The stage was concluded within budget.

As noted within the *Governance* objective (above), the Programme Group had not received any financial reporting to the date of the audit (*Key Finding 3*). We recognise that going forward, cost monitoring and reporting will be supported by the external cost adviser.

Whilst noting the absence of adviser contracts (see *Objective 3*), the tender process included the provision of costed schedules of services, and purchase orders were raised for each appointment. Purchase orders were amended to reflect the re-negotiated prices and at this stage they were also split into individual purchase orders for each scheme.






Invoices had to date been assessed against the agreed purchase orders and approved for payment if within the approved total fee for the stage. Whilst recognising RIBA stage 2 was delivered on budget, we note the limitations of this approach in managing fee payments at complex projects and have highlighted the benefits of greater control over fee management going forward.

Key Findings	Risk & Impact	Agreed Management Action
<p>10 Fee Management</p> <p>Payments to date have been made against agreed fixed lump sum awards.</p> <p>Payments to advisers had to date been assessed against the approved Purchase Order value for each scheme, and providing the invoice fell within this value, payments have been approved.</p> <p>This prevents the over-payment of an adviser above the pre-agreed fixed fee for each scheme.</p> <p>It does not, however, enable more nuanced assessment of adviser delivery, e.g. against forecast cash flow, costed activity schedules, or agreed changes in scope.</p> <p>It was noted that invoices submitted to date had contained insufficient detail of the work undertaken in the period to support a more detailed assessment. Applications for payment should ideally include a breakdown of work completed in the period against the agreed scope, and clearly indicate any additional work completed, to facilitate client review. The implementation of contracts (see <i>Key Finding 6</i>) will help clarify the required processes in this area.</p> <p>It is recognised that RIBA Stage 2 activities were delivered within budget and therefore no risk has materialised to date. As</p>	<p>Payments may be made ahead of delivery of agreed activities.</p> <p>Performance management controls are weakened.</p>	<p>Agreed Action:</p> <p>We will require advisers to provide more detailed information about activities completed, and this will be reviewed against the defined cash flow for the lump-sum appointment before payments are made.</p> <hr/> <p>Expected Evidence of Implementation:</p> <p>More detailed invoicing from advisers.</p> <p>A clear audit trail of the invoice review process.</p>

<p>the complexity and cost of adviser work increases, and as contracts may be subject to variation/change in terms of time and cost, improved controls over the review of adviser payments would be beneficial going forward.</p>		
<p>Theme: Finance Management & Control</p>	<p>Medium Priority</p> <p>Control Operation</p>	<p>Officer: Project Director, Major Infrastructure Projects</p> <p>Target Implementation Date: 30th June 2026</p>

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](#)

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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.

Public Sector Internal Audit Standards

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



3.4

10:30, 10 Mins

3.4 - Withybush General Hospital – Fire Precautions Works Phase 2 (Reasonable Assurance)

James Johns (NWSSP - Internal Audit), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science), Rob Elliott (Hywel Dda UHB - Programme Director Major Infrastructure Projects)

| For assurance

Attachments

[3.4 WGH Fire Precautions Phase 2 Final IA Report.pdf](#)

Withybush General Hospital – Fire Precautions Works Phase 2.

Final Internal Audit Report

2025/26

Hywel Dda University Health Board



Reasonable Assurance

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Review Reference

HDU-SSU-2526-31

Fieldwork

January – March 2026

Executive Sign Off

28th April 2026

Audit Committee

May 2026

Executive Lead

James Severs, Executive Director Allied Health Professions and Health Science

Lee Davies, Executive Director of Strategy & Planning

Audit Team

Huw Richards, Deputy Director, SSu & Murray Gard, Deputy Head Internal Audit, SSu



Executive Summary

Purpose

This audit was commissioned in accordance with the Integrated Audit Plan provided and approved within the Business Justification Case (BJC). This was the first audit of phase 2 with a second scheduled during 2026/27 financial year. This review considered the establishment of the control environment to progress Withybush Fire Precaution Works: Phase 2.

Overview

The scope of works is to complete fire precaution upgrade and improvement works to comply with the Mid & West Wales Fire & Rescue Services (MWWF&RS) enforcement notice (KS/890/04) dated 07 February 2020. As of February 2026, the project remained within the £8.1m approved cost envelope, with a remaining risk contingency of £1.14M; the 22-month construction programme began in January 2026.

Appropriate governance and financial management arrangements were demonstrated. Following Welsh Government funding approval, clear leadership and effective oversight through the Project Group and key committees has been demonstrated. Financial governance arrangements were well established, with a Project Bank Account in place, monthly finance meetings, and detailed cost reporting evidenced. A phased "mini" final accounts approach covering the 24 work zones through the construction period represents good practice and ongoing financial control. The revised Procurement arrangements from phase 1 reflect lessons learned, with potentially improved cost certainty utilising the National Engineering Contract (NEC 4) Option A. Stakeholder engagement is a key strength, particularly given the progression of works within the live hospital environment, with positive collaboration demonstrated between the UHB and MWWF&RS.

The matters requiring management attention include, for example:

- The need to address the fire compliance training, which had achieved the aggregated 85% (MWWF&RS) target only in one instance (March 2026), presenting ongoing risk.
- Addressing contractual elements which require strengthening (e.g. Parent Company Guarantee, liability provisions, timing of appointments).
- Governance improvements (timely circulation of papers).
- The implementation of full lifecycle cashflow forecasts.

Overall, strong project management arrangements were evidenced, with opportunities to further strengthen controls and compliance. Accordingly, we have concluded **reasonable assurance** at this review.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunity for enhancement has been identified that does not impact the overall opinion and is highlighted for management information:

- The Request for Information (RFI) process had been established and actively monitored. The RFI process initially identified delays in responding to design queries, which have been raised with the Principal Designer during site meetings. As of February 2026, this had not impacted the project's critical path but will require ongoing monitoring to ensure timely resolution.

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	Governance: Assurance that appropriate governance arrangements were in place, including establishing the control environment e.g., allocation of roles and responsibility, effectiveness of the scrutiny arrangements, operation of effective reporting.	1,2	Reasonable
2	Financial Assurance: To obtain assurance that financial aspects of scheme delivery were established. The assessment may include e.g. appropriate approvals, compliance with Project Bank account requirements, risk management and associated management of contingency funds.	3	Reasonable
3	Appointments and Contracts: To obtain assurance that parties contracted to the Health Board had been appropriately appointed (e.g. external advisers, main contractor, other) and in accordance with national and local procurement requirements including the timely completion of appropriate contractual documentation.	4-7	Reasonable
4	Stakeholder Engagement - To evaluate the effectiveness, completeness, and appropriateness of stakeholder engagement during the initiation phase of the projects e.g. site management, clinical staff, MWWF&RS etc.	-	Substantial
5	Other: Consideration of any other issues arising from the review relevant to the objectives of the audit.	8	Limited

Management Actions

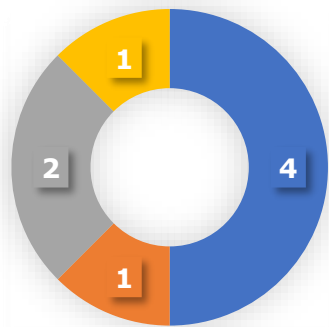


High Priority



Medium Priority

Themes



- Contractual
- Finance Management & Control
- Governance
- Training & Development

Risk Types

- Legal & Regulatory Non-Compliance
- Financial Loss
- Public Perception & Reputational Risk

Findings & Agreed Action Plan

Overview / Summary of Observations

Welsh Government capital funding was awarded in October 2025 and formally accepted by the UHB Chief Executive. A minor inconsistency has been identified in relation to the BREEAM (Building Research Establishment Environmental Assessment Method) requirement as defined within the approved BJC.

The project has benefited from a clear and appropriate allocation of key internal roles, including leadership from the Senior Responsible Officer and Project Director. Oversight and control are exercised through the Project Group, with senior management attendance ensuring continued engagement, particularly given the challenges of delivering works within a live hospital environment. Additional high-level oversight was provided through established governance forums, including the Capital Sub-Committee and Health and Safety Committee.

A Project Execution Plan (PEP) has been developed and approved in line with the updated Scheme of Delegation (May 2025). The PEP was comprehensive and provides assurance over key controls, including defined approval limits and change management arrangements to support timely decision-making.

A derogation schedule and project risk register had been established and actively monitored with the highest rated risks being reported to the Project Group via the Project Managers monthly report.

The Project Group operated under formal Terms of Reference and a standard agenda, with good attendance and quorum consistently achieved. Opportunities exist to further strengthen administrative processes, including the timely circulation of papers (ideally at least one week in advance), to enhance the quality of scrutiny and effectiveness of meetings. Accordingly, **reasonable** assurance has been determined in respect of the Governance arrangements applied to date.

Key Findings	Risk & Impact	Agreed Management Action
<p>1 Funding Award Letter</p> <p>The Welsh Government awarded capital funding in October 2025, which was formally accepted and signed by the Chief Executive of the UHB.</p> <p>The funding letter specifies a requirement to achieve a BREEAM rating of "Excellent," a framework used to assess environmental performance across design, construction, and operation.</p> <p>However, the approved BJC and associated funding application do not include a BREEAM requirement. Given the nature of the</p>	<p>Governance management arrangements may not be clearly defined and understood.</p>	<p>Agreed Action:</p> <p>We will seek formal clarification from Welsh Government on the applicability of the BREEAM "Excellent" requirement to this scheme; given its non-inclusion with the approved BJC.</p>

<p>works, achieving a BREEAM rating was not currently considered feasible.</p> <p>Clarification should therefore be sought from Welsh Government to confirm whether the requirement to achieve a BREEAM “Excellent” rating, as stated within the funding approval letter, was applicable to this scheme.</p>		<p>Expected Evidence of Implementation: Agreement form Welsh Government that BREEAM was not applicable.</p>
<p>Theme: Governance</p>	<p>Medium Priority</p> <p>Control Operation</p>	<p>Officer: Programme Director Major Infrastructure Projects</p> <p>Target Implementation Date: 30 July 2026</p>
<p>2 Project Group</p> <p>A review of Project Group documentation covering the period August 2025 to February 2026 identified weaknesses in operational effectiveness against the requirements set out in the Terms of Reference (ToR).</p> <p>Section 6 of the ToR specifies administrative and governance requirements, including:</p> <ul style="list-style-type: none"> • Meeting papers to be provided at least one week in advance. • Agendas and supporting papers to be distributed seven days prior to meetings. • Minutes and action logs to be circulated within two weeks for review and accuracy. <p>Testing identified that compliance with these requirements was achieved on only one occasion during the review period. We note that the Capital Team experienced high levels of sickness absence during this period, which contributed to reduced administrative capacity and oversight.</p> <p>An action log was maintained and reviewed at each meeting, with clear ownership and records of item closure. However, updates on actions were not consistently provided in advance of meetings, with reliance instead placed on verbal updates during meetings. This limited the ability of members to effectively</p>	<p>Delayed information flow reduces oversight and scrutiny.</p>	<p>Agreed Action:</p> <p>We will seek to strengthened governance and administrative control process to ensure compliance with the ToR requirements i.e. Reinforce expectations by reminding all members of the importance of timely submission of papers, agendas and updates to ensure full compliance with ToR requirements and effective scrutiny.</p> <p>Expected Evidence of Implementation:</p> <p>Formal communication to all relevant parties; with regular monitoring at Project Group.</p>

<p>scrutinise progress, as insufficient time was available for prior review.</p>	<p>Medium Priority</p>	<p>Officer: Programme Director Major Infrastructure Projects Target Implementation Date: 30 June 2026</p>
<p>Theme: Governance</p>	<p>Control Operation</p>	

Overview / Summary of Observations

In accordance with Standard Financial Instructions and Welsh Government policy, a Project Bank Account (PBA) was required for construction and infrastructure projects valued at £2 million or more and with a duration exceeding six months. Compliance with this requirement has been achieved for this project.

Robust financial governance arrangements were evidenced. Monthly finance meetings were established involving the project team, appointed advisers, and the UHB’s finance team. These provided scrutiny of financial performance and risks on an ongoing basis and follow the approach applied during Phase 1 of the works.

A 2025/26 cashflow forecast had been established and actively monitored, with regular engagement between project and finance teams to manage the forecast outturn. Further development of a full lifecycle cashflow forecast was planned.

Monthly cost reports were presented to the Project Group, including forecast total outturn costs, risk contingencies, and VAT recovery assumptions. In addition, separate monthly financial reporting was provided for the Fire Protection Upgrade Works and Refresh programme.

The works was being delivered across 24 hospital zones, with “mini” final account reports to be produced as each zone is completed (first expected April 2026). This approach supports effective monitoring, enhances transparency, and represents good financial management.

Accordingly, **reasonable** assurance has been determined in respect of financial assurance, at the current stage of the project’s progression.

Key Findings	Risk & Impact	Agreed Management Action
<p>3 Cashflow</p> <p>A cashflow forecast for the 2025/26 financial year has been developed and was being actively monitored, with regular engagement between project and finance teams to manage the forecast outturn. However, a full lifecycle cashflow forecast through to project completion was not currently in place.</p> <p>It is recommended that a cashflow forecast covering the full project duration be developed. This should be aligned to the latest programme, incorporate anticipated valuation profiles, and be subject to monthly review and reporting to the Project Group. Management has advised that this activity was planned for completion in April 2026; timely delivery will be important to strengthen forward financial planning and overall project control.</p>	<p>Weakened financial control due to lack of full lifecycle cashflow visibility.</p>	<p>Agreed Action:</p> <p>A full cash flow forecast v actual expenditure will be developed and incorporated in formal reporting to the Project Group.</p> <hr/> <p>Expected Evidence of Implementation: Cashflow forecast v actual expenditure within formal reports.</p>

It should be noted that project is currently performing to the expected financial levels and the established programme.

Medium Priority

Officer: Programme Director Major Infrastructure Projects

Target Implementation Date: 30 June 2026

Theme: Finance Management & Control

Control Operation

Overview / Summary of Observations

A revised procurement approach was implemented for Phase 2, reflecting lessons learned during Phase 1. In the earlier phase, it was not possible to fully define the scope of works due to the extent of surveys required and the operational sensitivities within the hospital environment. This necessitated a flexible contracting approach. With a more developed design and a clearer scope now established, the adoption of an NEC4 Option A (fixed price) contract, alongside a Design and Build model, offers a more robust and deliverable solution for Phase 2.

This updated strategy also introduced a dedicated UHB Design Team, supporting a more detailed and collaborative design process. As a result, efficiency improved, financial savings were achieved, and a revised BJC for the Phase 2 works package was delivered.

The audit examined procurement and contract arrangements for both the UHB's external advisers (Principal Designer, Project Manager, Cost Adviser, and NEC Supervisor) and the Principal Contractor. A key strength identified was the structured procurement of advisers through mini competitions from national frameworks with input from NWSSP Procurement Services. This demonstrated compliance with current procurement regulations and Standing Financial Instructions. The NEC4 Option A contract with the Principal Contractor was appropriately negotiated and executed as a deed prior to construction, in line with the agreed strategy.

Positive contractual practices were also noted. Two of the three adviser appointments were appointed utilising the NEC Professional Services Contract, providing a clear service framework and extended claim limitation periods. In addition, appropriate insurance provisions were generally included across contracts.

However, several areas for improvement were identified i.e.

- The requirement for a Parent Company Guarantee or performance bond for the Principal Contractor had not been fully formalised as at February 2026, with legal advice still being sought.
- One adviser contract was based on a shorter-form agreement and was signed initially by the UHB i.e prior to the adviser, increasing the risk of unauthorised changes being made, and being bound by unauthorised amendments.
- The NEC Supervisor was appointed two months after construction commenced.
- The Principal Designer contract was formalised ten months into the progression of the project, indicating delays in key appointments; and
- One adviser contract included a zero-liability clause, potentially limiting recourse in the event of a claim.

Overall, while procurement arrangements demonstrated strong compliance and a sound framework, these issues highlight opportunities to improve the timeliness and robustness of contractual arrangements in both this and future projects.

Based on these findings, **reasonable** assurance has been determined for appointments and contracts.

Key Findings	Risk & Impact	Agreed Management Action
<p>4 Contractual Protection</p> <p>The NEC4 Option A (fixed price) contract was negotiated and executed as a deed by the principal contractor prior to the commencement of construction, in line with the approved procurement strategy defined within the BJC.</p> <p>The original tender documentation required the contractor to provide either a Parent Company Guarantee (PCG) or a 10% performance bond to provide financial protection in the event of contractor default. However, as of February 2026, circa two months after construction commenced, this requirement had not been fulfilled.</p> <p>It is acknowledged that the UHB was seeking legal advice regarding the level of assurance provided by the contractor's proposed PCG. The UHB should ensure that financial protection arrangements are clarified and formalised at the earliest opportunity, and that for future projects with this contractor, such requirements are clearly agreed and in place prior to contract commencement.</p>	<p>Absence of agreed financial security (bond/guarantee) reduces protection against contractor default.</p>	<p>Agreed Action:</p> <p>A signed Parent Company Guarantee will be obtained and kept on file.</p> <hr/> <p>Expected Evidence of Implementation: Signed Parent Company Guarantee</p> <p>Actioned – Signed PCG received from the Contractor.</p>
<p>Theme: Contractual</p>	<p>Medium Priority</p> <p>Control Operation</p>	<p>Officer: N/A</p> <p>Target Implementation Date: N/A</p>
<p>5 Contractual Alignment</p> <p>The approved BJC (Section 5.1.1) notes that 'Contractual arrangements with all parties have been entered into using the NEC contract as prescribed under the Framework'</p> <p>A review of three adviser contracts found that two fully complied, using the NEC Professional Services Contract (PSC). The third contract used a shorter-form agreement, which provides a simpler framework. Key points include:</p> <ul style="list-style-type: none"> The PSC were executed as a deed, providing a 12-year limitation period for claims compared to 6 years for a standard contract signed under hand. 	<p>Inconsistent contracting approach and execution practices may weaken legal protection and increase overall project risk exposure.</p>	<p>Agreed Action:</p> <p>We will ensure that Future adviser appointments and contract documents comply with defined approval requirements. Any variations in approach will be formally approved as appropriate.</p> <hr/> <p>Expected Evidence of Implementation: Formal communication to all relevant parties surrounding contract execution process.</p>

<ul style="list-style-type: none"> The contract was signed by the UHB prior to the adviser; best practice suggests signing after appointed parties to confirm that the terms are final. <p>For future engagements the consistent application of the NEC (PSC) where appropriate and are signed after the adviser to confirm terms are final and maintain contractual integrity.</p>	<p>Medium Priority</p>	<p>Actioned – Staff notified of the appropriate contractual signing process.</p> <p>Officer: N/A Target Implementation Date: N/A</p>
<p>Theme: Contractual</p>	<p>Control Operation</p>	
<p>6 Engagement and Contract Formalisation of Advisers</p> <p>Engagement of the NEC Supervisor role was delayed until March 2026 (circa two months after construction began on a 22-month construction programme). This primarily arose due to changes in the procurement approach i.e. moving to a mini competition model rather than the direct award method. Additionally, the contracts for the Supervisor had not been formally signed at the time of reporting.</p> <p>Best practice is to appoint the Supervisor before works start to provide independent oversight. Delayed engagement can potentially reduce early verification and increases the risk of non-compliance.</p> <p>The Principal Designer contract was finalised around 10 months after commission commenced, largely due to the negotiation process. While this was ultimately resolved, applying lessons learned on managing contract timescales will support smoother and timelier formalisation on future projects.</p>	<p>Delayed and unsigned appointments potentially increasing risk of non-compliance.</p> <p style="background-color: yellow;">Medium Priority</p>	<p>Agreed Action:</p> <p>We will appoint the NEC Supervisor before construction begins at future project. With procurement routes and timelines planned to avoid delays.</p> <p>Expected Evidence of Implementation: This will be evidenced at future projects and included within future audit review.</p> <p>Officer: N/A Target Implementation Date: N/A (Future action)</p>
<p>7 Insurance Requirement</p> <p>A review of contracts and insurance certificates for the principal contractor and three advisers confirmed that insurance cover was generally included. However, one adviser's contract specified:</p> <p><i>Liability of the Consultant for claims arising from failure to use the skill and care normally expected of professionals providing</i></p>	<p>Insurer may deny claims due to contract terms, leaving liability for professional errors uninsured.</p>	<p>Agreed Action: A deed of variation to the contract should be agreed with the relevant consultant, which includes appropriate indemnity cover.</p>

<p><i>similar services</i> at zero, as no professional indemnity was requested in the original tender.</p> <p>Although the adviser had subsequently provided professional indemnity insurance, the contract as signed does not reflect this protection. Consequently, there remains a risk that the insurer could refuse a claim under this agreement.</p> <p>Consideration should be given to amending the contract and that all future engagements include appropriate indemnity provisions.</p>		<p>Expected Evidence of Implementation: Actioned - Deed of variation has been signed and returned to the HB.</p>
<p>Theme: Contractual</p>	<p>Medium Priority</p> <p>Control Operation</p>	<p>Officer: N/A</p> <p>Target Implementation Date: N/A</p>

Overview / Summary of Observations

The audit identified strong, positive engagement with the internal hospital hierarchy, particularly in agreeing the original programme of works and maintaining ongoing dialogue to ensure all parties are aware of expectations and any operational matters that may affect the programme. Given that the works were being progressed within a live hospital environment, this collaborative approach is viewed as essential to ensure minimised disruption to clinical services and ensuring patient safety remains a priority throughout the project.

Equally, relationships with MWWF&RS were also considered constructive and positive. The MWWF&RS had expressed their satisfaction with the level of engagement from the UHB's capital and estates teams. MWWF&RS was also routinely invited to site to observe progress and provide input where required. The capital and estates teams attended Project Group meetings, reinforcing clear communication and alignment across all parties. These arrangements support timely communication and help to address any issues that arise during the project lifecycle.

These engagement practices demonstrated a proactive, structured approach to stakeholder management, ensuring that all relevant parties were kept informed, consulted appropriately, and able to provide input at key stages. This culture of collaboration builds trust and confidence among key stakeholders.

Overall, a culture of proactive and constructive stakeholder engagement was observed, ensuring that project objectives are clearly understood, risks can be managed, and collaboration supports successful project delivery. Based on our review, we have determined **substantial assurance** for this area.

Overview / Summary of Observations

The MWWF&RS formally agreed, in its letter of 25th September 2025, an extension to the fire enforcement notice (KS/890/04) until 31 July 2027. The letter allows for applications for future extensions; noting that the current works were due for completion in September 2027 this would need to take place closer to completion. Within the letter there was also agreement to reduce the volume of remediation work if the following conditions were achieved:

1. Upgrade of the fire alarm and detection system to L1 standard.
2. Site staff training to be brought up to, and maintained at, a minimum of 85%.
3. Inclusion of additional Fire Wardens.

The above must be maintained for the lifecycle of the hospital.

The UHB had appointed fire wardens, and the fire alarm upgrade was in progress (February 2025) highlighting a positive position for those two items. However, the site staff training remains extremely challenging and the UHB had not met the set target since the issue of the letter. submitted to the fire service 27 February 2026 highlighted an aggregated site compliance rate of 83.32%.

Fire compliance rates are routinely monitored at the Project Group meetings, although it was noted that responsibility for improving the rates are outside the terms of reference of the group. Escalation had taken place to Executive level and the importance of attending training has been communicated to staff; this matter has also been raised at Clinical Care Groups.

Noting that this is a high-risk area in terms of compliance to agreed reduction of scope and compliance had only been achieved once in the periods period to end March 2026 and therefore not consistently maintained as required. Accordingly, we have determined **limited assurance** for this objective area.

Key Findings**Risk & Impact****Agreed Management Action**

8

Fire Training Compliance

Site staff training compliance had not achieved nor maintained the required 85% threshold as set out within the fire enforcement extension letter (September 2025). The reported aggregated position at the end of February 2026 being aggregated at 83.32% within the following breakdown by staff group.

Fire training non-compliance risks unprepared staff, increasing danger to patients, and potential regulatory consequences for failing to meet required standards.

Agreed Action:

Discuss with MWWFRS, endorsement of level 1, 2 and 3 fire training (e-learning) permanently.

Ensure availability of fire training compliance reports across the organisation.

Compliance Level - Staff Groups	Required	Achieved	Compliance Rate
Level 1 - All Staff	2,265	2,022	89.27%
Level 2 - Clinical/ward-based Cohort	1,033	728	70.47%
Level 3 - Estate Cohort	36	28	77.78%

Aggregate Figures	3,333	2778	83.32%
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Following the conclusion of audit fieldwork, an updated position was provided to the Project Group 25 March 2026 that highlighted the achievement of the target aggregated figure - 85.89%.

Compliance Level - Staff Groups	Required	Achieved	Compliance Rate
Level 1 - All Staff	2,265	2,023	89.84%
Level 2 - Clinical/ward-based Cohort	1,033	789	76.38%
Level 3 - Estate Cohort	36	23	63.89%

Aggregate Figures	3,333	2778	85.39%
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Whilst we acknowledge that clinical/estates facing cohorts of staff face serious operational/patient facing pressures; there was a need for further encourage individual uptake and express the necessity to comply and maintain mandated fire training requirements. A long-term plan may also be required to ensure where staff fire training is due for renewal; sufficient time is given to plan for attending the necessary training on a timely

Theme: Training & Development

Expected Evidence of Implementation:

Improved access to level 1, 2 and 3 fire training (e-learning) permanently

Fire training compliance records demonstrating completion at 85% (or above).

Clinical care group and corporate directorate governance meeting records.

High Priority





Officer: Executive Director of Allied Health Professions and Health Science

Target Implementation Date: 31 July 2026

Control Design

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.

Public Sector Internal Audit Standards

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



3.5

10:40, 0 Mins

3.5 - Infection Prevention & Control

James Johns
(NWSSP - Internal
Audit)

DEFERRED to 23 June 2026 meeting

| For assurance

3.6

10:40, 0 Mins

3.6 - Commissioning Third Sector

James Johns
(NWSSP - Internal
Audit)

DEFERRED to 23 June 2026 meeting

| For assurance

3.7

10:40, 0 Mins

3.7 - Wellsky System

James Johns
(NWSSP - Internal
Audit)

DEFERRED to 23 June 2026 meeting

| For assurance

3.8

10:40, 0 Mins

3.8 - Decision Making for High Cost Drugs

James Johns
(NWSSP - Internal
Audit)

DEFERRED to 23 June 2026 meeting

| For assurance

3.9

10:40, 0 Mins

3.9 - GP Out of Hours

James Johns
(NWSSP - Internal
Audit)

DEFERRED to 23 June 2026 meeting

| For assurance

4 - Governance

4.1

10:50, 5 Mins

4.1 - Report on the Adequacy of Arrangements for Declaring, Registering and Handling of Interests, Gifts, Hospitality, Honoraria and Sponsorship

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

| For assurance

Attachments

[4.1 Declaring Interests Gifts Hospitality and Sponsorship.pdf](#)

**PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	07 May 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Report on the Adequacy of Arrangements for Declaring, Registering and Handling Interests, Gifts, Hospitality, Honoraria and Sponsorship 2025-26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Sian-Marie James, Assistant Director of Corporate Legal Services and Public Affairs and Sonja Wright, Senior Corporate Information Officer

**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 is intended to enable the Audit and Risk Assurance Committee (ARAC) to review and to provide assurance to Board regarding the adequacy of arrangements in place within Hywel Dda University Health Board (the Health Board) for declaring, registering and handling Board Members' and staff interests, gifts, hospitality, honoraria and sponsorship during 2024/25.

This is in line with the following paragraphs of the Health Board's Standing Orders 2025:

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

Cefndir / Background

Effective arrangements to manage potential risks to decision-making arising from interests, gifts, hospitality, honoraria and sponsorship constitute an important element of the Health Board's governance arrangements. These arrangements are designed to safeguard the principles of selflessness and objectivity, and to provide members of the public with confidence that decisions are being taken in their best interests and not for the benefit of elected or appointed officials or their close personal associates.

In common with other public sector bodies, the Health Board has established arrangements to manage such risks, including:

- A 'Standards of Behaviour' policy that includes the acceptance and declaration of interests, gifts, hospitality, honoraria and sponsorship;
- Maintenance of publicly available registers of Board Members' and staff members' declarations;
- Procedures to record interests, gifts, hospitality, sponsorship and honoraria in the relevant registers;
- Processes to remind Board Members and staff of the policy's requirements; and
- Regular reporting on the adequacy of arrangements in place for declaring, registering and handling interests, gifts, hospitality, sponsorship and honoraria to the Health Board's Audit and Risk Assurance Committee.

Asesiad / Assessment

Review of the Standards of Behaviour Policy

In accordance with its review schedule, a revised version (v7) of the Health Board's [Standards of Behaviour Policy](#) was developed during 2025 and approved by the People, Organisational Development and Culture Committee (PODCC) at its meeting on 19 August 2025.

Full details of the policy review process, including stakeholder consultation and review of the 'high risk' groups of employees who are required to complete an annual Declarations of Interests (DoI) form are provided in the covering [SBAR](#) presented to PODCC at this meeting.

The policy has been made available on both the Hywel Dda UHB intranet and internet sites.

Raising awareness of the requirements of the Standards of Behaviour Policy

The Standards of Behaviour Policy, together with the requirement to submit Dols and to declare offers and acceptance of gifts, sponsorship, hospitality and honoraria, are highlighted to Board Members and to staff by the following means:

- Reference to the Standards of Behaviour Policy is included within staff Contracts of Employment issued to new employees within 12 weeks of commencing in post and to all existing employees upon a change of role. When signing their contract of employment, all staff must sign to confirm that they accept their appointment on the terms and conditions set out within the contract and contained within the Standards of Behaviour Policy.
- Staff Conditions of Employment also include reference to the requirement for members of staff within what are specified by the Standards of Behaviour Policy as 'high risk' groups to submit a Declaration of Interest.
- The requirement to declare any interests, and awareness of the Policy, are highlighted to Health Board employees in the Hywel Dda Induction Pack.
- On commencement in post, Independent Members receive a programme of induction and are provided with an Independent Member Handbook referencing the Standards of Behaviour Policy.
- Regular messages, including links to the policy and relevant forms, are circulated via Global E-mail and NHS Wales Daily Digest to remind employees and Board Members to report offers and acceptance of gifts, hospitality, sponsorship and honoraria and to declare any interests.

- Advice and awareness-raising regarding standards of behaviour are included on an *ad hoc* basis in the Health Board's Counter-Fraud Newsletter which is circulated to all Health Board staff.
- Meetings with individual teams have been held on request to provide guidance in relation to Standards of Behaviour Policy requirements; for example, the acceptance and declaration of gifts received from patients and their families.
- Tailored responses are provided to queries from individual staff members regarding whether, when and how to submit declarations of interests, gifts, hospitality, sponsorship and honoraria.

Review of the Adequacy of Arrangements in Place for Declaring, Registering and Handling Interests of Board Members and Staff

Board Members' Interests

It is a requirement within the Health Board's Standing Orders that all Board Members must declare any personal or business interests they may have which may affect, or be perceived to affect, the conduct of their role as a Board Member and their judgement in the course of conducting the Board's business. Board Members must be familiar with the Standards of Behaviour policy and must notify the Board of any such interests at the time of their appointment and as they arise throughout their tenure.

Provision is made at the beginning of each Public Board and Board Committee meeting for individual Board Members to identify and declare interests relating to any aspect of business included on the meeting agenda in order that appropriate action can be taken in response. A link to the Register of Board Members' Interests is included on the agenda for all Committee Meetings to allow members to review their entries and confirm accuracy of notify any amendments, as applicable. All declarations of Members' interests made at a meeting are recorded within the formal minutes.

In line with Standing Orders, a Register of Members' Interests (including interests held by family members or persons or bodies with which they are connected) is maintained by the Health Board. This records the interests of Board Members at the time of their appointment, and is updated, as appropriate, to record any new interests or changes to their interests throughout the year. An annual review of interests is undertaken as part of related party transactions/ year-end processes, where each Board Member is required to confirm the accuracy and completeness of the Register relating to their own interests. The Register of Members Interests for 2026-27 is published on the [Health Board's internet site](#).

The Health Board's Standing Orders 2025 (pp.16-17) require all Board Members to confirm their eligibility to hold office on an annual basis and also require the Chair, Vice Chair and Independent Members (and Associate Members) to confirm their understanding of their indemnity in relation to activity undertaken in their role. In order to record these confirmations, the Declaration of Members Interests form incorporates annual Declarations of Board Members' Eligibility and Chair and Independent Members' Indemnity.

Staff Interests

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

In line with this requirement, a Register of Staff Interests is maintained to formally record Dols made by employees (including any interests held by their spouse, civil partner, partner or other relation and any relationships with/ to other Health Board staff members or Independent Members). Each declaration made by staff members requires the approval of the relevant Director or Departmental/ Line Manager to confirm that the Dol form has been reviewed and appropriate safeguards have been identified to address any conflicts or potential conflicts of interest. Positive Dols are followed up with employees' line managers, to confirm that all necessary and appropriate safeguards are in place, prior to recording the interest on the Register.

In compliance with Standing Orders, the Register of Staff Members' Interests for 2026-27 is published on the [Health Board's internet site](#).

High Risk Staff Groups

As described in the Standards of Behaviour Policy and in the SBAR referenced and linked on page 2 of this paper, 'high risk' staff groups are defined, members who are required to complete an annual Dol form. Lists of staff included in each of the 'high risk' groups are refreshed annually, using data provided by individual Directors, Service Leads and Workforce and OD teams, to ensure that they are current.

All staff members included in 'high risk' groups, as defined within the Standards of Behaviour Policy, are individually contacted by email requesting them to complete a Dol form, even in the case of 'Nil' declarations. During 2025-26, an enhanced monitoring framework was implemented to ensure that as many staff as possible within the 'high risk' groups completed a Declaration.

Individual requests/ reminders to complete Declarations were issued to approximately 2,300 'high risk' staff, followed by further email reminders at set intervals. This yielded a response (declaration) rate of 63%, an increase from the 23% response figure for 2024-25.

In 2026-27, an additional stage of escalation will be introduced to further increase this rate of compliance, whereby line managers will be notified of staff within their teams who have not submitted declarations and asked to ensure that these staff members complete and submit a declaration form.

Declarations of Gifts, Hospitality, Sponsorship and Honoraria

Due to IT issues, the link to the online form for declaring gifts, hospitality, sponsorship and honoraria became non-functional for a period during 2025, in that entries were not visible on the list held on Sharepoint. This was identified by the Corporate Team and resolved in collaboration with the IT department. All declarations submitted during the period when declarations were not automatically included on the Sharepoint list were forwarded by IT and were entered manually on the Register of Gifts, Hospitality, Sponsorship and Honoraria by the Corporate Team, until the link was restored in November 2025.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to:

- **TAKE ASSURANCE** from the adequacy of the arrangements in place for declaring, registering and handling interests, gifts, hospitality, sponsorship and honoraria during 2025-26, for onward assurance to the Board.

- **NOTE** the improved Declaration of Interests compliance rate among staff in 'high risk' groups, as compared with the previous year.
- **NOTE** the consultation undertaken to inform the scheduled review of the Standards of Behaviour Policy.

Amcanion: (rhaid cwblhau)	
Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.11: To receive annually a full report of all offers of gifts, hospitality, sponsorship and honoraria recorded by the UHB and report to the Board the adequacy of these arrangements.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	Not Applicable

Gwybodaeth Ychwanegol:	
Further Information:	
Ar sail tystiolaeth: Evidence Base:	HDdUHB Standards of Behaviour Policy Declaration Registers
Rhestr Termau: Glossary of Terms:	Included within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Director of Corporate Governance/ Board Secretary Assistant Director of Corporate Legal Services and Public Affairs

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

4.2

10:55, 5 Mins

4.2 - Draft Audit and Risk Assurance
Committee Annual Report 2025/26

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

| For approval

Attachments

[4.2 SBAR Draft ARAC Annual Report.pdf](#)

[4.2 Draft ARAC Annual Report 2025-26.pdf](#)

**PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	07 May 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Draft Audit and Risk Assurance Committee Annual Report 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Cllr. Rhodri Evans, Chair of Audit and Risk Assurance Committee
SWYDDOG ADRODD: REPORTING OFFICER:	Cllr. Rhodri Evans, Chair of Audit and Risk Assurance Committee

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 purpose of this report is to present the Audit and Risk Assurance Committee (ARAC) Annual Report to Members. The attached report provides assurances in respect of the work that has been undertaken by ARAC in the 2025/26 financial year and provides information relating to the continued development of the role of the Committee and its members.

The attached report supports the compilation of the Annual Governance Statement and sets out how ARAC has met its Terms of Reference. The report has been compiled by the Chair of ARAC, based upon the work of the Committee.

Cefndir / Background

The Committee, through its in-year reporting, has regularly kept the Board informed about the results of its reviews of assurances, together with any exceptional issues that arose. In accordance with the NHS Wales Audit Committee handbook and generally accepted standards of good practice, the ARAC Chair is required to issue an Annual Report of the matters that have been considered by the Committee during the financial year.

The report provides the Board and the Accountable Officer with assurance in respect of the adequacy and effectiveness of the Health Board's procedures and systems in maintaining a sound system of internal control and the conclusions drawn for the 2025/26 financial year. This is to include assurance about the rigour of the processes and the quality of the data which lie behind the statements and provide its own assurance about the reliability of the disclosures when they are subsequently submitted to the Board for approval.

Asesiad / Assessment

Please see the attached ARAC Annual Report 2025/26.

Please note that Chair's Action will be required, as the report will need to be updated following completion of the Internal Audit Plan for 2025/26 and the Final Head of Internal Audit Opinion being issued, before the report can be submitted to Board at its meeting scheduled for 25 June 2026.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to provide feedback on the ARAC Annual Report within one week and request Chair's Action to approve the content of the report, prior to onward submission to the Board.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	10.5 The Committee Chair, supported by the Committee Secretary, shall: 10.5.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report as well as the presentation of an annual report within six weeks of the end of the financial year and timed to support the preparation of the Accountability Report. This should specifically comment on the adequacy of the assurance framework, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self assessment activity against relevant standards. The report will also record the results of the Committee's self assessment and evaluation.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	ARAC Agenda and Papers
Rhestr Termiau: Glossary of Terms:	Not Applicable
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	ARAC Chair

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	A sound system of financial control enacts robust financial control, safeguards public funds and the Health Board's assets and resources. Robust governance arrangements underpinning financial management contribute towards internal control and value for money being achieved.
Ansawdd / Gofal Claf: Quality / Patient Care:	A sound system of internal control ensures that any risks to the achievement of the Health Board's objectives are identified, assessed and managed.
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	<ul style="list-style-type: none"> • Has EqIA screening been undertaken? No • Has a full EqIA been undertaken? No

AUDIT AND RISK ASSURANCE COMMITTEE

ANNUAL REPORT

2025/26

1. Introduction and Chair's summary

The Audit and Risk Assurance Committee (ARAC) was established under Board delegation with approved Terms of Reference and Operating Arrangements that are aligned to the NHS Wales Audit Committee Handbook, published by the Welsh Government (WG). The Committee is an independent Committee of the Board and has no Executive powers other than those specifically delegated in the Terms of Reference.

The Committee through its in-year reporting, has regularly kept the Board informed regarding the results of its reviews of assurances, together with any exceptional issues that arose. In accordance with the NHS Wales Audit Committee Handbook guidance and generally accepted standards of good practice, the Committee is required to issue an Annual Report constituting a formal report of the matters that it has considered during the year. The purpose of this report is to provide the Board and the Accountable Officer with assurance in respect of the adequacy and effectiveness of the Health Board's procedures and systems in maintaining a sound system of internal control, and the conclusions drawn for the 2025/26 financial year.

This report supports the compilation of the Accountability Report and details how the Committee has met its Terms of Reference.

2. Role and Purpose

The Committee supports the Board by critically reviewing governance and assurance processes on which the Board places reliance. The primary role of the Committee is to ensure the system of assurance is valid and suitable for the Board's requirements. It reviews whether:

- Processes to seek and provide assurance are robust and relevant;
- The controls in place are sound and complete;
- Assurances are reliable and of good quality; and
- Assurances are based on reliable, accurate and timely information and data.

The Committee provides a key source of assurance to the Board, ensuring that the organisation has effective controls in place to manage the significant risks to achieving its objectives and that controls are operating effectively. The Committee's principal duties have consistently included reviewing *"the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical"*.

The Committee discharges this duty by fulfilling its responsibilities as outlined in its [Terms of Reference](#). In performing its duties, the ARAC works to an approved workplan, based on scheduled agenda topics, together with a range of specific issues, which are subject to review. It is supported by the activities of Audit Wales (AW) as the External Auditor; NHS Wales Shared Services Partnership (NWSSP): Audit and Assurance – Internal Audit (IA) and Specialist Services Unit (SSU), and Local Counter Fraud Specialists.

In discharging these responsibilities, the Committee is required to review:

- Internal financial control matters, such as safeguarding of assets, the maintenance of proper accounting records and the reliability of financial information;
- Adequacy of disclosure statements (Annual Report and Annual Accounts), which are supported by the opinion of the Head of IA, the AW Annual Audit Report and other opinions;
- The adequacy of relevant policies, legality issues and the Codes of Conduct;
- The policies and procedures relating to fraud and corruption; and
- The system for risk management, to ensure this is robust in identifying and mitigating risks, enabling the Committee to provide the Board with assurance.

3. Terms of Reference and Workplan

The [Terms of Reference](#) (TOR) for ARAC are reviewed on an annual basis or following any significant changes. The TORs were approved by Board at its meeting in July 2025. Changes of note included the addition of reference to the Regional Joint Committee (RJC).

The Committee has an annual [workplan](#) to enable forward planning for the forthcoming year. The workplan is produced to incorporate the duties outlined in the Committee's Terms of Reference and any suggested areas of focus identified during the self-assessment process.

The Committee workplan covers a range of activities, including statutory reporting duties, regular items of business and priority planned pieces of work which support Board and Committee objectives. The workplan is regularly updated throughout the year, to ensure that it remains responsive to emerging issues and risks.

The Committee reviewed and approved the audit strategies and plans for the auditors as listed below, and received audit reports produced in support of them during 2025/26:

- Audit Wales;
- NWSSP Audit and Assurance Services:
 - Internal Auditors;
 - Specialised Services Unit.

Acting upon the outcomes of effectiveness reviews is as important as undertaking them. It is essential that outcomes and associated actions are reported appropriately. Throughout the year, Executive Directors and Lead Officers of audit reports have been requested to attend ARAC meetings to provide an opportunity to discuss the reports more fully. This also provides an opportunity for the Committee to satisfy itself that findings raised in reports are being addressed, with recommendations implemented to address control weaknesses or compliance issues.

The Committee continues to receive progress updates directly as and when requested, as well as referring reports to the Board and other Board Committees to ensure their wider aspects or impacts are fully understood.

4. Committee Structure and Meetings

A key element of the Committee is that it comprises solely of Independent Members, providing a basis for it to operate independently of any decision-making process and to apply an objective approach in the conduct of its business.

Although invited to attend certain meetings to provide assurances and explanations to the ARAC on specific issues, neither the Health Board Chair, Chief Executive Officer (CEO), nor any other Executive Director of the Health Board, are members of the Committee. The CEO is invited annually to present the Accountability Report and to co-present progress reports at each meeting on the Health Board's Escalation Status and scrutiny meetings with WG.

Having a key role to play in establishing and maintaining a sound system of internal financial control, the Executive Director of Finance has attended all meetings. The ARAC has also been supported on key matters by means of the attendance of the Director of Corporate Governance/Board Secretary, who is the Lead Officer for the Committee, and who has been present at all meetings.

The Committee also has regular attendance from representatives of:

- The Auditor General/AW;
- NWSSP Audit and Assurance Services (IA and SSU);
- NHS Counter Fraud Services.

The membership of the Committee for 2025/26 was as follows, along with their attendance at meetings:

Name	15.04.25	08.05.25	24.06.25	12.08.25	14.10.25	09.12.25	10.02.26
Members							
Cllr Rhodri Evans – Committee Chair	✓	✓	✓	x	✓	✓	✓
Winston Weir – Committee Vice-Chair	x	✓	✓	✓	✓	x	✓
Maynard Davies - Committee Member	✓	x	✓	✓	✓	✓	✓
Eleanor Marks - Committee Member	✓	x	✓	✓	✓	✓	✓
In Attendance							
Huw Thomas – Director of Finance	✓	✓	✓	✓	✓	✓	✓
Joanne Wilson – Director of Corporate Governance / Board Secretary	✓	✓	✓	✓	✓	✓	✓
Charlotte Wilmshurst – Assistant Director of Assurance and Risk	✓	✓	✓	✓	✓	✓	✓
Audit Wales Representative	✓	✓	✓	✓	✓	✓	✓
James Johns – Head of Internal Audit	✓	✓	✓	✓	✓	✓	✓

Benjamin Rees – Local Counter Fraud Specialist	✓	x	✓	✓	✓	✓	✓
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All meetings were quorate (figures include deputising arrangements).

5. Private meeting of Audit and Risk Assurance Committee Members with the Auditors

In line with the Audit Committee Handbook and the ARAC Terms of Reference, Committee Members met privately at individual meetings with Audit Wales, Internal Audit and Counter Fraud on 19 March 2026. The meetings were attended as follows:

Independent Members	Attended by
<ul style="list-style-type: none"> • Cllr Rhodri Evans, Committee Chair • Mr Winston Weir, Committee Vice-Chair • Mrs Eleanor Marks, Committee Member • Mr Maynard Davies, Committee Member 	<p>Meeting with Internal Audit</p> <ul style="list-style-type: none"> • Mr James Johns, Head of Internal Audit • Ms Sophie Corbett, Deputy Head of Internal Audit <p>Meeting with Counter Fraud</p> <ul style="list-style-type: none"> • Mr Benjamin Rees, Head of Local Counter Fraud Services <p>Meeting with Audit Wales</p> <ul style="list-style-type: none"> • Mr Anthony Veale, Engagement Director and Audit Director • Ms Anne Beegan, Audit Manager • Ms Urvisha Perez, Audit Lead

Healthcare Inspectorate Wales (HIW) was offered a private meeting with Committee Members, however declined, advising that it has set up separate engagement meetings via its Head of NHS Assurance.

The purpose of holding a private session between Members and auditors, without management present, is to build a relationship of trust and to support the independence of the audit functions. It also provides an opportunity for the auditors to provide feedback to the Committee on its own performance. The discussion is not minuted, although the Chair provides appropriate feedback to the Lead Officer of the Committee where there are areas of improvement required.

6. Committee Activities – Alert and Advise

The Committee is required to report to the Board after each Committee meeting by presenting a report highlighting the key discussion items at the Committee. Items which the Committee sought to either Alert or Advise the Board during 2025/26 are summarised below:

Alert – *The following matters were areas where the Committee was unable to take an assurance or had a lack of confidence that the action in place was sufficient to address the issue satisfactorily and/or it was within the scope of the operational team to resolve, and was alerting the Board as engagement action or intervention was required:*

- No matters raised as an Alert

Advise – *The following matters were areas of concern where assurance had been taken on actions in place but required close monitoring. The ongoing monitoring of the timely implementation of recommendations related to the reports mentioned below is done by the Board's Committees via the Assurance and Risk Reports.*

- The **Audit Wales Review of Urgent and Emergency Care (UEC) report** was received at the June 2025 ARAC meeting with all recommendations accepted, focusing on improving data quality, clarifying funding, enhancing patient signposting aligned with Welsh Ambulance Services University NHS Trust (WAST) and strengthening patient and staff feedback. Further actions included addressing dental contract performance, ensuring compliance with Same Day Emergency Care (SDEC) guidance, and improving access to patient information, particularly GP records where integration challenges persist. Planned developments in eObservations and Patient Flow were identified as being vital to facilitate these improvements. Concerns were raised around dental service access, prompting a request for a detailed report on sustainable dental services to the July 2025 Public Board. The report also highlighted issues around staff engagement and a perceived blame culture which should be addressed through the new operational structure, unified within the Community and Integrated Medicine Clinical Care Group.
- The **Audit Wales Planned Care Review** was received at the June 2025 ARAC meeting and evaluated progress in tackling planned care challenges. Management responses focussed on waiting list backlogs and barriers to improvement, with six recommendations raised including the need for clarity around funding strategies, long-term planning beyond the Clinical Services Plan, a dedicated Planned Care risk register, and completion of recommendations from Getting It Right First Time (GIRFT) reports. Concerns were raised regarding inconsistent clinical prioritisation of urgent cases and the need for better risk stratification of waiting lists. It was also noted that crucial support services like Radiology and Pathology are often overlooked in funding applications aimed at reducing waiting lists.
- The **Standards of Cleanliness Internal Audit** was received by ARAC in June 2025, with Limited Assurance awarded. It was recognised that whilst some progress had been made to address issues raised in the original 2023/24 audit, several actions remained ongoing associated with inconsistent reporting of cleaning audit scores, missed meetings with poor representation, incomplete documentation, non-compliance with cleaning standards, and failure to meet target scores. The ARAC questioned the lack of progress and whether the Health Board has the management capacity to deliver the improvements required. Following an agreement to develop more focussed management responses, a Task and Finish Group was established and an update was provided at the August

2025 ARAC meeting advising that the most pressing actions were now complete, with ongoing monitoring of compliance to be reported on a weekly basis to the Cleaning Standards Sub-Group. The follow up audit has been deferred to 2026/27.

- The Board was advised about concerns raised at the August 2025 ARAC meeting around the lack of progress with the **new operational structure** and the impact on staff, noting that the Health Board is extremely dependent on its effectiveness to improve delivery and performance. The ARAC requested the update scheduled to be presented to the People, Organisational Development and Culture Committee (PODCC) and to also be provided to ARAC Members.
- The **Escalation Status Update** as presented to the ARAC in August 2025 highlighted the additional Targeted Intervention (TI) criteria relating to responses to concerns raised by Regulators, including Healthcare Inspectorate Wales (HIW). Concerns were also raised around the change to the financial de-escalation criteria from the Target Control Total of £31.5m deficit to £24m, and the wider implications of this shift to the overarching plan. This amendment would require the identification and delivery of an additional £6m of savings in the space of 7 months, making the need to enact potential options presented to Public Board in July 2025 more likely.

An updated position was presented at the March 2026 Board meeting providing assurance that there were robust governance arrangements in place to support the Health Board's compliance with its de-escalation criteria, whilst recognising there is a capacity and capability deficit within operational governance due to ongoing operational pressures across Clinical Care Groups.

- The **Sickness Management Internal Audit** was awarded Limited Assurance and discussed at the August 2025 ARAC meeting. The audit reviewed the arrangements in place for managing sickness absence in compliance with the All Wales Managing Attendance at Work Policy, training and support available to staff and line managers, and the monitoring and reporting arrangements. Non-compliance with key requirements of the policy relating to Fit Notes, Return-to-Work interviews and reviewing prompts for frequent absences were highlighted. Audited staff were aware of the requirements, therefore non-compliance suggested underlying capacity or cultural issues. Concerns were also raised regarding the small audit sample size, with agreement made to revisit the associated guidance and principles involved. It was agreed to establish a planned programme of reviews with service areas supported by the Workforce team, while emphasising that responsibility for managing attendance rests with line managers. Compliance targets in these areas were

confirmed as 100%, and members agreed that a follow-up audit with an expanded sample should be undertaken later in the year to strengthen assurance. A follow up on sickness management is scheduled to report to the ARAC in May 2026.

- Concerns were raised at the August 2025 meeting regarding the **Nursing Management Internal Audit**, which was awarded Limited Assurance as a follow-up of the 2024/25 audit. The audit focussed on rostering processes and absence management. Whilst audit findings were broadly consistent with the previous report, an improving trend in rostering controls and practices was observed. However, the audit identified a deterioration in sickness management and widespread non-compliance with key requirements of the All Wales Managing Attendance at Work Policy. It was highlighted that the Health Board received two Limited Assurance reports due to the same underlying reason of sickness absence management. It was noted that these findings would be reported to Welsh Government, and that there is a clear need for decisive action. The value of an appreciative inquiry and Quality Improvement approach was reiterated, and if upscaled across nursing areas alone, would offer the opportunity to influence significant numbers. A follow up on sickness management, which will incorporate nursing sickness, is scheduled to report to the ARAC in May 2026.
- In considering the **Financial Assurance Report** at the August 2025 Committee, concerns around breaches of **Standing Financial Instructions (SFIs)** and the use of retrospective Purchase Orders were raised. It was emphasised that the SFIs reported are not material in nature, however, an active programme of education is in place.
- Concerns were raised at the October 2025 ARAC meeting regarding the findings of the **Validation of Emergency Department Waiting Time Data Internal Audit**, which was issued with Limited Assurance. The audit focused on validating Emergency Department data, particularly the four-hour target and the breach validation process in place. A Standard Operating Procedure (SOP) was in place, however this had not been approved via formal processes and further work was required to address issues with this to ensure appropriate dissemination across the four acute sites, and to establish if clinical involvement in the process is required. Since April 2025, it was noted that validation had only been undertaken at Bronglais Hospital (BGH) following a change in management. The audit had concluded Limited Assurance overall, with a follow-up planned for 2026/27 (this has been deferred to 2026/27 due to operational pressures in Q4).

- The **Human Tissue Authority Internal Audit**, which was awarded Limited Assurance, found that the Health Board is compliant with key Human Tissue Authority (HTA) standards in relation to secure tissue storage and adherence to family wishes regarding disposal. However, instances were found of missing and incomplete records, and delays in disposal leading to tissue being retained without consent which had not been reported to the HTA as 'reportable incidents'. A rigorous action plan with challenging but achievable deadlines was established in response, recognising that that none of the concerns raised in the Internal Audit were highlighted during a statutory visit to the Health Board's licensed premises. Whilst the contents of the report were concerning, it was recognised that the Health Board is compliant with HTA standards. The Committee requested a follow-up audit which was reported to ARAC in April 2026 which reported all recommendations had been completed.
- Discussions around the **Internal Audit Plan Progress Report** as presented to ARAC in December 2025 raised concerns around responses to audits. The Internal Audit Charter sets out requirements to be timely, honest and open, and engagement with audit partners must be effective and constructive. Specific issues in this round of internal audits included re-auditing following completion of an initial draft, the subsequent receipt of contradictory information, and delays in submitting information and evidence. The Committee escalated these concerns to the Chief Executive.
- The ARAC received and discussed the **Audit Wales Report Urgent and Emergency Care: Flow out of Hospital – West Wales Region**, highlighting ongoing challenges in patient flow affecting Urgent and Emergency Care (UEC). The report, which was developed jointly with Local Authority partners and cleared for factual accuracy through the Regional Partnership Board (RPB), identified persistent delays in discharges that continue to impact ambulance handovers, emergency department waiting times and overall system performance. The report highlighted barriers such as increasing complexity of patient need, capacity constraints and weakness in discharge planning, despite a range of programmes underway. The report outlined four recommendations for the Health Board, as well as nine joint recommendations with Local Authorities and two specifically for Local Authorities, and concluded that sustained, system-wide action is required to achieve meaningful improvement. The Senior Operational Team noted that all issues raised are already recognised by the Health Board, with work in progress to address them, although the pace of delivery and the need for strengthened joint working remain key considerations. Concerns were raised regarding capacity and capability within the operational team to take forward these recommendations in a timely manner, the fragility of the care sector, the

need for consistent seven day service provision, and differing levels of priority placed on delayed discharges across partner organisations. The Committee were appraised of a business case due to be presented to Board in January 2026 (subsequently approved at the meeting held on 28 January 2026), seeking to address these challenges alongside wider programmes of work. Additionally, work on a Memorandum of Understanding with local authorities was underway to support more aligned approaches, alongside efforts to improve public messaging on the risks of prolonged hospital stays. The ARAC were reminded that Health Board-specific actions will be monitored via the Audit Tracker, with joint recommendations potentially overseen through the RPB. The Committee noted the absence of clear completion dates and variable quality in management responses, which may affect the ability to track progress and could have implications for Clinical Care Group escalation status. A follow up meeting with RPB leads was held in March 2026 to address these concerns.

- In March 2026, the Board were advised of discussions at the February 2026 ARAC meeting around operational pressures inhibiting **timely responses to requests for access to information from Audit Wales and Internal Audit** that could potentially impact on the assurance received from individual audits and affect the overall audit opinion of the Health Board.
- Discussions around the **Internal Audit of Managed Practices**, which provided Reasonable Assurance, as presented to ARAC in February 2026 noted the need to develop the strategic vision for the management of managed GP practices within the Health Board through the Primary Care and Community Services Strategy, now the Community by Design Strategic Plan, to ensure that processes are in place to provide clarity to the strategic intent for the oversight of managed practices. The Committee were advised that processes have been implemented to ensure that the appropriate financial management, budget setting and development of savings plans for managed practices were in place.
- A discussion around the **Internal Audit of the Health Board's vaccination and immunisation processes**, which provided Limited Assurance, was held at the February 2026 meeting. The Committee noted that they received assurance that the actions required to remedy the issues identified by the audit were now in place and on track to be implemented within the agreed timescales, however there was a need to improve and develop the vaccination and immunisation strategy within the wider Primary Care Strategic Plan. It was recommended that the Strategy and Planning Committee undertake a review of the governance arrangements pertaining to the Health Board's Vaccination and Immunisation Strategy in order to obtain assurance

regarding the robustness of the strategic direction and programme planning in response to the audit findings. This is scheduled for July 2026.

7. Committee Activity – regular reporting

The Committee regularly receives the following reports at its meetings, with items which the Board were either alerted to or advised of during 2025/26 noted:

Escalation Status Reports

At the start of the financial year the Health Board's escalation levels against the Welsh Government's six domains were:

Level 4 (targeted intervention) across four domains due to significant concerns:

- Finance, Strategy and Planning;
- Performance and Outcomes*;
- Fragile Services; and
- Quality of Care

Level 3 (enhanced monitoring status) across two domains:

- Leadership, Capability and Culture;
- Governance

*Two key areas of the Performance and Outcomes domain were de-escalated in March 2025 to Level 3 (enhanced monitoring status): Child and Adolescent Mental Health Services (CAMHS) and Planned Care.

The Health Board were further de-escalated during the financial year in the following areas:

- Performance and Outcomes relating to Child and Adolescent Mental Health from Level 3 (enhanced monitoring) to Level 1 (routine arrangements) in July 2025;
- Performance and Outcomes relating to Cancer from Level 4 (targeted intervention) to Level 3 (enhanced monitoring) in July 2025, and further de-escalation to Level 1 (routine arrangements) in February 2026;
- Governance from Level 3 (enhanced monitoring) to Level 1 (routine arrangements) in December 2025; and
- Leadership, Capability and Culture from Level 3 (enhanced monitoring) to Level 1 (routine arrangements) in December 2025.

During 2025/26, routine performance management, including Joint Executive Team (JET) and Integrated Quality, Planning and Delivery Group (IQPD) meetings, quarterly escalation meetings and a Public Accountability Meeting in December 2025, provided intervention, support and monitoring arrangement by Welsh Government, along with the updated de-escalation criteria. Welsh Government are introducing a new approach to NHS Wales/Welsh Government

oversight and interface arrangements for 2026/27, that will require us to meet the following requirements:

- Providing timely, accurate data and updates via the common reporting pack.
- Utilising the single reporting pack within Board papers and discussions.
- Maintaining delivery plans (IMTP/annual plan) and corrective action plans aligned to escalation requirements.
- Participating in risk-based CEO/Executive Review Meetings with the NHS Wales CEO (cadence set by escalation level) to reinforce earned autonomy.

The Escalation Status Report, provided at each meeting, aims to provide the Committee with assurance on the Health Board's progress in addressing WG's de-escalation requirements.

The Board was:

- **Advised** of the additional criteria relating to concerns raised by regulators, particularly Healthcare Inspectorate Wales (HIW) and Health Education and Improvement Wales (HEIW) inspections and report, and concerns around the change to the financial de-escalation criteria from £31.5m to £24m, and the wider implications of this shift to the overarching plan. This amendment would require the identification and delivery of an additional £6m of savings in the space of 7 months, making the need to enact potential options presented to Public Board in July 2025 more likely.
- **Advised** that the Escalation Status Update Report provided assurance that there were robust governance and operational governance arrangements in place to support the Health Board's compliance with its de-escalation criteria, however there is a capacity and capability deficit within operational governance due to on-going operational pressures across Clinical Care Groups.

Financial Assurance Report

The Financial Assurance Report was presented at every meeting throughout 2025/26. This is consistent with the Committee's role of maintaining an appropriate financial focus by demonstrating robust financial reporting and ensuring that the maintenance of sound systems of financial control is enacted. To comply with Standing Orders and Standing Financial Instructions (SOs and SFIs), the Committee must review losses and special payments reports and where appropriate, recommend them to the Board for approval. This element of the Committee's work is discharged through consideration and approval of the losses and debtors' write-offs provided in the Financial Assurance Report.

Matters discussed by the Committee during the year and on which assurances were provided included:

- Compliance with Standing Financial Instructions (SFIs) requirements;
- Compliance with Purchase to Pay requirements (Public Sector Payment Policy);

- Compliance with National Minimum Wage (NMW) requirements;
- Compliance with Single Tender Action (STAs) requirements;
- Losses and Special Payments and Write Offs; and
- Controls in place to manage staff overpayments.
-

The Board was:

- **Advised** of breaches of Standing Financial Instructions (SFIs) and the use of retrospective purchase orders, that whilst the SFIs reported are not material in nature, an active programme of education is in place.

Risk Assurance Report

The Committee is responsible for reviewing the adequacy of the underlying assurance processes that indicate the degree of the achievement of strategic and planning objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

The purpose of the Risk Assurance Report is to provide assurance on the effectiveness of the Risk Management Framework, the implementation of the Risk Management Strategy and progress made against the objectives contained within. The revised [Risk Management Framework and Risk Management Strategy](#) were approved by the Board in September 2025.

The report also provides a high-level summary of each Clinical Care Group and Executive Function's internal escalation status in relation to their risk management processes. This is consistent with the Committee's role of reviewing the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical, that supports the achievement of the organisation's objectives.

The Committee was presented with the outcomes of the annual risk maturity for 2024/25 self-assessment at its meeting in April 2025. The assessment was undertaken in accordance with the Orange Book (a recognised risk management standard for the public sector). The outcomes of this assessment informed the objectives for the [Risk Management Strategy](#).

No items arose during the year which the Committee either alerted or advised the Board.

External Recommendations and Welsh Health Circulars Assurance Report

Audits, inspections and reviews play an important independent role in providing the Board with assurance on internal controls, and that systems and processes are sufficiently comprehensive and operating effectively. Therefore, it is essential that recommendations from audits, inspections and reviews as well as mandatory guidance, policy updates and operational requirements from Welsh Health Circulars are implemented in a timely way.

All reports from audits, inspections and reviews carried out across the Health Board and all Welsh Health Circulars are logged and tracked on the Audit Management and Tracking (AMaT) system, with progress updated by relevant service leads regarding implementation against each recommendation. The AMaT system enables a high-level summary of report activity from auditors, inspectorates and regulators to be produced and reported on for each Clinical Care Group and Executive Function, informing its escalation status. Data is assessed as at the most recent month-end position, to align with the escalation framework. The report aims, therefore, to provide assurance on the progress made in respect of implementing recommendations as raised from audits, inspections and Welsh Health Circulars.

The Board was:

- **Assured** that significant progress has been demonstrated in reducing the number of open and overdue external recommendations particularly within the Estates and Facilities Clinical Care Group at its meeting in February 2026, however the Committee **advised** the Board of the deterioration in performance of the Community and Integrated Medicine Clinical Care Group and that should satisfactory improvement not be demonstrated to the Committee in April 2026, the Chief Operating Officer would be asked to attend the Committee in June 2026.

8. Committee Activity – other Committee work

Other items identified by the Committee as requiring Board attention during 2025/26 included:

- The ratification of the **Health Board's Standing Orders (SOs) at its meeting in April 2025**, and approved by Board at its meeting on 29 May 2025;
- The ratification of the **Health Board's Standing Financial Instructions (SFIs) at its meeting in June 2025**, and approved by Board at its meeting on 31 July 2025;
- The review of the adequacy of the **Declaring, Registering and Handling Interests, Gifts, Hospitality, Honoraria and Sponsorship** arrangements currently in place via its annual review in May 2025;
- The approval of all year-end documentation for 2024/25 at its meeting on 24 June 2025;
- The ratification of the **Risk Management Framework and Strategy** at its meeting in August 2025, and approved by Board at its meeting in September 2025;
- The ratification of the **Scheme of Delegation** at its meetings in April 2025 and February 2026, and approved by Board at its meeting in May 2025 and March 2026 respectively;
- The **Annual Summary of Single Tender Action and Quotation Reports** was presented to the Committee in June 2025, detailing the Single Tender Actions awarded by the Health Board during 2024/25, to obtain assurance that there were no consistent or recurring themes which might indicate any attempt to

circumvent due process, thereby enabling any trends or other issues of concern to be monitored and acted upon.

The Committee received the Annual Statement of Financial Procedures at its meeting held on 10 February 2026, detailing planned reviews of the financial systems operated by the Health Board planned to be undertaken during 2026/27.

9. External Audit

The external audit service is provided by Audit Wales (AW), with its work in 2025/26 falling under the two broad headings of:

- Audit of financial statements, and providing an opinion thereon;
- Performance audit work, including an All-Wales thematic review of cancer services, and local project work.

The outline AW Annual Plan 2025 was discussed in April 2025 by the Committee. The plan set out proposed AW work to examine the Health Board's financial statements, expenditure and measures to secure economy, efficiency and effectiveness in the use of resources. An appropriate programme of performance audit work will also be undertaken. Areas to be tested have been selected based upon identified financial risk specific to the Health Board.

Progress against the AW Audit Plan is monitored via regular update reports presented to the Committee with some timings changing in-year.

Outcomes of Structured Assessment 2025

In 2025, the [AW Structured Assessment](#) focused on how well the Health Board is governed and whether it made the best use of its resources. This was presented to the Public Board meeting held on 29 January 2026 following presentation to the Committee on 9 December 2025. The overall conclusion was that *'the Health Board remains strongly committed to public transparency and continues to have good governance arrangements'*. Other key messages in the report relating to Board transparency, effectiveness and cohesion included:

- We continue to have a strong commitment to public transparency, ensuring our Board business remains open and accessible.
- We have robust arrangements in place to support the effective conduct of Board and committee business.
- Our Board and committees are operating effectively, with strengthened arrangements to escalate high-risk matters to the Board.
- We are progressing well with preparations to establish a joint committee with Swansea Bay University Health Board.
- We continue to receive good-quality, timely papers that are strengthening further through ongoing improvements.
- We continue to hear from a broad range of patients and staff, supported by enhanced arrangements for patient safety walkabouts.

- Our Board is managing a significant period of change well and is taking positive steps to maintain cohesion and effectiveness through development and continuous improvement.

AW found that in relation to corporate systems of assurance that “there are strong arrangements to oversee risk, performance, service quality and safety and audit recommendations. The Health Board is taking steps to improve data quality and further strengthen governance arrangements for quality and safety. There is an opportunity to clarify committee oversight in the Board Assurance Framework dashboard”.

In respect of the corporate approach to planning, AW found that “the Health Board is refreshing its long-term strategy and maintains good oversight for developing and delivering corporate plans and strategies. While the Health Board is progressing its Clinical Services Plan, the plan currently only covers nine of its most fragile services”.

AW found that in relation to the management of financial resources, “the financial position remains a concern, with a forecast year-end deficit for 2025/26 and the savings plan currently off track. As in previous years, the Health Board was unable to submit a financially balanced three-year Integrated Medium Term Plan to the Welsh Government. However, the Health Board has improved on its opening plan deficit of £31.5 million, and at month seven, is forecasting a deficit of £28.3 million. It is also taking steps to improve the deficit position and achieve financial sustainability by 2028- 29”.

AW reviewed the progress made against recommendations from previous Structured Assessment reports. Of the 18 recommendations raised in previous reports, 17 were confirmed as complete, and 1 noted as in progress, which has now been completed.

Two new recommendations were issued in the Structured Assessment for 2025. Both recommendations have now been completed and were approved by AW in February 2026.

ISA260 Report and Letter of Representation

The Committee received the AW ISA 260 report and Letter of Representation at its meeting held on 24 June 2025, setting out the results of the audit of the Health Board’s financial statements. There were no trivial misstatements identified in the financial statements, nor were there any uncorrected misstatements above the agreed trivial level of £0.717 million. Initial misstatements in the accounts were corrected by management.

Recommendations previously raised had been addressed, with no new recommendations identified relating to 2025/26.

The audit found that the Health Board did not meet the two statutory financial duties as it did not meet its revenue resource allocation over a three-year period ending 31 March 2025, and does not have an approved three-year integrated medium-term plan in place for the period 2024/25 to 2026/27.

Performance Audits 2025/26

AW reported on the following performance work during 2025/26:

- **Review of Capital Investment Prioritisation** - The report presented in June 2025 found that “the Health Board has an effective and improving approach to capital prioritisation and there are good oversight arrangements for its Board approved capital investment plan. However, the feasibility of the plan is uncertain due to the extent of the backlog costs and limited capital funding.” One recommendation was raised within this report.
- **Review of Urgent and Emergency Care: Arrangements for Managing Demand** - The report presented in June 2025 found that “changes to urgent and emergency care services are leading to some improvements in managing demand, supported by reasonable plans and effective oversight. However, poor performance in areas including ambulance handover delays continue, and there is a need to strengthen staff and patient engagement.” 14 recommendations were raised within the report.
- **Tackling the Planned Care Challenges** - The report presented in June 2025 found that “the Health Board is now making good progress addressing its longest waits but needs to do more to ensure timely diagnostic and therapy services. Referral demand is increasing, and the Health Board needs to agree a financially and clinically sustainable plan to meet current and future patient needs. The Health Board also needs to address its service inefficiencies and strengthen its approach for identifying and reporting on harm resulting from delays in access to care.” Six recommendations were raised within the report.
- **Discharge Planning Progress Update** – The report presented in October 2025 found that “the Health Board has made slow progress in addressing the previous recommendations we made in 2017 to help improve discharge planning. Our 2017 report made six recommendations that set out 12 specific actions for the Health Board. Noting that the Health Board had accepted these recommendations, our follow up work found that:
 - no progress has been made against four of the actions;
 - work is still on-going against four of the actions;
 - one of the actions has been superseded by other developments;
 - three of the actions have been implemented.”

Of the six recommendations in the 2017 report, 3 remain outstanding. One new recommendation arose from the follow up report.

- **Urgent and Emergency Care: Flow out of Hospital** - The report presented in December 2025 found that “despite patient flow being a key aspect of plans across partners, high numbers of delayed discharges continue to negatively affect urgent and emergency care services, including ambulance handovers and emergency department waiting times. Increased complexity of demand, capacity constraints, and weaknesses in the discharge planning process are all key barriers to more effective patient flow. Partners understand the need to

drive improvements, but more action is needed to secure the sustainable improvements required.” Fifteen recommendations were raised within the report.

The following reports were deferred during 2025/26:

- **Review of the Management of Outpatients** – This review was deferred to April 2026 and assessed whether the Health Board had effective arrangements in place to manage its outpatient appointments. AW found that “the Health Board has significantly reduced the number of patients waiting over one year for a first outpatient appointment, meeting the Welsh Government target by March 2025. However, the focus on first outpatient appointments has affected its ability to reduce the number of patients experiencing delayed follow-up outpatient appointments, with numbers continuing to increase. In October 2025, approximately 17,000 patients were waiting twice as long as they should be for a follow-up outpatient appointment”. Two recommendations were raised within the report
- **Structured Assessment 2024 Deep Dive - review of investment in digital systems** - The review, expected in May 2026, will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.
- **Structured Assessment 2025 Deep Dive - review of the arrangements to manage estates** - The review, expected August 2026, will examine the effectiveness of corporate arrangements to manage the Health Board’s estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose. When undertaking this work, Audit Wales will take into account the local work which examined the Health Board’s arrangements for managing capital prioritisation.
- **Review of cancer services** - This review, expected in August 2026, will follow on from the review of national leadership arrangements for cancer services undertaken in 2024/25. Whilst the exact focus of this work is to be determined, it is likely to consider the progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services as well as the efficacy of local plans and associated actions to recover cancer waiting lists. It will also consider the use of the additional Welsh Government financial allocations to improve cancer services.
- **Review of radiology services** - This review, expected in June 2026, will examine the effectiveness of arrangements to manage current and future demand for the Health Board’s radiology services and will assess the extent of progress made in implementing the recommendations from the 2017 radiology service review.

10. Internal Audit

Internal Audit (IA) services are provided by the NHS Wales Shared Services Partnership (NWSSP). The service provision is in accordance with a Service Level Agreement agreed by the Shared Services Partnership Committee, on which the Health Board has permanent membership.

IA provide an independent and objective opinion to the Accountable Officer, the Board and the ARAC, on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives. The Committee approved the content of the 2025/26 NWSSP IA Strategy, Plan and Charter at its meeting held on 15 April 2025, following a detailed review. The scope of this work is focused on significant risk areas and local improvement priorities. The Committee requested the need for audits to be delivered to the agreed timescales and were kept informed of any slippages in the Internal Audit Plan 2025/26.

The Head of IA has met weekly with the Director of Corporate Governance/Board Secretary throughout 2025/26, to discuss and consider any changes to the IA plan, and in discussion with the Chair of the Committee with any changes approved by the Committee. Changes to the IA plan resulted from the need to accommodate fluctuations in operational demand or to support the Health Board in response to emerging concerns and the increase in its escalation status within the Health Board. The Head of IA has also met with the Chair of the Committee on a regular basis to monitor the audit programme. Further work is need by both Internal Audit and the Health Board to reduce the number of deferred audits and ensure compliance with set timescales and reporting of audits.

The Committee has received progress reports against delivery of the IA Plan at each meeting, with individual assignment reports also being received. Executive Directors, accompanied by lead officers, have been requested to attend to be held to account and to provide assurance that remedial action is being taken to address the findings within the IA reports. The outcome of each audit, providing an overall conclusion on the adequacy and application of internal controls for each area under review, was considered by the Committee. The assessment of adequacy and application of internal control measures is graded in terms of 'no assurance' through to 'substantial assurance'.

The Audit and Assurance Shared Services Unit (SSU) provide an objective assessment of whether the Health Board's systems and controls for capital and estates projects are working effectively. During 2025/26, the Committee has continued to work effectively with the Audit Team to further strengthen the Health Board's internal control processes surrounding capital projects and estates assurance.

The assurance ratings for these audits are outlined below. In considering the IA reports the Committee engaged in discussion with the Head of IA where it was felt appropriate, to obtain further information about the assurance rating given by IA. The audit reviews reported as part of the IA Plan for 2025/26 are outlined below:

Substantial Assurance	<ul style="list-style-type: none"> • Medical Devices Regulations • Cyber Security
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Reasonable Assurance	<ul style="list-style-type: none"> • Escalation Governance • Corporate Risk: Ophthalmology • Commissioning – Long Term Agreements • Patient Experience • Managed Practices • Departmental /Shadow IT systems management
Limited Assurance	<ul style="list-style-type: none"> • Nursing Management (Follow Up) • Sickness Management • Validation of Emergency Department Waiting Time Data • Human Tissue Authority • Vaccination and Immunisation • <i>Level 3/4</i> • <i>Operational governance arrangements</i>
Unsatisfactory Assurance	<ul style="list-style-type: none"> • N/A
Advisory/Non-opinion	<ul style="list-style-type: none"> • Estates Assurance – Space Utilisation • Control of Contractors • Capital Governance Arrangements • <i>Space Utilisation</i> • <i>Human Tissue Authority Follow Up</i>

**Reports in Italics were reported to ARAC in 2026/27 (post 31 March 2026)*

The Global Internal Audit Standards (the Standards), issued by the Institute of Internal Auditors in January 2024 and effective from January 2025 apply to UK public sector audits from 1 April 2025, and has informed the Internal Audit Plan for 2025/26. The new Standards require that a risk-based internal audit plan is created that supports the achievement of the organisation's objectives. The Plan will be delivered in accordance with the Internal Audit Mandate and Charter and agreed Key Performance Indicators.

Head of Internal Audit Opinion (Section to be updated when Head of Internal Audit Opinion has been finalised)

The IA plan has been agile and responsive during the year to ensure that key developing risks are covered. As a result of this approach, and with the support of officers and independent members across the Health Board, the plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Committee. In addition, regular audit progress reports have been submitted to the Committee. Although changes have been made to the plan during the year, IA have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

The Head of Internal Audit has concluded the following assurance rating for 2025/26:

**Head of Internal Audit Opinion not available –
Insert rating when issued**

Whilst there were no audited areas that resulted in ‘no assurance’, the following audit reports were issued with a conclusion of limited assurance during 2025/26:

Report Title and Date of Issue	Lead Director	Total Number of Recommendations	Of Which High Priority
Nursing Management (Follow Up) (July 2025)	Chief Operating Officer	3	1
Sickness Management (July 2025)	Director of Workforce & Organisation Development	2	1
Validation of Emergency Department Waiting Time Data (September 2025)	Chief Operating Officer	6	2
Human Tissue Authority (October 2025)	Chief Operating Officer	6	2
Vaccination & Immunisation (January 2026)	Director of Public Health	9	5
Internal Escalation: Level 3 & 4 Functions (March 2026)	Director of Finance	7	3
Operational Governance Arrangements (April 2026)	Chief Operating Officer	4	4

Table above to be updated should any further limited assurance reports be presented to Committee in May

Management responses that detail the actions to address gaps in control were included in all final IA reports presented to the Committee. The delivery of these actions is tracked via the Health Board’s audit tracker which is overseen by the Committee. The minutes and all final IA reports can be found within the ARAC section of our website: <https://hduhb.nhs.wales/about-us/governance-arrangements/board-committees/audit-and-risk-assurance-committee-arac/>.

Where audit assignments planned this year did not proceed to full audits following preliminary planning work, these were either: removed from the plan, removed from the plan and replaced with another audit, or deferred until a future audit year. Subsequent to the approval of the plan in April 2025, the following audits were deferred:

Review Title	Reason
Estates & Facilities Directorate	Time reallocated to be used for cleanliness standards re-audit follow up, which was itself subsequently deferred to 2026/27.

Cleanliness Standards re-audit	Re-audit of previous multiple limited assurance audits deferred as whilst actions were in process of being implemented, there was insufficient progress made with embedding the previously agreed actions.
Health & Safety	Re-audit of previous limited assurance audit deferred to 2026/27 as insufficient progress made with implementing the previously agreed actions.
Theatres Stock system implementation	Deferred as a result of the impact of additional time taken on other audits.
Primary Care Corporate Risk	Deferred due to a reduction in the risk score which was reported to the Board.
Complaints	Deferred due to the implementation of new arrangements.
ED Data Follow up	Follow up deferred due to limited progress with implementation of actions.

IA is aware of the plans and actions put in place by the Health Board in response to their recommendations and will follow these up in 2026/27 to ensure they have been enacted.

11. Counter Fraud

The Health Board must effectively seek to promote the Counter Fraud agenda and ensure that appropriate action is taken when an allegation of fraud is received. The role of the Committee is to ensure the promotion and implementation of the Counter Fraud policy, with compliance monitored by the Committee through the reports of Counter Fraud activity received and the Annual Counter Fraud Work Plan.

The Committee received and approved the 2025/26 Annual Work Plan of the Local Counter Fraud Officer at its meeting held on 15 April 2025, ensuring that it had an appropriate level of coverage, and subsequently received regular reports to monitor progress against the plan. These reports provided an overview of current cases, details of concluded fraud investigations, policy and procedure reviews, actions being taken to deter and prevent fraud and to raise fraud awareness throughout the Health Board.

The Committee received the Counter Fraud Annual Report 2025/26 at its meeting held on 15 April 2025. The Health Board's Counter Fraud provision has demonstrated compliance with the requirements of the WG Directions to NHS Bodies on Counter Fraud Measures. The overall 'green' rating from the Quality Assurance assessment ("Self-Review Tool" (SRT)), demonstrates the continued efforts from the Local Counter Fraud Service (LCFS) in working in an innovative way

to achieve a balance of both reactive and proactive work to meet the NHS Counter Authority's Standards. A key strategy from previous years has been to change the view amongst the wider Health Board of the Counter Fraud Team, from being a reactive unit for referral and investigation, to a proactive unit purposed to prevent fraud and reduce fraud risk. This is showing signs of taking effect, with increased contact seeking advice and assessment. This strategy will continue, whilst being mindful that the message around the importance of investigation should not be lost. The Counter Fraud Team can demonstrate a continued trajectory of improvement across the service, with continued success shown across key measurables. Key areas of work for next year will be to maintain focus on inform and involve, continuing to raise awareness of Fraud, Bribery and Corruption and further embedding a counter fraud culture fostered over preceding years as well as further developing work associated with Prevent and Deter, including building on Fraud Risk Analysis, identifying specific Fraud Risk based proactive exercises and recording outcomes on Clue3 against the Government Functional Standards.

The Local Counter Fraud Officer has been in regular attendance at Committee meetings during 2025/26, and issues have been discussed in detail, as appropriate, with Committee members. Progress details for cases highlighted as part of the Counter Fraud Investigations Report have regularly been provided at In-Committee meetings.

12. Committee Effectiveness – Feedback from self-assessment process

As stipulated within the Standing Orders, the Committee undertakes a regular and rigorous self-assessment and evaluation of the performance of the Committee. This involves the completion of a short digital form which requested feedback on the following areas for the self-assessment undertaken for 2024/25:

- Governance and administration;
- Committee's inputs;
- Conduct of Committee meetings;
- Interface with other Committees, including the Board;
- Committee's impact; and
- Individual role on Committee.

The Committee was presented with a progress update at its meeting in August 2025 on the actions in response to the outcomes of the 2024/25 self-assessment, noting all five actions were complete.

The self-assessment for 2025/26 focussed on five core areas of governance and assurance:

- Governance, Assurance and Oversight;
- Risk Management and Internal Control;
- Internal and External Audit;
- Financial and Annual Reporting; and
- Committee Effectiveness and Continuous Improvement.

Outcomes from the self-assessment for 2025/26 were presented to the Committee at its meeting in December 2025, with three actions identified - two noting the continuation of existing processes, and one with a completion date of March 2026.

13. Assurance on Clinical Governance

It is a requirement of the NHS Wales Audit Committee Handbook that the Committee reviews the Clinical Audit Programme at the beginning of each year. The role of the Committee is to seek assurance on the plan and to consider the following:

- Does the Health Board have a plan which is fit for purpose and is completed on time?
- Does it cover all relevant issues?
- Is it making a difference and leading to demonstrable change?
- Is change supported by recognised improvement methodologies?
- Does the organisation support clinical audit effectively?

The Committee was presented with an update on the Health Board's Clinical Audit functions and programmes, and an update on plans for 2025/26 at its meetings on 15 April 2025 and 14 October 2025. The Committee took assurance from the updates presented at both meetings.

The 2026/27 programme will be shared with the Committee, Clinical Audit Scrutiny Panel (CASP) and Operational clinical care groups.

14. Assurance on regulatory directions

The Health Board's compliance against with Welsh Health Circulars (WHCs) is reported to alternate meetings. WHCs are guidance documents issued to Health Boards, providing a streamlined, transparent and traceable method of communication between the NHS Wales and NHS organisations relating to areas including workforce, finance, estates, quality and safety, legislation, governance, performance / delivery, information technology, science, research, planning, public health, policy, and health professional letters.

Of the 32 open WHCs presented to ARAC in February 2026, 13 were reported as being non-compliant:

- 4 are overdue as they have passed their original implementation dates;
- 4 cannot be progressed due to factors external to the Health Board;
- 4 are pending an internal decision within the Health Board before they can be progressed; and
- 1 is unable to be completed in the manner initially proposed.

Reasons for non-compliance with overdue WHCs include:

- Ongoing development work and cross-CCG coordination requirements;
- Dependency on Clinical Service Plan (CSP) outcomes;

- Joint-leadership actions required to secure additional funding and resources; and
- Awaiting relevant national guidance.

Reasons for non-compliance with WHCs that are reliant on external factors or internal decisions include:

- Projects stalled due to lack of funding;
- Dependence on Welsh Government approvals or superseding national frameworks;
- Suspended national programmes with no reinstatement
- Significant service capacity gaps requiring major investments
- Service changes awaiting funding
- System rollouts which require resources and national direction; and
- Lack of national data systems and essential administration system upgrades from Digital Health and Care Wales (DHCW).

15. Forward Plan

The Committee, in addressing issues identified in previous years, has continued to provide additional assurance that the Board is functioning effectively.

The Committee will continue to focus on those areas which will be subject to increased scrutiny, and ensuring those areas which received limited assurance during 2025/26 improve. Further work is need by both Internal Audit and the Health Board to reduce the number of deferred audits and ensure compliance with set timescales and reporting of audits.

The Committee will continue to receive assurance on effectiveness of the Risk Management Framework, and the implementation of the Risk Management Strategy, and the processes in place across the Health Board to track the progress on the implementation of recommendations identified by auditors, inspectorates and regulators, along with Welsh Health Circulars (WHCs).

Any areas of Committee concern raised during 2025/26, including scrutiny of outstanding improvement plans, will be followed up in 2026/27. Any learning taken from the self-assessment of committee effectiveness exercise will be acted upon as appropriate.

In order to continue the triangulation of assurance for the Board and provide the required degree of scrutiny, it is the Committee's intention to continue to refer matters of concern, to the Quality, Safety and Experience Committee (QSEC), People, Organisational Development and Culture Committee (PODCC), Strategy and Planning Committee (SPC), Finance and Performance Committee (FPC), Digital, Data and Innovation Committee (DDIC) and Health and Safety Committee (HSC). This is being taken forward through the Chairs of Committees meeting.

16. Conclusions

It is acknowledged that the Committee is a well-established Committee of the Board with a detailed annual workplan in place. It provides a key source of assurance to the Board that the organisation has effective controls in place to manage the significant risks to achieving its objectives and that controls are operating effectively. It is vital that risk management is at the heart of this process. The Committee will continue to receive assurance during 2026/27 on the effectiveness of the risk management framework via the regular presentation of the risk assurance report, and the implementation of its risk management objectives as defined in the Risk Management Strategy.

The Committee believes it has met the duties of its Terms of Reference through the completion of a comprehensive workplan and has provided assurance to the Board on a significant number of matters in respect of the adequacy and effectiveness of the organisation's functions and systems to maintain a sound system of governance and internal control. However, during the year, the Committee alerted and advised the Board on a number of areas via Committee Update Reports where it was not being provided with the required degree of assurance to enable it to discharge its duties.

Focus will continue to be placed on work that is undertaken in collaboration and partnership, with the Committee seeking assurance that robust processes and reporting arrangements are in place where significant activity is shared with another organisation, e.g. NWSSP, or the new Joint Commissioning Committee.

It is the opinion of the Committee that the Accountability Report, incorporating the Governance Statement, which was received at the Committee meeting held on 7 May 2026, is consistent with the view of the Committee on the Health Board's system of internal control. **TO BE COMPLETED FOLLOWING RECEIPT OF THE HEAD OF INTERNAL AUDIT OPINION.**

The Board is therefore asked to endorse the contents of this report as a summary of the work and findings of the Audit and Risk Assurance Committee for the financial year 2025/26.

4.3

11:00, 15 Mins

4.3 - Draft Head of Internal Audit Opinion and Annual Report 2025/26 (Verbal Update)

James Johns
(NWSSP - Internal Audit)

| For assurance

4.4

11:15, 5 Mins

4.4 - Assurance Report on Board Effectiveness

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

| For assurance

Attachments

[4.4 Board Effectiveness Report 2025 26.pdf](#)

[4.4 Appendix 1 - HDUHB Board Maturity Matrix 2025-26.pdf](#)

[4.4 Appendix 2 - Progress against Action Plan 2024-25.pdf](#)

[4.4 Appendix 3 - Corporate Governance Code 2017 2025-26 Assessment.pdf](#)

**PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	07 May 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Assurance Report on Board Effectiveness Assessment 2025/26
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)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

To comply with Standing Orders, the Board should introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. This is one of the mandatory requirements set out within the Governance Statement (GS) that the Health Board prepares for Welsh Government.

This report is to provide the Audit and Risk Assurance Committee (ARAC) with assurance on the process the Health Board has undertaken to review the effectiveness of the Board, recognising that this has been discussed by the Board at the Board Seminar meeting held on 23 April 2026.

Cefndir / Background

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

Asesiad / Assessment

The Board has developed a maturity matrix based on the [Good Governance Handbook](#) from the Healthcare Quality Improvement Partnership, which is a collaborative document first produced by the Healthcare Quality Improvement Partnership (HQIP) and the Good Governance Institute (GGI) in 2015, but more recently updated in 2021. This matrix describes 10 key areas of good governance for NHS organisations and provided a maturity matrix which has been amended to better align to NHS Wales requirements and expectations.

At the Board Seminar on 23 April 2026, the Board reviewed the evidence to support the assessment of its effectiveness against the criteria in the maturity matrix (Appendix 1) and the action plan to improve maturity across the 10 areas (Appendix 2). This included the following assurances:

- The Health Board has completed a self-assessment against the Corporate Governance in Central Governance Departments: Code of Good Practice 2017. The Health Board used the “Comply” or “Explain” approach in relation to the Code of Good Practice. The Self-Assessment is available at Appendix 3, confirming there are no matters to ‘explain’.
- Board Committee Effectiveness – There is a programme in place to ensure the Committees delegated by the Board review or undertake the following activity on an annual basis:
 - Terms of Reference and Operating Arrangements
 - Committee Self-Assessment of Effectiveness Exercise and 6 month follow up review of agreed actions
 - Committee Cycle of Business/Work Plan
 - Annual Committee Report on Activity to the Board
- External Assurances
 - Joint Escalation and Intervention Arrangements status – At the start of the financial year, the Health Board was in targeted intervention (Level 4) for the following four domains: Finance, Strategy and Planning, Performance & Outcomes*, Fragile Services; and Quality of Care; and enhanced monitoring status (Level 3) for the following two domains: Leadership, Capability & Culture; and Governance. Two key areas of the Performance and Outcomes domain were de-escalated in March 2025 to Level 3 (enhanced monitoring status): Child and Adolescent Mental Health Services (CAMHS) and Planned Care. In July 2025, Performance and Outcomes relating to Child and Adolescent Mental Health were de-escalated from enhanced monitoring (Level 3) to routine arrangements (Level 1). Also in July 2025, Performance and Outcomes relating to Cancer were de-escalated from targeted intervention (Level 4) to enhanced monitoring (Level 3), and further de-escalated to routine arrangements (Level 1) in February 2026. In December 2025, the Governance and Leadership domain was de-escalated from enhanced monitoring (Level 3) to routine arrangements (Level 1).
 - Audit Wales (AW) Structured Assessment 2025 - The structured assessment in 2025 (available to read here: [Hywel Dda University Health Board – Structured Assessment 2025](#)) focused on our corporate arrangements for ensuring that resources are used efficiently, effectively, and economically. The overall assessment concluded that
 - The Health Board remains strongly committed to public transparency and continues to have good governance arrangements.
 - There are strong arrangements to oversee risk, performance, service quality and safety and audit recommendations. The health board is taking steps to improve data quality and further strengthen governance arrangements for quality and safety. There is an opportunity to clarify committee oversight in the Board Assurance Framework dashboard.
 - The Health Board is refreshing its long-term strategy and maintains good oversight for developing and delivering corporate plans and strategies. While the health board is progressing its Clinical Services Plan, the plan currently only covers nine of its most fragile services.
 - The financial position remains a concern, with a forecast year-end deficit for 2025-26 and the savings plan currently off track. As in previous years, the health board was unable to submit a financially balanced three-year integrated medium-term plan to the Welsh Government. However, the health board has improved on its opening plan deficit of £31.5 million, and at month seven, is forecasting a deficit of £28.3 million. It is also taking steps to improve the deficit position and achieve financial sustainability by 2028-29.

Audit Wales reviewed our progress against recommendations made in previous reports and issued two new recommendations in the structured assessment for 2025. They recommended that the health board clarify the use of the Triple A (Alert, Advise,

Assure) process and update the Board Assurance Framework Dashboard to include committee oversight arrangements. Both of which have now been completed.

- Internal Audit Reports - ARAC have scrutinised internal audit reports throughout the year, seeking assurance on behalf of the Board that management responses are robust and will reduce risk in the areas reviewed. Whilst the Internal Audit Plan for 2025/26 will not conclude until June 2026; to date, below is a summary of reports as per assurance level:

Assurance Rating	Reviews undertaken up to end of April 2026
Substantial Assurance	<ul style="list-style-type: none"> • Medical Devices Regulations • Cyber Security • Escalation Governance
Reasonable Assurance	<ul style="list-style-type: none"> • Corporate Risk: Ophthalmology • Commissioning – Long Term Agreements • Patient Experience • Managed Practices • Departmental /Shadow IT systems management
Limited Assurance	<ul style="list-style-type: none"> • Nursing Management (Follow Up) • Sickness Management • Validation of Emergency Department Waiting Time Data • Human Tissue Authority • Vaccination and Immunisation • Level 3/4 • Operational governance arrangements
Unsatisfactory Assurance	<ul style="list-style-type: none"> • N/A
Advisory/Non-opinion	<ul style="list-style-type: none"> • Estates Assurance – Space Utilisation • Control of Contractors • Capital Governance Arrangements

Following due consideration of the evidence outlined against the Board Maturity Matrix (see Appendix 1) at Board Seminar on 23 April 2026, the Board agreed the following levels:

Key criteria	Maturity level	Maturity level description	Changes
1. Clarity of purpose, roles and behaviours	3	The Board has agreed cultural and ethical values and strategic objectives, combined with a robust mechanism for developing care services and settings against these	No change
2. Oversight and administration principles	4	Using these principles has helped Board members to better understand their roles in governance. Governance activities that provide little value and do not meet the principles have been stopped	No change

3. Leadership and strategic direction	3	An induction and development programme is in place for Board/and aspirant members. Diversity is embedded in the approach.	No change
4. Effective external relationships	3	Effective citizen involvement is in place, and evidenced by improvement initiatives that are put into operation as a result.	No change
5. Effective internal relationships	3	The organisation prioritises staff and internal stakeholder involvement, and formal and informal input and feedback from all staff, new staff, and leavers, is sought and valued.	No change
6. Transparency and public reporting	3	The Board publicly demonstrates conflicts are examined and covered within contracts; Limited use of In-Committee meetings; integrated public reporting is central to organisational finance, quality, and performance management.	No change
7. Systems and structures: quality and safety	4 ↑	Integrated quality reports demonstrate quantifiable improvements in the domains within the within the health and care quality standards. The organisation is to demonstrate the duty of quality in some services.	Improvements in demonstrating compliance with Duty of Quality
8. Delivery of agreed outcomes	2	Performance reports including benchmarking data and key performance indicators are in development.	No change
9. Risk management and compliance	3 ↓	Regular review of the Board Assurance Framework (BAF) supports the management of risks to achieving strategic objectives, and an annual exercise ensures review of the organisation's Emergency and Business Continuity Plan.	Review of BAF was on hold until Strategy Refresh was approved by Board in January 2026. The Refreshed BAF will now be reported to the Board in July 2026.
10. Effectiveness and added value	3	The annual cycle of business is planned and the Board Assurance Framework is used by the Board to identify opportunities for increased effectiveness and added value.	No change

Overall Assessment

Overall, the assessment indicates that Hywel Dda University Health Board is operating at a level of “firm progress”, with governance systems, leadership behaviours and assurance arrangements largely embedded and increasingly effective. The Board demonstrates growing maturity in oversight, quality governance and risk management, with evidence of tangible results in several domains, supported by positive external assurance from Audit Wales and Internal Audit. However, organisational maturity is not yet consistently translating into improved outcomes, and further development is required to strengthen delivery, embed outcome-focused performance management and realise the full impact of governance at scale. The assessment reflects that Hywel Dda is on a clear improvement trajectory, however is not yet operating at a mature or exemplar level.

In 2026/27, development should focus on strengthening delivery of outcomes, closing the gap between assurance and operational grip, embedding the refreshed strategy across planning and risk, and ensuring governance arrangements consistently drive improvement and impact rather than process compliance.

The improvement work being undertaken by the Health Board in respect of its escalation status will help to strengthen the effectiveness of the Board, as well as embedding the new operational governance arrangements.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to take an assurance from the process that has been undertaken this year to review the Board’s effectiveness, recognising that this has been discussed by the Board at the Board Seminar meeting held on 23 April 2026.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1 The Committee shall review the adequacy of the Health Board’s strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control, across the whole of the organisation’s activities (both clinical and non-clinical) that supports the achievement of the organisation’s objectives. 3.2 In particular, the Committee will review the adequacy of: 3.2.1 all risk and control related disclosure statements (in particular the Accountability Report and the Performance Report), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply

Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Internal and External sources of assurance listed in report
Rhestr Termiau: Glossary of Terms:	Contained in the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Chair Chief Executive Board

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts
Gweithlu: Workforce:	No direct impacts
Risg: Risk:	No direct impacts
Cyfreithiol: Legal:	No direct impacts
Enw Da: Reputational:	Board effectiveness is a core component of good corporate governance, and it is essential that the Board addresses any areas of weakness.
Gyfrinachedd: Privacy:	No direct impacts
Cydraddoldeb: Equality:	No direct impacts

Maturity levels	0	1 Basic Level – Principle Accepted and Commitment to Action	2 Early Progress – In Development	3 Firm Progress – In Development	4 Results being achieved	5 Maturity – Comprehensive Assurance in place	6 Exemplar
Key criteria	None						
1. Clarity of Purpose, Roles & Behaviours	None	The members of the Board have agreed that a formal statement of organisational purpose, values, and priorities needs to be developed, and have plans for doing so	National targets and local priorities have been agreed with stakeholders. Purpose and vision is affirmed in public and partnership document.	The Board has agreed cultural and ethical values and strategic objectives, combined with a robust mechanism for developing care services and settings against these	Evidence that national targets and local priorities are being met. Regular reviews of strategy in line with strategic objectives	Annual Board debate on in-year achievements against strategic objectives, issues impacting achievements, action planning and re-affirming or adjusting strategic objectives for the coming year.	Success has allowed both the Board and the organisation to redefine/extend its purpose and roles
2. Oversight & Administration Principles	None	The Board is actively reflecting on how they work and how governance is structured, and is testing whether what is in place makes the best use of these underlying principles.	As a result of discussion around these principles, changes have started to be made to the governance of the organisation.	The annual review of governance and developing cycle of Board business planning will be used to test these principles, and where required, change governance arrangements.	Using these principles has helped Board members to better understand their roles in governance. Governance activities that provide little value and do not meet the principles have been stopped.	As the organisation develops, these principles have led to improvements in governance arrangements to efficiently and effectively support new challenges.	Other organisations have referred to the structure and systems of the organisation, to understand the application of these principles and support similar changes.
3. Leadership & Strategic Direction	None	The roles of all Board/ members are clear, agreed and specified.	A Board succession plan is in place for both Executive and Non-Executive Directors/ Lay Members. Board diversity is valued.	A Board succession plan is in place for both Executive and Non-Executive Directors/ Lay Members. Board diversity is valued.	The organisation is recognised by partner organisations as a leader in the local health and wellbeing system.	The Board is leading, rather than following, national and local agendas.	The Board is recognised as a national thought leader.
4. Effective External Relationships	None	Engagement and consultation policies are in place and consistent with the NHS Constitution. Service users, staff, and the public are recognised as a resource to help design and deliver service improvement	A system of accountability to and involvement of the local community is in place to design and deliver service improvement.	Effective citizen involvement is in place, and evidenced by improvement initiatives that are put into operation as a result.	Effective citizen codesign is in place and evidenced through improvements made as a result.	Effective citizen codesign has led to improved outcomes. A review against the NHS Constitution shows our organisation is trusted by patients, service users, and citizens.	Co-production has led to tangible operational and strategic benefits, as well as measurable improved outcomes for the population.
5. Effective Internal Relationships	None	Staff and other internal stakeholder engagement strategies are developed and these include feedback mechanisms.	The Board receives reports about staff and internal stakeholder engagement, including actions taken as a result of findings.	The organisation prioritises staff and internal stakeholder involvement, and formal and informal input and feedback from all staff, new staff, and leavers, is sought and valued.	The Chair, Independent Members, Directors, and Partners are effective ambassadors for the organisation, involving all staff and internal stakeholders and partners in organisational development.	Board and senior leadership recruitment is competitive and reputational audit finds that staff and internal stakeholder involvement is an asset to robust organisational development.	The organisation can demonstrate they are an employer of choice, and staff retention is high.

6. Transparency & Public Reporting	None	Board members absent themselves from discussions due to conflicts of interest; public reporting takes place when required.	The conflicts of interest register is updated by the Board monthly and identified conflicts are reviewed and appropriate actions taken; edited performance reports are publicly shared.	The Board publicly demonstrates conflicts are examined and covered within contracts; integrated public reporting is central to organisational finance, quality, and performance management.	Identified conflicts are publicly addressed; patients, service users, citizens, and staff are involved in developing integrated finance, quality, and performance metrics	Integrated finance, quality and performance reports steer organisational development, with public oversight and input into required improvements.	Demonstrable improvements have been made due to public involvement in integrated reporting.
7. Systems & Structures: Quality & Safety	None	A quality management system strategic framework which focusses on, a system-wide approach to achieving quality of care using the health and care quality standards is in development	A Board approved quality management system strategic framework which focusses on a system-wide approach to achieving quality of care using the health and care quality standards is in use.	Quality management system strategic framework implementation demonstrates improvements the domains within the-within the health and care quality standards.	Integrated quality reports demonstrate quantifiable improvements in the domains within the health and care quality standards. . The organisation is to demonstrate the duty of quality in some services.	Resources are used to make quality improvements, with measurable returns that demonstrate innovation and improvement. This is demonstrable in all of the domains (STEEP) within the health and care quality standards. The organisation is to demonstrate the duty of quality in its services on an annual basis.	Significant resources are invested in continuous innovation, improvement, and integration between value-based health care and quality improvement programmes which evidence efficiency and improvements. There is equal importance in the six domains and six enablers of the health and care quality standards. The organisation is to demonstrate the duty of quality in its services throughout the year through routine reporting.
8. Delivery of Agreed Outcomes	None	The Board has agreed how outcome measures will be used in performance reports, including benchmarking data and key performance indicators	Performance reports including benchmarking data and key performance indicators are in development.	There are no surprises when the organisation is inspected or otherwise challenged, as there is full awareness of performance and action plans are in place for improvements as required	The Board is fully satisfied that its strategic objectives have been met, as a result of performance monitoring and action.	Board members report confidence in using integrated reporting to support constructive challenge where required.	Demonstrable improvements have been made as a result of the delivery of agreed outcomes.
9. Risk Management & Compliance	None	A process is in place to proactively evaluate risk, and a Board Assurance Framework is organised to promote focused discussion on key business issues	A risk appetite statement has been agreed, and built into the Board Assurance Framework, which covers the risks to achieving strategic objectives, including quality, performance, finance, and activity, aligned to targets, standards, and local priorities	Regular review of the Board Assurance Framework supports the management of risks to achieving strategic objectives, and an annual exercise ensures review of the organisation's Emergency and Business Continuity Plan.	The Board Assurance Framework is central to the management of risks to achieving strategic objectives, with a quarterly update and annual action planning to drive business. Emergency and Business Continuity Plans are improved through a range of scenario tests in year	The Board is confident that it is aware of risks faced, including risks associated with compliance, these are managed, and required actions are prioritised and planned.	The organisation has proactively identified and managed all known risks and opportunities, and successfully meets its strategic objectives
10. Effectiveness & Added Value	None	More effective practices are being adopted. A review of governance mechanisms is agreed.	The Board has reviewed governance practices for efficiency savings, and agreed improvements to add value	The annual cycle of business is planned and the Board Assurance Framework is used by the Board to identify opportunities for increased effectiveness and added value.	The annual cycle of business is planned and the Board Assurance Framework and integrated reports are used by the Board to identify opportunities for increased effectiveness and added value.	The annual cycle of business is planned, the Board Assurance Framework and integrated reports are used by the Board to identify opportunities for increased effectiveness and added value, and external governance reviews.	Demonstrable savings and efficiencies have been made as a result of streamlined governance arrangements.

(based on the [Good Governance Handbook](#), Healthcare Quality Improvement Partnership, 2021)

**BOARD MATURITY
ASSESSMENT AS AT
MARCH 2026**

1. CLARITY OF PURPOSE, ROLES & BEHAVIOURS – Agreed level of maturity – 3

Evidence

- Refreshed strategic objectives agreed by Board in January 2025, with Refreshed Healthier Mid and West Wales Strategy – Healthier Lives, Well Lived approved by Board in January 2026
- Board considered and made decisions on the future reconfiguration of 9 clinical services set out in the Clinical Services Plan presented to the Board in February 2026
- Annual Plan agreed by Board every March with plans aligned to ministerial priorities and planning objectives – latest approved March 2026
- Board agreed Values and Behaviour Framework – approved by Board in July 2016
- In January 2024, WG increased the escalation status to targeted intervention (level 4) for the entire organisation. Targeted Intervention targets and local priorities agreed with WG and incorporated into Annual Plan. Level 4 for finance, strategy and planning, and performance and outcomes related to urgent and emergency care, fragile services, (including ophthalmology) and Healthcare Associated Infections (HCAIs), Level 3 for performance and outcomes related to planned care and cancer and Level 1 for leadership and governance.
- West Wales Regional Partnership Board priorities agreed
- Public Service Board Well-Being Plans in place for Carmarthenshire, Ceredigion and Pembrokeshire which reflect the findings from the Well-being Assessments, with an over-arching theme of reducing inequalities, inequity and poverty agreed in 2023, and monitored by the Board.
- Joint Regional Committee with SBUHB established in January 2025 to strengthen arrangements for planning and delivering healthcare services on a regional basis where it is appropriate to do so to ensure continued safety, quality and ongoing viability of services, agreed purpose and vision priorities
- [Annual Planning Matrix](#) undertaken and reported to Board – latest July 2025
- Ethics panel in place since 2020
- Internal escalation framework in place to oversee internal delivery of performance across a number of domains and delivery of Health Board priorities – Internal Audit Level 3 / Level 4 Directorates provided *Limited Assurance* (Apr26)
- Board assurance framework measure success against the strategic objectives – this is currently being updated to align to Refreshed AHMWW Strategy
- Internal Audit on Annual Planning provided *Reasonable Assurance* (May 2025)
- Audit Wales Structured Assessment 2025 found that respect of:
 - *Preparing strategies and plans*, ‘the Health Board is refreshing its long-term strategy and maintains good oversight for developing and delivering corporate plans and strategies’

Maturity levels	0	1	2	3	4	5	6
Key criteria	None	Basic Level – Principle Accepted and Commitment to Action	Early Progress – In Development	Firm Progress – In Development	Results being achieved	Maturity – Comprehensive Assurance in place	Exemplar
Clarity of Purpose, Roles & Behaviours	None	The members of the Board have agreed that a formal statement of organisational purpose, values, and priorities needs to be developed, and have plans for doing so.	National targets and local priorities have been agreed with stakeholders. Purpose and vision are affirmed in public and partnership document.	The Board has agreed cultural and ethical values and strategic objectives, combined with a robust mechanism for developing care services and settings against these.	Evidence that national targets and local priorities are being met. Regular reviews of strategy in line with strategic objectives.	Annual Board debate on in-year achievements against strategic objectives, issues impacting achievements, action planning and re-affirming or adjusting strategic objectives for the coming year.	Success has allowed both the Board and the organisation to redefine/extend its purpose and roles.

2. OVERSIGHT & ADMINISTRATION PRINCIPLES - Agreed level of maturity – 4

Evidence

- Standing Orders including Standing Financial Instructions and Scheme of Delegation reviewed and approved annually – last reviewed May 2025, July 2025 and Mar 2026 respectively
- Robust appointments system in place for all Board Members – current Board Members are identified in Annual Report and on the HB website
- Chairs, Vice-Chair, Executive Directors appraisal process in place, undertaken at least annually
- Board Meetings in Public held at least bi-monthly, with all Board and Committee papers made available at least 5 days prior to meetings.
- Limited use of In-Committee meetings, Private Board agenda items are published in advance and report of meetings provided to the Board
- Board Committee structure regularly reviewed – latest review January 2025 [Revised Board Committee Governance](#), with Terms of Reference and workplans reviewed annually
- Board Schedule and Workplan developed and maintained throughout the year and reported to each meeting – these routinely monitor quality, provide assurance, and identify and mitigate emerging risks.
- Committee Annual Reports undertaken annually to report activity undertaken through the year and detailing the results of a review of its performance and effectiveness
- Committee Self-Assessment process undertaken annually, with feedback report to Committees, action plans and 6 monthly review, high level messages are also fed into the Board Development programmes
- Joint Regional Committee TORs agreed in January 2025, with supporting governance structure developed and approved by Board in March 2025
- ARAC hold private meetings with internal and external audit, and Counterfraud
- Remuneration and Terms of Service Committee in place and reports decisions to the Board
- Board Development Programme is in place, with new IM annual PADR process and 360-degree assessment
- New operational governance structure and governance arrangements implemented in 2025/26 – operational governance arrangements to be further strengthened in Q1 2026/27.
- Internal Audit Operational Governance provided *Limited Assurance* (April 2026)
- Internal, External and Clinical Audit Plans are agreed and reported through relevant Board Committees
- Triple A (Alert, Advise, Assure) reporting process has strengthened Board/Committee assurance and escalation (AW Wales Structured Assessment 2025)
- Code of Corporate Governance – The code operates on a “comply or explain” basis, any deviation must be explained as part of the Governance Statement - no matters to ‘explain’
- Escalation domain of Governance and Leadership has been de-escalated from level 3 to level 1 in December 2025
- Internal Audit Reviews of Escalation Governance provided *Substantial Assurance* (Feb25), with Level 3 / Level 4 Directorates provided *Limited Assurance* (Apr26)
- Audit Wales Structured Assessment 2024 found that respect of:
 - *Effectiveness of Board and openness*, ‘The Board and its committees continue to work well, remain transparent and committed to hearing from patients and staff’
 - *Providing board assurance*, ‘there are strong arrangements to oversee risk, performance, service quality and safety, and audit recommendations’

Maturity levels	0	1	2	3	4	5	6
Key criteria	None	Basic Level – Principle Accepted and Commitment to Action	Early Progress – In Development	Firm Progress – In Development	Results being achieved	Maturity – Comprehensive Assurance in place	Exemplar
Oversight & Administration Principles	None	The Board is actively reflecting on how they work and how governance is structured, and is testing whether what is in place makes the best use of these underlying principles.	As a result of discussion around these principles, changes have started to be made to the governance of the organisation.	The annual review of governance and developing cycle of Board business planning will be used to test these principles, and where required, change go	Using these principles has helped Board members to better understand their roles in governance. Governance activities that provide little value and do not meet the principles have been stopped.	As the organisation develops, these principles have led to improvements in governance arrangements to efficiently and effectively support new challenges.	Other organisations have referred to the structure and systems of the organisation, to understand the application of these principles and support similar changes.

3. LEADERSHIP & STRATEGIC DIRECTION - Agreed level of maturity – 3

Evidence

- The Board has been stable during 2025/26, with forward planning of appointments and reappointments in place, to avoid gaps. There have been no interim positions on the Executive Team in 2025/26
- There are 7 male and 4 female Independent Members on Board as at March 2026, with 6 male and 3 female Executive Directors on the Board.
- Local induction programme in place for new Independent Members, with IM Handbook, and new National Programme of Induction for all Board Members introduced in 2025
- Optional Lunch and Learn sessions in place for Board Members cover topics such as patient safety walkarounds, finance, patient service and complaints, risk and estates/capital projects
- New IM annual PADR process and 360-degree assessment
- Board succession plan in place
- In 2025, the Health Board delivered two Independent Member development sessions, two full Board development days and three Executive Team time-outs, each aligned to performance objectives and tailored personal development plans. Executive coaching has also been provided and continues to be offered, where appropriate
- Patient safety visits undertaken by Board members
- Board adoption of the HEIW Compassionate Leadership pledge in July 2024
- Participation in the WG Aspiring Board Members programme and supporting our Aspiring Member who joined Board in 2025/26
- Considerable change at operational level following the implementation of phase one of its new operational structure in April 2025 – Phase 1 is complete, with Phase 2 yet to be implemented.
- Delivery of an agreed programme of OD support to support the new Clinical Care Groups
- The LEAP programme has continued to be delivered to four cohorts each year and 126 leaders have already completed this with 56 currently progressing through the programme. Five cohorts of the New Consultant Programme have been delivered to 58 senior clinicians
- Equality, Diversity and Inclusion (EDI) Task Force established, led by an Independent Member and Deputy Chief Executive, to drive a set of actions to improve equity across the Health Board; Board Allyship is one of the sub-groups of this work, in addition to Engagement and Co-production and enhancing our use of data
- Escalation domain of Domain 5: Leadership, Capability and Culture has been de-escalation from level 3 to level 1 in December 2025
- Audit Wales Structured Assessment 2025 found that ‘the Board continues to demonstrate a strong commitment to learning and development’ and its ‘approach to evaluating its effectiveness is well established, continuing to draw on internal and external sources of assurance’.

Maturity levels	0	1	2	3	4	5	6
Key criteria	None	Principle Accepted and Commitment to Action	Early Progress – In Development	Firm Progress – In Development	Results being achieved	Maturity – Comprehensive Assurance in place	Exemplar
Leadership & Strategic Direction	None	The roles of all Board/ members are clear, agreed and specified.	A Board succession plan is in place for both Executive and Non-Executive Directors/ Lay Members. Board diversity is valued.	An induction and development programme is in place for Board/ and aspirant members. Diversity is embedded in the approach.	The organisation is recognised by partner organisations as a leader in the local health and wellbeing system.	The Board is leading, rather than following, national and local agendas.	The Board is recognised as a national thought leader.

4. EFFECTIVE EXTERNAL RELATIONSHIPS – Agreed level of Maturity – 3

Evidence

- The Health Board has a longstanding commitment to continuous engagement with our patients, public, staff, and stakeholders. In 2019, and updated in 2022, the Health Board developed its Framework for Continuous Engagement and Consultation in partnership with the then Community Health Council (now Llais). The Framework provides a basis for the Health Board’s engagement work, both from a formal perspective and a wish to move towards ongoing engagement that is part of our day-to-day business as an organisation.
 - This work is underpinned by several key pieces of legislation and guidance, including the National Health Services (Wales) Act 2006 s184, Social Services and Well-being (Wales) Act 2014, Well-being of Future Generations Act (Wales) 2015, Health and Social Care (Quality and Engagement) (Wales) Act 2020, and the Welsh Government Guidance for Engagement and Consultation on Changes to Health Services 2022, Gunning and Bracking principles, Equality Act 2010 – Public Sector Equality Duty s149, including the Socio-Economic Duty, and other legislation and guidance . This approach aims to ensure that a diverse range of voices from across the Hywel Dda community are integral to the planning, development, and decision-making process.
- Reports received by the Board show the Health Board’s commitment to hearing from the public and stakeholders to inform its decisions. The Health Board invites feedback from the public and stakeholders using a variety of methods such as in-person drop-in events, postal and online surveys and via email and telephone. Examples include managed dispersal at St David’s GP Practice in Pembrokeshire, and in-patient beds in Tregaron Community Hospital in Ceredigion. Health Board’s on-going approach to continuous engagement with our communities - discussion paper to Board March 2025
- Engagement and consultation activities in 2025/26 in line with principles of codesign included PPH Minor Injuries Unit, Clinical Services Plan and the Strategy Refresh
- Best Practice Quality Assurance accreditation achieved from The Consultation Institute for the consultation process for the selection of a site for the new hospital and for the consultation process for the selection of an option for the future provisions to urgent and emergency services for children and young people at Withybush and Glangwili Hospital
- Stakeholder Reference Group, advisory group to the Board - quarterly meetings for early strategic engagement, service improvement advice, and social care and wellbeing discussions. Health Board is a member of networks and partnerships including Public Services Boards (PSBs) in Carmarthenshire, Ceredigion, and Pembrokeshire, West Wales Regional Partnership Board. A Regional Collaboration for Health (ARCH), Mid Wales Joint Committee for Health and Care, Dyfed Powys Local Resilience Forum (LRF)
- Siarad Iechyd/Talking Health, the health board’s involvement and engagement scheme, includes members of local community, in place since 2011 [Speak Up](#) framework in place for reporting concerns openly or anonymously, including whistle-blowing, suggestions for improvement.
- Llais attendance and active participation at discussions at Board meetings
- Audit Wales Structured Assessment 2025 found that respect of
 - Board Effectiveness and Openness, ‘the Board and its committees continue to work well, remain transparent and committed to hearing from patients and staff.

Maturity levels	0	1	2	3	4	5	6
Key criteria	None	Basic Level – Principle Accepted and Commitment to Action	Early Progress – In Development	Firm Progress – In Development	Results being achieved	Maturity – Comprehensive Assurance in place	Exemplar
Effective External Relationships	None	Engagement and consultation policies are in place and consistent with the NHS Constitution. Service users, staff, and the public are recognised as a resource to help design and deliver service improvement	A system of accountability to and involvement of the local community is in place to design and deliver service improvement.	Effective citizen involvement is in place, and evidenced by improvement initiatives that are put into operation as a result.	Effective citizen codesign is in place and evidenced through improvements made as a result.	Effective citizen codesign has led to improved outcomes. A review against the NHS Constitution shows our organisation is trusted by patients, service users, and citizens.	Co-production has led to tangible operational and strategic benefits, as well as measurable improved outcomes for the population.

5. EFFECTIVE INTERNAL RELATIONSHIPS – Agreed level of Maturity – 3

Evidence

- Values and Behaviours Framework in place
- Staff stories heard at People, Organisational Development and Culture Committee (PODCC)
- Partnership Forum established which reports into PODCC
- Staff Survey 2024 – results reported with action plan to PODCC May 2025
- Speak Up framework, guardians, guidance, reporting and platform in place on staff intranet to report issues and deep-dive update provided to PODCC in February 2026
- Corporate induction for new starters and local induction explained in [Organisational Induction Policy](#)
- Stay and Exit interview process and digital and paper questionnaire available on staff intranet can be completed on own, with line manager, with member of OD team
- Learning Development policy in place that promotes a learning culture through statutory, mandatory, and CPD
- Hywel Dda whole organisational meeting – Q&A from staff
- Organisational Development information available on staff intranet
- A suite of Management and Leadership Development programmes are available
- Staff engagement is reported in the IPAR
- The Health Board also continues to have active staff networks including BAME network, unpaid carers group, Neurodivergent group, LGBTQ+ and armed forces groups.
- An EDI Task Group has been established led by an Independent Member and Deputy Chief Executive to drive a set of actions to improve equity across the Health Board
- Audit Wales Structured Assessment 2025 found that respect of:
 - *Board Effectiveness and Openness, ‘the Board and its committees continue to work well, remain transparent and committed to hearing from patients and staff.*

Maturity levels	0	1	2	3	4	5	6
Key criteria	None	Basic Level – Principle Accepted and Commitment to Action	Early Progress – In Development	Firm Progress – In Development	Results being achieved	Maturity – Comprehensive Assurance in place	Exemplar
Effective Internal Relationships	None	Staff and other internal stakeholder engagement strategies are developed and these include feedback mechanisms.	The Board receives reports about staff and internal stakeholder engagement, including actions taken as a result of findings.	The organisation prioritises staff and internal stakeholder involvement, and formal and informal input and feedback from all staff, new staff, and leavers, is sought and valued.	The Chair, Non-Executive Directors, Members, and Governors are effective ambassadors for the organisation, involving all staff and internal stakeholders and partners in organisational development. Internal stakeholder engagement is sought at earliest opportunity.	Board and senior leadership recruitment is competitive and reputational audit finds that staff and internal stakeholder involvement is an asset to robust organisational development	The organisation can demonstrate they are an employer of choice, and staff retention is high.

6. TRANSPARENCY & PUBLIC REPORTING – Agreed level of Maturity – 3

Evidence

- Declarations of interest are declared annually by all Board members and are included at the start of all Board and Committee meetings
- A register of interests is published on the health board website. Any conflicts are managed appropriately and members withdraw from discussions
- Register of gifts, sponsorship and hospitality is maintained and published on the health board website
- All Board and Committee papers are published on our website ahead of meetings
- Limited use of Private Board and Committee meetings to ensure openness and transparency with our stakeholders
- The Integrated Performance Assurance Report (IPAR), which summarises progress against a range of national and local performance measures, is presented at every Board meeting
- Improving People and Community Experience Report presented to every Board, summarises feedback from experience to enable the Board to demonstrate that it is actively listening to individuals who access our services, and is undertaking measures to improve the quality of services provided to further enhance that experience
- The Finance Report presented to every Board outlines the Health Board’s financial position to date against the Annual Financial Plan and assesses the key financial projections, risks and opportunities for the financial year, including the implications of in-year recurrent delivery for the forthcoming financial year.
- The Annual Report and Accounts details how we have performed against Welsh Government targets and actions planned to improve our performance, how we have spent our money and met our obligations under The NHS Finance (Wales) Act 2014, our key accountability requirements and about how we manage and control our resources and risks and comply with governance arrangements
- The Duty of Quality and Candour Report demonstrates how we met the duties set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020
- The Internal Audit Plan is prepared on a risk based planning approach, including areas that the health board had specifically identified as know risks areas and areas of potential concerns.
- Audit Wales Structured Assessment 2025 found that respect of:
 - *Board Effectiveness and Openness, ‘the Board and its committees continue to work well, remain transparent and committed to hearing from patients and staff.*
- List has been collated of frequently asked questions and related topics from the general public. Data sources are being investigated. A focus group will be established with members of the public to consult on the proposed list of items to be made available.
- We are working with CGI to develop an AI bot for our internet site, which will look at the health board’s website and meeting papers to answer queries.

Maturity levels	0	1	2	3	4	5	6
Key criteria	None	Basic Level – Principle Accepted and Commitment to Action	Early Progress – In Development	Firm Progress – In Development	Results being achieved	Maturity – Comprehensive Assurance in place	Exemplar
Transparency & Public Reporting	None	Board members absent themselves from discussions due to conflicts of interest; public reporting takes place when required.	The conflicts of interest register is updated by the Board quarterly and identified conflicts are reviewed and appropriate actions taken; edited performance reports are publicly shared.	The Board publicly demonstrates conflicts are examined and covered within contracts; Limited use of In-Committee meetings; integrated public reporting is central to organisational finance, quality, and performance management.	Identified conflicts are publicly addressed; patients, service users, citizens, and staff are asked which finance, quality, and performance metrics are made routinely available.	Integrated finance, quality and performance reports steer organisational development, with public oversight and input into required improvements.	Demonstrable improvements have been made due to public involvement in integrated reporting.

7. SYSTEMS AND STRUCTURES: QUALITY AND SAFETY – Agreed level of Maturity – 4 ↑ (Due improvements in demonstrating compliance with Duty of Quality)

Evidence

- The Quality Management System Strategic Framework was approved by Board in March 2023. A SharePoint page is in place to provide guidance and updates as further support materials become available
- New templates for the Clinical Care Group’s Integrated Governance Group (focus on quality) have been developed. These templates include terms of reference; agenda; and regular report to Quality, Safety and Experience Sub-Committee
- Routine quality assurance reporting to Quality, Safety and Experience Committee using Health and Care Quality Standards
- Revised quality governance arrangements implemented in 2025/26, *these will be further strengthened in 2026/27*
- Our Safety Dashboard provides information to services and directorates
- WalkRounds™ (Board to Floor / Walkarounds), Clinical Audit, NICE and National Guidance, Healthcare Inspectorate Wales (HIW) improvement action plans, and other assurance reports captured and monitored through AMaT
- Quality impact Assessment process, Fragile Services Framework, Equality Impact Assessment and Health Equity impact Assessment in place to promote quality considerations
- Introduction of ‘carer assurance visits’ where the Quality Assurance Team undertake a review of clinical areas using principles of HIW
- Internal Audit Review of Learning Lessons (Apr25) provided *Reasonable Assurance* and Internal Audit of Patient Experience (Feb26) provided *Reasonable Assurance*
- Audit Wales Structured Assessment 2025 found that respect of:
 - *Board Effectiveness and Openness, ‘the Board and its committees continue to work well, remain transparent and committed to hearing from patients and staff’*
 - *Providing board assurance, ‘there are strong arrangements to oversee risk, performance, service quality and safety, and audit recommendations’, and recognised that the Health Board was ‘strengthening oversight of service quality and safety to improve strategic focus at committee level and strengthen operational oversight’*
- The Duty of Quality and Candour Report demonstrate how we met duties set out in Health and Social Care (Quality and Engagement) (Wales) Act 2020 received at the AGM in Sep25
- Evidence that quality is informing Board decision-making, for example, Clinical Services Plan decisions (Feb26)

Maturity levels	0	1	2	3	4	5	6
Key criteria	None	Basic Level – Principle Accepted and Commitment to Action	Early Progress – In Development	Firm Progress – In Development	Results being achieved	Maturity – Comprehensive Assurance in place	Exemplar
Systems & Structures: Quality & Safety	None	A quality management system strategic framework which focusses on, a system-wide approach to achieving quality of care using the health and care quality standards is in development	A Board approved quality management system strategic framework which focusses on a system-wide approach to achieving quality of care using the health and care quality standards is in use.	Quality management system strategic framework implementation demonstrates improvements the domains within the health and care quality standards.	Integrated quality reports demonstrate quantifiable improvements in the domains within the health and care quality standards. The organisation is to demonstrate the duty of quality in some services.	Resources are used to make quality improvements, with measurable returns that demonstrate innovation and improvement. This is demonstrable in all of the domains (STEEEP) within the health and care quality standards. The organisation is to demonstrate the duty of quality in its services on an annual basis.	Significant resources are invested in continuous innovation, improvement, and integration between value-based health care and quality improvement programmes which evidence efficiency and improvements. There is equal importance in the six domains and six enablers of the health and care quality standards. The organisation is to demonstrate the duty of quality in its services throughout the year through routine reporting.

8. DELIVERY OF OUTCOMES – Agreed level of Maturity – 2

Evidence

- The IPAR includes a range of national* and local performance measures and is reported monthly to every Board and relevant Board Committees. Key areas for improvement are included in the report.
- The IPAR Power BI dashboard provides benchmarking data and key performance indicators. Context, actions, risks and mitigation, current target and when we will meet target are included for some of the measures.
- A targeted intervention tracker is maintained which provides reports to WG, Board, Committees and Executive Team on progress against key TI criteria. Action plans are in place to address areas of Alert and Advise
- The internal escalation framework includes domains of (1) finance, (2) performance, (3) quality and safety, (4) strategy and planning, fragile services, (5) governance and (6) leadership, and(7) population health, and has helped to drive improvements in a number of areas, such as finance, and resulted in WG de-escalation for governance and leadership to Level 1. This framework was refreshed for 2025/26, *and will be further developed in 2026/27* to strengthen arrangements following the Internal Audit of Level 3&4 Clinical Care Groups which provided Limited Assurance.
- Delivery of strategic objectives (SO) is measured through the Board Assurance Framework presented to Board 3 times a year. 3-4 outcome measures aligned to each of the SOs. SOs are delivered through our planning objectives which are developed and agreed annually as part of the annual planning process. *This will be updated in 2026/27 following the Strategy Refresh.*
- Outcomes dashboard in development, which will include PROMs for specific pathways
- Internal Audit Review of Performance Management Arrangements (Apr25) provided *Substantial Assurance*
- Audit Wales Structured Assessment 2025 found that respect of:
 - *Providing board assurance, ‘there are strong arrangements to oversee risk, performance, service quality and safety, and audit recommendations’ also recognising that ‘the Health Board has enhanced IPAR reporting by providing detailed escalation status updates for Clinical Care Groups and Corporate Directorates. The new format provides performance domain-level overviews, shows areas of greatest concern, and outlines reasons for escalation and de-escalation criteria. This reflects the Health Board’s maturing and transparent approach to performance management’*
- Our Actions dashboard and supporting action trackers have been developed to track progress against agreed improvement actions.

*The 2025/26 NHS Wales Performance Framework provides a set of indicators developed by Welsh Government to reflect the National Programme areas as outlined in the NHS Wales Planning Framework 2025-2028. The framework outlines the Ministerial priorities for this financial year, along with key targets

Maturity levels	0	1	2	3	4	5	6
Key criteria	None	Basic Level – Principle Accepted and Commitment to Action	Early Progress – In Development	Firm Progress – In Development	Results being achieved	Maturity – Comprehensive Assurance in place	Exemplar
Delivery of Agreed Outcomes	None	The Board has agreed how outcome measures will be used in performance reports, including benchmarking data and key performance indicators	Performance reports including benchmarking data and key performance indicators are in development.	There are no surprises when the organisation is inspected or otherwise challenged, as there is full awareness of performance and action plans are in place for improvements as required.	The Board is fully satisfied that its strategic objectives have been met, as a result of performance monitoring and action.	Board members report confidence in using integrated reporting to support constructive challenge where required.	Demonstrable improvements have been made as a result of the delivery of agreed outcomes.

9. RISK MANAGEMENT & COMPLIANCE – Agreed level of Maturity – 3 ↓ (Due to refresh of the BAF which started post Strategy Refresh January 2026)

Evidence

- Board approved Risk Management Strategy in place which sets out the organisation’s objectives for risk management
- Board approved Risk Management Framework is in place and is updated to reflect changes in process and systems – risks are assessed against objectives, operational quality and delivery and compliance
- Board Assurance Framework is in place and is reported to the Board 3 times a year, includes principal risks, planning objections, actions, and outcome measures. This has been recognised by Audit Wales as a good practice model. *This will be updated in 2026/27 following the Strategy Refresh*
- Board annually reviews its Risk Appetite Statement and tolerance approach which is included in the BAF
- Annual risk maturity assessment against The Orange Book Risk Management Standard
- Corporate risk register is in place – reviewed monthly by Executive Team, reported to Board and Committees 3 times a year
- Operational risk registers in place reported to Committees 3 times a year as part of the new Assurance and Risk Reports to provide assurance on risk management
- Assurance and risk reports provided to all committees reporting on the management of principal, corporate and operational risks, as well as compliance with audits, inspectorates and regulators, Ministerial Directions and Welsh Health Circulars (WHCs)
- ARAC receive Risk Assurance Report to provide assurance on the systems and processes in place to manage risk
- ARAC receive External Recommendation Assurance Report to provide assurance on the systems and processes in place to oversee the implementations of audit, inspectorate and regulator recommendations and WHCs
- Fragile Services Framework in place
- The annual planning process has taken a risk-based approach in 2025/26
- Board approved Major Incident Plan in place which is reviewed annually and tested in line with Civil Contingencies Act (2004) requirements
- Disclosures made in Annual Governance Statement in respect of compliance with Civil Contingencies Action and breaches with GDPR
- Emergency Preparedness, Resilience and Response (EPRR) Annual report submitted to WG NHS Performance & Improvement annually
- EPRR risks identified and assessed via review of National Security Risk Assessment and Wales Risk & Preparedness Register.
- EPRR risk mitigation supported by participation in Wales Resilience Partnership work programme.
- Core partner in Dyfed Powys Local Resilience Forum which takes a risk management approach and delivers a subsequent training and exercising programme.
- Business Continuity now included in Health Board Escalation Metrics which drives review and maintenance of business continuity plans at service level.
- Internal Audit Corporate Risk Ophthalmology (Aug25) provided *Reasonable Assurance*
- Audit Wales Structured Assessment 2025 found that respect of:
 - *Providing board assurance, ‘there are strong arrangements to oversee risk, performance, service quality and safety, and audit recommendations’, and reported that ‘the Board continues to have a mature approach to overseeing strategic risks’*

Maturity levels	0	1	2	3	4	5	6
Key criteria	None	Basic Level – Principle Accepted and Commitment to Action	Early Progress – In Development	Firm Progress – In Development	Results being achieved	Maturity – Comprehensive Assurance in place	Exemplar
Risk Management & Compliance	None	A process is in place to proactively evaluate risk, and a Board Assurance Framework is organised to promote focused discussion on key business issues	A risk appetite statement has been agreed, and built into the Board Assurance Framework, which covers the risks to achieving strategic objectives, including quality, performance, finance, and activity, aligned to targets, standards, and local priorities	Regular review of the Board Assurance Framework supports the management of risks to achieving strategic objectives, and an annual exercise ensures review of the organisation’s Emergency and Business Continuity Plan.	The Board Assurance Framework is central to the management of risks to achieving strategic objectives, with a quarterly update and annual action planning to drive business. Emergency and Business Continuity Plans are improved through a range of scenario tests in year	The Board is confident that it is aware of risks faced, including risks associated with compliance, these are managed, and required actions are prioritised and planned.	The organisation has proactively identified and managed all known risks and opportunities, and successfully meets its strategic objectives

10. EFFECTIVENESS & ADDED VALUE – Agreed level of Maturity – 3

Evidence

- Board annual workplan is developed and maintained throughout the year, and contains periodic matters of business, approval of annual accounts
- Annual Report and Accounts submitted annually to WG demonstrate good governance and accountability
- Duty of Quality and Candour Report is produced annually to demonstrate the quality of services within the health board
- Internal and external audit plans agreed annually with review reports presented to ARAC
- AW Structured Assessment 2025 found that *‘the Board continues to demonstrate a strong commitment to learning and development’* and that *‘the Board’s approach to evaluating its effectiveness is well established, continuing to draw on internal and external sources of assurance’*
- Annual Board Effectiveness assessment undertaken against a refreshed maturity matrix providing a clear understanding of its strengths and areas of improvement
- Committee effectiveness process is undertaken annually to identify areas of good practice and improvement
- Revised quality governance arrangements and health and safety governance implemented in 2025/26, *the effectiveness of these arrangements is being undertaken and will be reported and addressed in 2026/27*
- Board Assurance Framework is in place and is reported to the Board 3 times a year
- The IPAR includes a range of national and local performance measures and is reported to every Board and relevant Board Committees
- Board regularly reviews its governance arrangements to ensure it is streamlined and fit for purpose (last reviewed January 2025 and responded to feedback received in previous year’s Committee self-assessment process)
- Revised operational governance arrangements implemented and reviewed in 2025/26, *these will be further strengthened in 2026/27 to address Internal Audit on Operational Governance Arrangements (Apr26) which provided Limited Assurance*
- Internal Audit on Escalation Governance provided *Substantial Assurance (Feb26)*
- Internal Audit on Executive Team working (due May2025)
- Audit Wales Structured Assessment 2025 found that respect of:
 - Board effectiveness and openness, ‘the Board and its committees continue to work well, remain transparent and committed to hearing from patients and staff

Maturity levels	0	1	2	3	4	5	6
Key criteria	None	Basic Level – Principle Accepted and Commitment to Action	Early Progress – In Development	Firm Progress – In Development	Results being achieved	Maturity – Comprehensive Assurance in place	Exemplar
Effectiveness & Added Value	None	More effective practices are being adopted. A review of governance mechanisms is agreed.	The Board has reviewed governance practices for efficiency savings, and agreed improvements to add value	The annual cycle of business is planned and the Board Assurance Framework is used by the Board to identify opportunities for increased effectiveness and added value.	The annual cycle of business is planned and the Board Assurance Framework and integrated reports are used by the Board to identify opportunities for increased effectiveness and added value.	The annual cycle of business is planned, the Board Assurance Framework and integrated reports are used by the Board to identify opportunities for increased effectiveness and added value, and external governance reviews.	Demonstrable savings and efficiencies have been made as a result of streamlined governance arrangements.

Appendix 2 – Update on agreed actions to improve Board maturity in 2025/26 & Action for 2026/27

Key Criteria	Maturity level	Next Maturity level description	Next steps /actions	By Whom	By when	Status
1. Clarity of Purpose, Roles & Behaviours	3	4 - Evidence that national targets and local priorities are being met. Regular reviews of strategy in line with strategic objectives	Meeting Level 4 will only be evidenced when national targets and local priorities are being met. This is monitored through the IPAR to Board and WG Escalation	Andrew Carruthers	Timescale for delivery will be in line with agreed timescales and trajectories set out Health Board Annual Plans	In progress
			To review of A Healthier Mid and West Wales Strategy to be presented to the Board in January 2026	Lee Davies	31 January 2026	Complete
			Identify 4 key deliverables to be completed through the Regional Joint Committee that will demonstrate improved patient outcomes	Phil Kloer	30 June 2026	New action
2. Oversight & Administration Principles	4	5 - As the organisation develops, these principles have led to improvements in governance arrangements to efficiently and	To respond to the de-escalation criteria for the Governance domain of the WG Escalation Framework to reduce escalation status to level 2	Joanne Wilson	30 September 2026	Complete
			To continue to embed and strengthen operational governance, responding to	Andrew Carruthers	31 March 2026	Complete

		effectively support new challenges.	findings of any internal and external reviews			
3. Leadership & Strategic Direction	3	4 - The organisation is recognised by partner organisations as a leader in the local health and wellbeing system.	To improve diversity on the Board by supporting the Aspiring Board Member Programme through 2025/26	Joanne Wilson	31 March 2026	Complete
			To establish an independent member-led equality, diversity and inclusion taskforce to drive a set of actions to improve equity across the Health Board	Lisa Gostling	31 March 2026	Complete
			To ensure succession plans are in place for all Executive Directors and Independent Members	Neil Wooding and Phil Kloer	31 March 2026 31 March 2027	Bring forward to 2026/27
4. Effective External Relationships	3	4 - Effective citizen codesign is in place and evidenced through improvements made as a result.	To undertake the following engagement and consultation activities in 2025/26 in line with principles of codesign:	Alwena Hughes-Moakes		
			<ul style="list-style-type: none"> PPH Minor Injuries Unit consultation – 2 of the 4 options we are consulting on have been co-designed/developed with community representatives. Clinical Services Plan – 13.5 week public consultation to feed into options and suggest 		31 March 2026	Complete
					31 March 2026	Complete

alternate ideas to deliver 9 services across the Health Board.

- Strategy Refresh/Primary and Community Strategic Plan development – public involved in early stages of strategy review and being asked to engage on “What is important for you to live a healthy life?”, this will then feed into which areas of the strategy will need to be redesigned, alongside more targeted and focussed public engagement across both areas in autumn.
- Ahead of Clinical Services Plan 2 – Transformation Programme Office are looking at developing a framework for change programmes and we are working with them to increase community involvement/ representation in options development, ahead of public consultations. This will ensure representation from are communities are co-designing options with

31 March 2026 Complete

~~31 March 2026~~
30 September 2026
This action is still in progress. The framework will be based on 1. Lessons learnt from Phases 0-2 of CSP 1 and 2. Recommendations for future complex change programmes. Phases 0 and 1 are complete. Lessons learnt

us, that then later go out to wider public engagement/consultation.

- This is alongside on-going engagement activity, Community Development Outreach Team work and service changes outlined with annual plans.

from Phase 2 (public engagement phase) will be led by Engagement Team.

To undertake the following engagement and consultation activities in 2026/27 in line with principles of codesign:

- Clinical Services Plan, phase 2 – stroke services, eight-week engagement period to understand views on preferred option, impacts and mitigations.
- Roll-out of refreshed Strategy across staff, communities, and partners as part of our continuous engagement.
- An eight-week engagement period on the revised Pharmaceutical Needs Assessment.
- We will be carrying out engagement linked to capital projects and

31 March 2027 New actions

			<p>impacts on locations where services will be delivered.</p> <ul style="list-style-type: none"> • Further consultation and engagement activities will evolve as priorities develop throughout the year and these will be delivered in-line with codesign principles. 			
5. Effective Internal Relationships	3	4 - The Chair, Non-Executive Directors, Members, and Governors are effective ambassadors for the organisation, involving all staff and internal stakeholders and partners in organisational development. Internal stakeholder engagement is sought at earliest opportunity.	To involve and consult with staff and trade unions on the refresh of the Clinical Services Plan.	Lee Davies/ Alwena Hughes-Moakes	31 March 2026	Complete
			To involve staff and trade unions embedding in the refresh of the Health Board's Wellbeing Objectives in line with the Social Partnership Act duty.	Ardiana Gjini	31 March 2026	Complete
			To build on the NHS Staff Survey and culture work by involving staff in each Clinical Care Group and trade unions in the development of actions that respond to the staff survey feedback to promote a positive and supportive workplace culture.	Lisa Gostling	31 March 2026	Complete
6. Transparency & Public Reporting	3	4 - Identified conflicts are publicly addressed;	Identify potential data sources for the list of frequently asked questions / topics from the public.	Huw Thomas	30 June 2026	In progress

		patients, service users, citizens, and staff are asked which finance, quality, and performance metrics are made routinely available.	Establish a focus group with members of the public to review the proposed list of items to be made available to the public.	Huw Thomas	30 September 2026	Not started
			Make agreed items available to the public via the health board's internet site.	Huw Thomas	31 December 2026	Not started
			Work with CGI to develop an AI for our internet site, which will look at the health board's website content and meeting papers to answer queries.	Huw Thomas	30 September 2026	In progress
			Engage with citizens and service users on the 7 programme groups of the 20-four-7 framework to define how success will be measured and develop meaningful metrics	Lee Davies	31 March 2027	Not started
7. Systems & Structures: Quality & Safety	4	5 - Resources are used to make quality improvements, with measurable returns that demonstrate innovation and improvement. This is demonstrable in all of the domains (STEEEP) within	Clinical Care Groups and Service Groups to use the STEEEP framework to support consistent, well-evidenced decision-making and to clearly articulate implications and next steps within their services.	Andrew Carruthers (via the Assistant Directors of Quality and Patient Experience (Nursing and Operational Allied Health	31 March 2027	New action

		the health and care quality standards. The organisation is to demonstrate the duty of quality in its services on an annual basis.		& Health Science)		
8. Delivery of Agreed Outcomes	2	3 - There are no surprises when the organisation is inspected or otherwise challenged, as there is full awareness of performance and action plans are in place for improvements as required.	To ensure that Internal Audit undertake a review of the effectiveness of the new operational governance arrangements to gain assurance on its effectiveness to identify and address issues, and to escalate these promptly and appropriately, in order that outcomes are delivered. This will be undertaken by Internal Audit in Q4, and the Health Board will respond promptly to any findings raised.	Andrew Carruthers	31 March 2026 31 March 2027	Not completed - The report concluded Limited Assurance and will be reported to ARAC in April 2026. Further work will be taken to strengthen and streamline operational governance arrangements in 2026/27. Not started
			Ensure all improvement actions relating to the seven improvement domains within the escalation framework are captured within the Our Actions dashboard and supporting tracker.	Dependant on new operational governance arrangements	Dependant on new operational governance arrangements	In progress
				Huw Thomas	30 June 2026	

			Review the Board Assurance Framework (BAF) outcome measures to ensure they are aligned with the strategic objectives set out in the health board's 2026/27 annual plan.			
9. Risk Management & Compliance	3	4 - The Board Assurance Framework is central to the management of risks to achieving strategic objectives, with a quarterly update and annual action planning to drive business. Emergency and Business Continuity Plans are improved through a range of scenario tests in year	To improve alignment between the Annual Plan and the agreed actions that have been agreed to be taken forward to manage our risks, and ensure that the 'target risk score' outlines a true reflection of our ability to manage individual risks based on the Health Board's agreed priorities and available resources/capacity	All Executive Directors	31 March 2026	Completed - Approach has been agreed and has been shared with all functions. All risk owners receive training and are advised to base their Target risk score on credible and deliverable actions - Risk Maturity Assessment has identified this as an area that staff need further training on. Planning process for the Annual Plan for 2026/27 has taken a risk based approach however this has highlighted that further work is needed to ensure

						risk registers fully reflect the organisational risk profile. Increased scrutiny at Committees of risks through Assurance and Risk Reports.
						New action
			To ensure that timely and meaningful risk assessments are undertaken to inform business and strategic prioritisation, decision-making and planning.	All Executive Directors	31 March 2027	New action
			Align Health Board EPRR risk approach further with newly formed Wales Resilience Partnership work programme.	Ardiana Gjini	31 March 2027	
10. Effectiveness & Added Value	3	4 - The annual cycle of business is planned and the Board Assurance Framework and integrated reports are used by the Board to identify opportunities for increased	To review the Board Assurance Framework alongside the strategy refresh and to start to use the BAF to inform Board and Committee agendas	Lee Davies and Joanne Wilson	31 March 2026	In progress – this was delayed until Strategy Refresh was approved by Board in January 2026. New timeline agreed by Executive Team and reported to the Board. Work

effectiveness and added value.

has started and is on track and the refreshed BAF will be presented to the Board in July 2026.

Further work required on enacting the value opportunities catalogue to produce efficiencies and productivities

Huw Thomas/
Andrew Carruthers

31/03/2027

New action

2025/26 HYWEL DDA UNIVERSITY HEALTH BOARD SELF ASSESSMENT AGAINST THE CORPORATE GOVERNANCE – CODE OF PRACTICE 2017

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
CGC 1	Each organisation should have an effective board, which provides leadership for the business, helping it to operate in a business-like manner. The board should operate collectively, concentrating on advising on strategic and operational issues affecting the organisation's performance, as well as scrutinising and challenging organisational policies and performance, with a view to the long-term health and success of the organisation. (2.1 and 2.2)	<p>The Board is scheduled to meet every alternate month. During 2025/26, 3 extraordinary Board meetings (one in Private) were held. These were held for the following purposes:</p> <ol style="list-style-type: none"> To consider approve the Annual Report and Accounts and conclude end of year reporting for 2024/25. To consider the financial Plan – Choices and Decisions (Private Board). To consider and approve the decisions within the scope of the Clinical Services Plan and endorse the programme moving into phase 4, to produce a programme implementation plan. <p>A Board Cycle of Business is in place. This is developed on an annual basis and updated throughout the year.</p> <p>The Board routinely receives information on strategic activity, risk and performance matters as standing agenda items.</p> <p>The Annual Plan is scrutinised by the Board and its Committees.</p> <p>Joint Executive Team and Targeted Intervention meetings are held with Welsh Government colleagues.</p> <p>The Board collaborates with partners and key stakeholders as described in the Annual Plan.</p> <p>The Board has been stable throughout 2025/26. Substantive appointments were made for the posts of Executive Director of Nursing, Quality and Patient Experience and Executive Medical Director, with the interim appointees being successfully appointed in quarter 1. There were 2 new Independent Member (IM) appointments made to replace both IM (Community) positions due to completion of tenures.</p>	<p>Title: AW Structured Assessment 2025</p> <p>Reference Point: Board effectiveness and openness – Paragraph 10-36</p>	Comply	<p>Board and Committee Minutes – demonstrate scrutiny and support.</p> <p>Board Papers.</p> <p>Board Work Plan 2025/26.</p> <p>Joint Executive Letters.</p> <p>AW Structured Assessment report 2025.</p>
CGC 2	<p>The Board does not decide policy or exercise the powers of the ministers. The organisation's policy is decided by ministers alone on advice from officials. The Board advises on the operational implications and effectiveness of policy proposals. The Board will operate according to recognised precepts of good corporate governance in business:</p> <ul style="list-style-type: none"> Leadership – articulating a clear vision for the organisation and giving clarity about how policy activities contribute to achieving this vision, including setting risk appetite and managing risk 	<p>The Health Board refreshed its 'A Healthier Mid and West Wales' Strategy in January 2026, which reinforced its strategic vision to move care closer to home for our communities and to more sustainable as an organisation. The strategy is underpinned by 4 strategic objectives, and supported by 8 planning goals.</p> <p>The submission of a three year Integrated Medium Term Plan (IMTP) to Welsh Government (WG) is a statutory obligation. However, for an IMTP to be approvable it must show financial balance over the lifecycle of the Plan and, as such, HDdUHB has not produced an approvable Plan to date. Given the financial position and the escalation status to the entire organisation, the health board submitted an Annual Plan for the period 2025-26. The Annual Plan set out the key actions and ambitions for the Health Board for 2025-26 was</p>	<p>Title: AW Structured Assessment 2025</p> <p>Reference Point: Preparing Strategies and plans – Paragraph 58-73</p> <p>Corporate Approach to Managing Finances – Paragraph 74-92</p>	Comply	<p>Strategy Refresh 2026</p> <p>Annual Plan 2025/26</p> <p>Annual Plan 2025/26 reports to Board during 2025/26</p> <p>CEO Reports to Board include updates on Escalation status</p> <p>Escalation Status update reports to ARAC</p> <p>Standing Orders and Standing Financial Instructions.</p>

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
	<ul style="list-style-type: none"> Effectiveness – bringing a wide range of relevant experience to bear, including through offering rigorous challenge and scrutinising performance Accountability – promoting transparency through clear and fair reporting. Sustainability – taking a long-term view about what the organisation is trying to achieve and what it is doing to get there. <p>(2.3)</p>	<p>intentionally more focused on a smaller set of objectives (termed the planning objectives (POs)) and on delivery over the shorter term. The Annual Plan plan prioritised POs aligned to the Welsh Government Planning Framework, the Ministerial Priorities and key programmes of work. The plan was submitted to the Welsh Government in March 2025, although given the financial position this was unsupportable and unacceptable by Welsh Government (letter of 6 June 2025).</p> <p>In March 2026, the Board approved the Annual Plan for 2026/27, recognising that whilst the financial Plan met the WG Target Control total, it would not deliver against the breakeven duty and will consequently breach the Health Board’s statutory duty and will consequently receive a qualified regularity opinion.</p> <p>The Annual Plan outlines how the Health Board engages and ensures that it considers the principles of citizen engagement, the Wellbeing of Future Generations Act and also the Health Boards Wellbeing Statement.</p> <p>The Health Board has been in Targeted Intervention escalation status since September 2022 for ‘finance’ and ‘planning’ and enhanced monitoring for some quality issues related to performance resulting in long waiting times and poor patient experience. However, due to WG concerns of the Health Board’s lack of sustained progress over a period of time on integrated planning, finance and delivery, in January 2024, WG increased the escalation status to targeted intervention for the entire organisation. Over the last year we have been de-escalated for the following areas:</p> <ul style="list-style-type: none"> July 2025 - de-escalated to level 3 for cancer and to level 1 for CAMHS. December 2025 - de-escalated to level 1 for leadership and governance. February 2026 - The health board was further de-escalated to level 1 for cancer. <p>Therefore, our current escalation status is:</p> <ul style="list-style-type: none"> Level 4 for finance, strategy and planning Level 4 for performance and outcomes related to urgent and emergency care, fragile services (including ophthalmology), and Healthcare Associated Infections (HCAIs) Level 3 for performance and outcomes related to planned care Level 1 for leadership and governance Level 1 for performance and outcomes related to cancer. <p>The Health Board adopted its revised Model Standing Orders (SOs) in May 2025, with a further review of Standing Financial Instructions (SFIs) in July 2025 to reflect changes in procurement legislation. The SOs and SFIs are designed to</p>			<p>AW Structured Assessment report 2025</p> <p>Well-being Statement</p> <p>Risk Appetite Statement</p> <p>Board Effectiveness Report and Committee Effectiveness Report</p> <p>Annual Report and Accounts 2025/26</p>

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
		<p>translate the statutory requirements set out in the National Health Service Trusts (Membership and Procedure) Regulations 1990 (S.I.1990/2024) into day to day operating practice, and, together with the adoption of a Schedule of Decisions reserved to the Board of Directors; a Scheme of Decisions to Officers and Others, they provide the regulatory framework for the business conduct of the Health Board. These documents form the basis upon which the Health Board's governance and accountability framework is developed and, together with the adoption of its Values and Behaviour Framework and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.</p> <p>The Board reviewed its Risk Appetite Statement in January 2026.</p> <p>Board effectiveness is assessed annually with the Board assessing itself against a maturity matrix and agreeing future work to strengthen its maturity across 10 areas. Board Committees also undertake an annual effectiveness review which produces a development plan to support continuous learning and improvement.</p> <p>The Board is also supported by a Board Development Programme.</p>			
CGC 4	<p>The Board should meet on at least a quarterly basis; however, best practice is that boards should meet more frequently. The Board advises on five main areas:</p> <ul style="list-style-type: none"> • Strategic Clarity • Commercial Sense • Talented People • Results focus • Management information (2.4 and 3.10) 	<p>The Board meets every alternate month. During 2025/26, 3 extraordinary Board meetings were also held (see CGC 1 for further detail). The Board also holds a Board Seminar meeting in the alternate month with additional Board Development sessions through the year.</p> <p>There is a Board Cycle of Business in place, developed on an annual basis and updated throughout the year.</p> <p>Board agendas are divided into Preliminary Matters, Delivering on our Purpose – Quality, Safety and Performance, Maintaining Good Governance, and Working in Partnership.</p> <p>The Board routinely receives information on strategic activity, annual plan delivery, business cases, improving patient experience, risk and integrated performance, as standing agenda items.</p> <p>In January 2026, the Board refreshed its A Healthier Mid and West Wales strategy, due to the time that had elapsed since it was approved in 2018 and significant changes that have taken place during the intervening period.</p>	<p>Title: AW Structured Assessment</p> <p>Reference Point: Board effectiveness and openness – Paragraph 10-36</p>	Comply	<p>Standing Orders and Standing Financial Instructions.</p> <p>AW Structured Assessment report 2025</p> <p>Board Annual Workplan</p> <p>Board agendas and papers throughout 2025/26</p>
CGC 5	<p>The Board also supports the accounting officer in the discharge of obligations set out in <i>Managing Public Money</i> for the proper conduct of business and maintenance of ethical standards.</p>	<p>The Board approves the Accountability Report on an annual basis which includes the Statement by the Accountable Officer assuring the Board on the System of Internal Control. This is reviewed by Audit Wales, as part of the Annual Report and Accounts, prior to submission of the final documents.</p>	<p>Audit Wales and Internal Audit receive and review the Accountability Report for comment and ensuring</p>	Comply	<p>Annual Accountability Report</p> <p>Board papers</p> <p>AW Structured Assessment 2025</p>

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
	(2.7)		compliance with the Manual for Accounts.		
CGC 6	Where Board members have concerns, which cannot be resolved, about the running of the organisation or a proposed action, they should ensure that their concerns are recorded in the minutes. (2.12)	<p>Any concerns raised at Board and Committee meetings will be formally recorded in the minutes.</p> <p>Following each meeting, Committee Chairs meet with Independent Members to reflect on the meeting and whether there is any learning. These reflections and any concerns are considered at the Committee Chairs Meeting with the Health Board Chair, these meetings were reinvigorated for 2025/26.</p> <p>The role of the Director of Corporate Governance (DoCG)/Board Secretary is to be responsible for ensuring these matters are effectively managed, recorded and resolved where possible.</p>	<p>Title: AW Structured Assessment</p> <p>Reference Point: Board effectiveness and openness – Paragraph 10-36</p>	Comply	<p>Role of the DoCG/Board Secretary is detailed in job description</p> <p>AW Structured Assessment report 2025</p> <p>Board and Committee Minutes – available on the Health Board Internet site.</p>
CGC 7	The Board should have a balance of skills and experience appropriate to fulfilling its responsibilities. The membership of the board should be balanced, diverse and manageable in size. (3.1, 3.11, 3.12 and 3.13)	<p>Constitution is set out in the Organisation’s Establishment and Membership Orders and the Health Board abides by this composition. This set out specific roles for Board members.</p> <p>Standing Orders also capture the composition of the Board.</p> <p>Executive Director skill mix is considered prior to recruitment to align with organisational objectives and required Executive Portfolios, and this is considered prior to new appointments. Recruitment process includes internal and external stakeholder panels. The Board (voting members) is made up of 7 females and 13 males.</p> <p>The IM roles are appointed in areas of expertise to ensure appropriate skill mix. Gaps between outgoing and incoming IMs have been minimal, with no implications on attendance or continuity at Board and committee meetings.</p> <p>Board development programme in place.</p> <p>Public Appointments Unit support the process – set criteria within an IM Role. Maximum of 2 tenures of up to 8 years.</p> <p>IM membership on Board Committees is rotated at appropriate times to ensure there is a mix and balance of experience across all meetings. The most recent rotation took place on 1 January 2026.</p>	<p>Title: AW Structured Assessment</p> <p>Reference Point: Board effectiveness and openness – Paragraph 10-36</p>	Comply	<p>Establishment Orders</p> <p>Standing Orders</p> <p>AW Structured Assessment report 2025</p> <p>Board and Committee Terms of Reference</p>
CGC 8	The roles and responsibilities of all board members should be defined clearly in the organisation’s board operating framework. (3.2)	<p>Constitution is set out in the Organisation’s Establishment and Membership Orders and the Health Board abides by this composition.</p> <p>Standing Orders also outline the composition of the Board.</p>	<p>Title: AW Structured Assessment</p> <p>Reference Point: Board effectiveness and openness – Paragraph 10-36</p>	Comply	<p>Establishment Orders</p> <p>Standing Orders</p> <p>AW Structured Assessment report 2025</p>

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
CGC 9	The Finance Director should be professionally qualified. (3.3)	Executive Director of Finance is professionally qualified.	N/A	Comply	Recruitment and appointment documentation for the Executive Director of Finance
CGC 10	Independent Members will exercise their role through influence and advice, supporting as well as challenging the executive. (3.5)	<p>Annual Committee Self-Assessment process addresses the effectiveness of how Committees operate and conduct meetings, allowing debate and constructive challenge.</p> <p>Meeting principles adopted that support this constructive challenge.</p> <p>The WG IM training captures effective challenge and scrutiny role on the Board. There is also a new national and local induction programme in place to advise Board Members on to discharge their role.</p> <p>Standing Orders outline the role of the Board Members.</p> <p>Reflective exercise held at the end of each Committee meeting.</p> <p>Board Seminars which are held every other month provide the Board with the opportunity for debate on key issues facing the organisation and enable IMs to influence and advise the Executive Team.</p> <p>The committee chairs meetings which meet to triangulate information from the Committees have been reinvigorated in 2025/26.</p> <p>As part of their roles, IMs also undertake engagement visits and quality visits across services within Hywel Dda, to gain knowledge and assurance on systems and processes, and will key findings are reported back to Committees on the key outcomes and themes.</p>	<p>Title: AW Structured Assessment</p> <p>Reference Point: Board effectiveness and openness – Paragraph 10-36</p>	Comply	<p>AW Structured Assessment report 2025</p> <p>Committee Self-Assessment Approach and Outcome Reports</p> <p>Standing Orders</p>
CGC 11	The board should agree and document in its board operating framework a <i>de minimis</i> threshold and mechanism for board advice on the operation and delivery of policy proposals.	<p>Standing Orders detail how the Board regulates its proceedings and business.</p> <p>There is a Board Cycle of Business in place developed on an annual basis and updated throughout the year.</p> <p>The Terms of Reference Operating Arrangements for the Board Committees articulate their remit and the information that should be received. Committee Workplans are in place and updated throughout the year to support the flow of information through the Board Committees.</p> <p>The Scheme of Delegation outlines the information that should flow through to Board and its Committees as appropriate.</p> <p>The Scheme of Delegation for Officers details 'top level' delegations and responsibilities within the Health Board.</p>	<p>Title: AW Structured Assessment</p> <p>Reference Point: Board effectiveness and openness – Paragraph 10-36</p>	Comply	<p>AW Structured Assessment report 2025</p> <p>Committee Terms of Reference and Operating Arrangements</p> <p>Board and Committee Cycles of Business.</p> <p>Standing Orders and Scheme of delegation</p> <p>Scheme of Delegation for Officers</p>

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
CGC 12	<p>The Board should ensure that arrangements are in place to enable it to discharge its responsibilities effectively, including:</p> <ol style="list-style-type: none"> 1. formal procedures for the appointment of new board members, tenure and succession planning for both board members and senior officials 2. allowing sufficient time for the board to discharge its collective responsibilities effectively 3. induction on joining the board, supplemented by regular updates to keep board members' skills and knowledge up-to-date 4. timely provision of information in a form and of a quality that enables the board to discharge its duties effectively 5. a mechanism for learning from past successes and failures within the organisational family and relevant external organisations 6. a formal and rigorous annual evaluation of the board's performance and that of its committees, and of individual board members 7. a dedicated secretariat with appropriate skills and experience (4.1) 	<p>IMs Terms of Office are monitored by the Chair with support from the DoCG/Board Secretary to ensure succession planning is timely and managed in conjunction with the Public Appointments Unit in WG.</p> <p>Agenda planning is managed by the Chair and supported by DoCG/Board Secretary and CEO to ensure adequate time is spent on the appropriate matters at Board meetings.</p> <p>National induction programme in place for new Board Members. The Health Board has a robust induction programme for IMs. This programme consists of the following areas to ensure that a robust and supportive induction plan is in place for all new Board appointments:</p> <ul style="list-style-type: none"> • Attendance at the Mandatory Welsh Government Induction Training. • Provision of a detailed induction pack/manual which includes information about the role of each Board Committee, their role as a Trustee as well as an IM. • Core Induction Programme – planned within the first month, three months and six months. This includes meeting with Executive Directors, Directors and site visits • A mentoring / shadow arrangement with an existing/experienced IM. • To further support IMs ongoing development, the Chair undertakes regular and robust Personal Appraisal and Development reviews in accordance with WG guidance, supported by 360 Assessments in 2025/26. • The Health Board has a schedule of Board Development Sessions throughout the year to discuss topical issues. <p>Committee Terms of Reference direct that agenda and papers are circulated to members at least 7 days prior to meeting.</p> <p>The Standard Operating Procedure for the Management of Board and Committees provides guidance in relation to Board and Committee arrangements and management of papers.</p> <p>Report templates are continually reviewed to ensure they support effective reports being received at the Board.</p> <p>Dedicated Committee Services Officers support the Board and Committee business to ensure high quality and consistency of papers.</p> <p>Annual Board effectiveness assessment and annual Committee Self-Assessment of Effectiveness process ensures Board and Committees remains fit-for-purpose and identifies areas of improvement.</p>	<p>Title: AW Structured Assessment</p> <p>Reference Point: Board effectiveness and openness – Paragraph 10-36</p>	Comply	<p>AW Structured Assessment report 2025</p> <p>Terms of Reference and Operating Arrangements</p> <p>Board and Committee Cycles of Business</p> <p>Standing Orders and Scheme of delegation</p> <p>Committee Terms of Reference</p> <p>Standing Operating Procedure for the Management of Board and Committees</p> <p>Board Effectiveness Assessment</p> <p>Committee Self-Assessment Reports</p>
CGC 13	<p>The terms of reference for the nominations committee will include at least the following three central elements:</p>	<p>Remuneration and Terms of Service (RTSC) Committee Terms of Reference. The RTSC key responsibilities are as follows:</p>	N/A	Comply	<p>RTSC Terms of Reference and Operating Arrangements.</p> <p>Board and Committee Cycles of Business</p>

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
	<ul style="list-style-type: none"> scrutinising systems for identifying and developing leadership and high potential scrutinising plans for orderly succession of appointments to the board and of senior management, in order to maintain an appropriate balance of skills and experience scrutinising incentives and rewards for executive board members and senior officials, and advising on the extent to which these arrangements are effective at improving performance (4.5) 	<p>With regard to its role in acting on behalf of the Board, and in providing advice and assurance to the Board, the Remuneration and Terms of Service Committee will comment specifically upon:</p> <ol style="list-style-type: none"> 1. Remuneration and terms of service for the Chief Executive, Executive Directors, other Very Senior Managers (VSMs) and others not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by Welsh Government are applied consistently; 2. Objectives for Executive Directors and other VSMs and their performance assessment; 3. Performance management systems in place for those in the positions mentioned above and its application; 4. Proposals to make additional payments to medical Consultants outside of normal terms and conditions; 5. Proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the provision of the Regulations and in accordance with Ministerial instructions; 6. Consider and approve Voluntary Early Release applications and redundancy/severance payments in respect of Executive Director/Director posts, in line with Standing Orders and extant Welsh Government guidance. The Committee to be advised also of all Voluntary Early Release Scheme applications and severance payments; 7. Approve any Strategic Advisor arrangements, including scope and pay; 8. To approve the University Health Board's honours submission recommendations. 			Standing Orders and Scheme of delegation
CGC 14	The attendance record of individual board members should be disclosed in the governance statement and cover meetings of the board and its committees held in the period to which the resource accounts relate. (4.6)	<p>Board Members attendance record for Board and Committees is captured in the Accountability Report on annual basis.</p> <p>Attendance at meetings is also considered at annual appraisal discussions.</p>	N/A	Comply	Accountability Report
CGC 15	Where necessary, board members should seek clarification or amplification on board issues or board papers through the board secretary. The board secretary will consider how officials can best support the work of board members; this may include providing board members with direct access to officials where appropriate. (4.10)	<p>This is the relationship between the DoCG/Board Secretary and the Board Members. Before each Board meeting, there is a meeting with the Chair, IMs and the Board Secretary to discuss the Board papers.</p> <p>The role of the DoCG/Board Secretary is to act as principal advisor to the Board and the organisation as a whole on all aspects of governance and to ensure that it meets the standards of good governance set for the NHS in Wales.</p> <p>Regular IM meetings with Chair and DoCG/Board Secretary.</p> <p>Chairs of committees have also retained a touchpoint meeting with the relevant lead executive officer between committee meetings.</p>	N/A	Comply	Board Secretary role description Standing Orders
CGC 16	An effective board secretary is essential for an effective board. Under the direction	DoCG/Board Secretary works closely with the Chair and Chief Executive to agree the next Board agenda following each	Title: AW Structured Assessment	Comply	AW Structured Assessment report 2025

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
	<p>of the Welsh Government, the board secretary's responsibilities should include:</p> <ul style="list-style-type: none"> developing and agreeing the agenda for board meetings with the chair and lead non-executive board member, ensuring all relevant items are brought to the board's attention ensuring good information flows within the board and its committees and between senior management and non-executive board members, including: challenging and ensuring the quality of board papers and board information ensuring board papers are received by board members according to a timetable agreed by the board providing advice and support on governance matters and helping to implement improvements in the governance structure and arrangements ensuring the board follows due process providing assurance to the board that the organisation complies with government policy, as set out in the code adheres to the code's principles and supporting provisions on a comply or explain basis (which should form part of the report accompanying the resource accounts) acting as the focal point for interaction between non-executive board members and the organisation, including arranging detailed briefing for non-executive board members and meetings between non-executive board members and officials, as requested or appropriate recording board decisions accurately and ensuring action points are followed up arranging induction and professional development of board members (including ministers) <p>4.11</p>	<p>meeting. Board agendas are based on the Board Workplan which is updated after each meeting. The DoCG/Board Secretary meets regularly with the Chair.</p> <p>Each Committee provides a report to Board after every meeting. Items for approval by Board are generally scrutinised by relevant Committee ahead of decision-making at Board.</p> <p>DoCG/Board Secretary attends Health Board Chairs and Independent Board Members meeting prior to Board to discuss agenda and papers.</p> <p>Papers are issued at least 5 clear days prior to each meeting in accordance with Standing Orders.</p> <p>DoCG/Board Secretary provides advice on governance matters, structures and arrangements.</p> <p>DoCG/Board Secretary ensures minutes are recorded, with table of action and decision log maintained.</p> <p>DoCG/Board Secretary led on the development of interactive handbook for IMs.</p> <p>DoCG/Board Secretary meets regularly with the Chair to discuss governance.</p> <p>DoCG/Board Secretary ensures that robust induction programme for IMs, as well as ongoing development through a formal Board Development Programme.</p>	<p>Reference Point: Board effectiveness and openness – Paragraph 10-36</p>		<p>Director of Corporate Governance/Board Secretary role description</p> <p>Standing Orders</p> <p>IM Handbook</p> <p>Board and Committees Decision log and Table of Actions</p>
CGC 17	<p>Evaluations of the performance of individual board members should show whether each continues to contribute effectively and corporately and</p>	<p>Board Member Appraisal process in place.</p> <p>Annual Committee Effectiveness Assessments undertaken.</p>	N/A	Comply	<p>Accountability Report</p> <p>Appraisal Documentation and Process</p>

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
	demonstrates commitment to the role (including commitment of time for board and committee meetings and other duties). 4.14	Attendance record reported in Accountability Report.			Committee Self-Assessment Reports
CGC 18	All potential conflicts of interest for non-executive board members should be considered on a case by case basis. Where necessary, measures should be put in place to manage or resolve potential conflicts. The board should agree and document an appropriate system to record and manage conflicts and potential conflicts of interest of board members. The board should publish, in its governance statement, all relevant interests of individual board members and how any identified conflicts, and potential conflicts, of interest of board members have been managed. 4.15	<p>The Health Board has an agreed process in place for managing Declarations of Interest.</p> <p>All Board Members are asked to formally declare on an annual basis and advised of their responsibility to notify of any changes in year.</p> <p>Declarations of interest are captured on a register which is available for public inspection, a link to which is included in the Accountability Report.</p> <p>A report on Declarations of Interest is received by the Audit and Risk Assurance Committee on an annual basis.</p> <p>Declarations of Interest are captured at the start of each Board and Committee meeting.</p> <p>The Standards of Behaviour Policy details the responsibility under Declarations of Interest.</p> <p>Standing Orders also outlines the responsibilities for Declarations of Interest.</p> <p>The Declarations of Interest form includes how declarations and potential conflicts are managed and these are recorded on the register.</p>	<p>Title: AW Structured Assessment</p> <p>Reference Point: Board effectiveness and openness – Paragraph 10-36</p>	Comply	<p>AW Structured Assessment report 2025</p> <p>Standards of Behaviour Framework Policy</p> <p>Accountability Report</p> <p>Standing Orders</p> <p>Declarations of Interest Process and Register</p> <p>Annual Report of the Adequacy of Arrangements for Declaring, Registering and Handling Interests, gifts and Hospitality presented to Audit and Risk Assurance Committee</p>
CGC 19	The board should ensure that there are effective arrangements for governance, risk management and internal control for the whole organisational family. Advice about and scrutiny of key risks is a matter for the board, not a committee. The board should be supported by: <ul style="list-style-type: none"> an audit and risk assurance committee, chaired by a suitably experienced non-executive board member an internal audit service operating to <i>Public Sector Internal Audit Standards</i>¹ (5.1 and 5.8)	<p>The Audit and Risk Assurance Committee is chaired by an experienced IM, supported by a Vice-Chair with a financial background.</p> <p>NWSSP Internal Audit Services are appointed as the Health Board's Internal Auditors. The Annual Internal Audit Plan is informed by the Board Assurance Framework, Corporate Risk Register, and previous audit work as appropriate.</p> <p>The Board has approved its Risk Management Framework and its latest Risk Management Strategy in September 2026.</p> <p>ARAC is provided with assurance on risk management activities through the Risk Assurance Report. This also includes an annual risk maturity assessment.</p>	<p>Title: AW Structured Assessment</p> <p>Reference Point: Providing board assurance – paragraph 37 - 42</p>	Comply	<p>AW Structured Assessment report 2025</p> <p>Terms of Reference & Operating Arrangements for the Audit and Risk Assurance Committee.</p> <p>Accountability Report</p> <p>Board Approved Risk Management Framework</p> <p>Board Approved Risk Management Strategy</p> <p>Risk Assurance Reports to ARAC</p>

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
CGC 20	<p>The board should take the lead on, and oversee the preparation of, the organisation's governance statement for publication with its resource accounts each year.</p> <p>The annual governance statement (which includes areas formerly covered by the statement on internal control) is published with the resource accounts each year. In preparing it, the board should assess the risks facing the organisation and ensure that the organisation's risk management and internal control systems are effective. The audit and risk assurance committee should normally lead this assessment for the board (5.2 and 5.13)</p>	<p>The Governance Statement is included within the Accountability Report which is received by the Audit and Risk Assurance Committee to endorse prior to approval formally by the Board each year.</p>	<p>Audit Wales and Internal Audit receive and review the Accountability Report for comment and ensuring compliance with the Manual for Accounts.</p>	<p>Comply</p>	<p>Accountability Report</p> <p>Board and Committee Minutes</p> <p>Annual Report Timetable</p>
CGC 21	<p>The board's regular agenda should include scrutinising and advising on risk management (5.3 and 5.10)</p>	<p>The Health Board has approved the following key documents within the Health Board:</p> <ul style="list-style-type: none"> • Risk Management Framework • Risk Management Strategy <p>During 2025/26, the Health Board receives the Corporate Risk Register at every other meeting as part of the CEO Report. The Board Assurance Framework was reported to the Board in July and November 2025 and is currently being updated following the Strategy Refresh approved by Board in January 2026.</p> <p>The Risk Appetite and tolerance levels are defined and approved by the Board.</p> <p>The Audit and Risk Assurance Committee provide assurance to the Board on the Risk and Assurance Framework.</p>	<p>Title: AW Structured Assessment</p> <p>Reference Point: Providing board assurance – paragraph 37 - 42</p>	<p>Comply</p>	<p>Board Cycle of Business</p> <p>AW Structured Assessment report 2025</p> <p>Corporate Risk Register reports to Board and Committees</p> <p>Operational Risk Reports to Committees and Sub-Committees of the Board</p> <p>Board Assurance Framework Reports to Board</p> <p>Board approved Risk Appetite Statement</p> <p>Committee Update Reports to the Board</p>
CGC 22	<p>The key responsibilities of non-executive board members include forming an audit and risk assurance committee.</p> <p>The board and accounting officer should be supported by an audit and risk assurance committee, comprising at least three members.</p> <p>An audit and risk assurance committee should not have any executive responsibilities or be charged with making or endorsing any decisions. It should take care to maintain its independence. The audit and risk assurance committee should be established and function in</p>	<p>Standing Orders are explicit that the Health Board as a minimum must establish Committees that cover certain aspects, one of which is the Audit and Risk Assurance Committee. The Audit and Risk Assurance Committee was established in 2010.</p> <p>The Terms of Reference and Operating Arrangements in respect of the Audit and Risk Assurance Committee are clear in relation to its authority and delegated responsibilities. These include the review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical.</p> <p>DoCG/Board Secretary is the lead officer for the Audit and Risk Assurance Committee, however only IMs are 'members',</p>	<p>Title: AW Structured Assessment</p>	<p>Comply</p>	<p>Standing Orders</p> <p>Terms of Reference for the Audit and Risk Assurance Committee</p> <p>Internet Site: Board Papers, Standing Orders and Statutory Committees of the Board webpages</p> <p>Audit and Risk Assurance Committee Annual Report</p> <p>AW Structured Assessment report 2025</p>

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
	<p>accordance with the <i>Audit and risk assurance committee handbook</i>.</p> <p>The board should ensure that there is adequate support for the audit and risk assurance committee, including a secretariat function.</p> <p>The terms of reference of the audit and risk assurance committee, including its role and the authority delegated to it by the board, should be made available publicly. The organisation should report annually on the work of the committee in discharging those responsibilities</p> <p>Boards should ensure the scrutiny of governance arrangements, whether at the board or at one of its subcommittees (such as the audit and risk assurance committee or a nominations committee). This will include advising on, and scrutinising the organisation's implementation of, corporate governance policy. (5.4 and 5.9, 5.11, 5.12 and 5.14 and 5.15)</p>	<p>of which there are four. Officer members are invited to attend for individual agenda items.</p> <p>Full secretariat function in place supporting the Audit and Risk Assurance Committee, with the DoCG/Board Secretary undertaking Lead Director role for the Committee.</p> <p>The Audit and Risk Assurance Committee Terms of Reference are published as an appendix to the Standing Orders on the Health Board's website.</p> <p>The Audit and Risk Assurance Committee also has its own webpage which publishes the Terms of Reference and papers for each meeting.</p> <p>Audit and Risk Assurance Committee Annual Report produced and presented to Board.</p> <p>The focus of the AW Structured Assessment is to review the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on Board transparency, cohesion, and effectiveness, corporate systems of assurance, corporate approach to planning, and corporate approach to financial management. The findings are reported to Board and the Audit and Risk Assurance Committee.</p>			
CGC 22	<p>The head of internal audit (HIA) should periodically be invited to attend board meetings, where key issues are discussed relating to governance, risk management processes or controls across the organisation and its ALBs (5.5)</p>	<p>The role of the HIA is clearly set out in Standing Orders.</p> <p>The HIA attends all Audit and Risk Assurance Committee meetings which report to Board.</p> <p>Audit and Risk Assurance Committee Terms of Reference state that the HIA has access to the Committee Chair.</p> <p>The HIA has a private meeting with members of the Audit and Risk Assurance Committee at least once a year.</p> <p>If there was anything specifically escalated to the Board then the HIA would be invited to attend.</p> <p>DoCG/Board Secretary has weekly meetings with HIA.</p> <p>Regular meetings between Chair of Audit and Risk Committee, HIA and CoCG/Board Secretary.</p>	N/A	Comply	<p>Standing Orders</p> <p>Terms of Reference for the Audit and Risk Assurance Committee</p> <p>Internet Site: Audit and Risk Assurance Committee webpage</p>
CGC 23	<p>The board should assure itself of the effectiveness of the organisation's risk management system and procedures and its internal controls. The board should give a clear steer on the desired risk appetite for the organisation and ensure that:</p>	<p>The Health Board approved the following key documents within the Health Board:</p> <ul style="list-style-type: none"> Risk Management Framework which sets out the foundation and organisational arrangements for supporting the risk management process in Hywel Dda Risk Management Strategy which sets out the key risk management objectives that the Health Board wants to achieve for the next 18 months. 	<p>Title: AW Structured Assessment</p> <p>Reference Point: Corporate Systems of Assurance – Paragraph 43-62.</p>	Comply	<p>AW Structured Assessment report 2025</p> <p>Risk Management Framework</p> <p>Risk Management Strategy</p> <p>Corporate Risk Register reports to Board and Committees</p>

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
	<ul style="list-style-type: none"> there is a proper framework of prudent and effective controls, so that risks can be assessed, managed and taken prudently there is clear accountability for managing risks organisational officials are equipped with the relevant skills and guidance to perform their assigned roles effectively and efficiently. <p>Advising on key risks is a role for the board. The audit and risk assurance committee should support the board in this role.</p> <p>(5.6, 5.7 and 5.10)</p>	<p>The Health Board's Risk Management Framework is based on the 3 lines of Defence model whereby management control is the first line of defence in managing risk, the various specialist functions such as Finance, Workforce, Quality, etc are the second line of defence, with the third line provided by independent assurance on effectiveness of the risk management framework.</p> <p>The Audit and Risk Assurance Committee receive a Risk Assurance Report which provides assurance on the effectiveness of the risk management framework and the implementation of the Risk Management Strategy.</p> <p>The Health Board has agreed and implemented its Risk Appetite and Tolerance levels.</p> <p>Managers take a lead on risk management and are responsible for role modelling a risk aware culture within their area. Managers receive training 121 training on the Health Board's Risk Information Management System.</p> <p>Tools, procedures and guides are available on the staff intranet site.</p> <p>Operational services are challenged on their risk management through the Executive operational Risk Reviews</p> <p>The Board receives the Board Assurance Framework and the Corporate Risk Register 3 times a year (BAF was received by Board twice in 2025/26 due to Strategy Refresh). Principal risks and corporate risks are aligned to the Board's Committees who ensure that risks are being effectively managed on behalf of the Board. These are reported to Committee as part of the Assurance and Risk Report.</p> <p>The Health Board makes an annual assessment of its risk maturity which is reported the Audit and Risk Assurance Committee as part of the Risk Assurance Report.</p>			<p>Operational Risk Reports to Committees and Sub-Committees of the Board</p> <p>Board Assurance Framework Reports to Board</p> <p>Internet Site: Board Papers, Standing Orders and Statutory Committees of the Board webpages</p> <p>Staff intranet: risk management webpage</p> <p>Terms of Reference for the Audit and Risk Assurance Committee</p> <p>Committee Update Reports</p> <p>Risk Assurance Reports</p> <p>Risk Maturity Assessments</p> <p>Risk Training Presentation</p>

4.5

11:20, 5 Mins

4.5 - Audit Enquiries to those Charged with
Governance and Management

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

| For approval

Attachments

[4.5 Audit Enquiries 2025-26.pdf](#)

[4.5 Appendix 1 - HD UHB Audit Enquiries Letter 2025-26.pdf](#)

**PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	07 May 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit Enquiries To Those Charged With Governance and Management
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Huw Thomas, Executive Director of Finance

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

Both the management of Hywel Dda University Health Board and 'those charged with governance' (the Board) must provide reasonable assurance to the Auditor General for Wales that the financial statements taken as a whole are free from material misstatement whether caused by fraud or error.

The Audit and Risk Assurance Committee (ARAC) is asked to note the evidence requested by Audit Wales to gain this assurance. A draft response is attached for review by ARAC that, subject to any amendment, will be forwarded to Audit Wales to meet the required deadline of 31 May 2026.

Cefndir / Background

The Auditor General for Wales is responsible for obtaining reasonable assurance that the financial statements taken as a whole are free from material misstatement whether caused by fraud or error.

Assurance is sought, in compliance with the International Standard for Auditing (UK and Ireland), in relation to four main areas namely fraud, laws and regulations, regularity and related party relationships and transactions that impact on the audit of the financial statements.

Asesiad / Assessment

The letter (attached at Appendix 1) details the assurance required, from both the management of Hywel Dda University Health Board and 'those charged with governance' (the Board), together with the evidence provided, in response to a number of governance areas that impact on the audit of the financial statements.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to review the response prepared and, subject to any required amendment, ratify for onward submission to Audit Wales.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.25 The Committee shall review the Annual Accounts and Financial Statements before submission to the Board, focusing particularly on: 3.25.1 the ISA 260 report to those charged with governance; 3.25.2 changes in, and compliance with, accounting policies and practices; 3.25.3 unadjusted mis-statements in the financial statements; 3.25.4 major judgemental areas; 3.25.5 significant adjustments resulting from the audit; 3.25.6 other financial considerations include review of the Schedule of Losses and Compensation.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	The Board's system of Internal Control and related processes.
Rhestr Termiau: Glossary of Terms:	Included within body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg	Not applicable

Parties / Committees consulted prior to Audit and Risk Assurance Committee:	
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Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	A sound system of financial control safeguards public funds and the Health Board's assets and resources. Robust governance arrangements underpinning financial management contribute towards internal control and value for money being achieved.
Ansawdd / Gofal Claf: Quality / Patient Care:	No specific impact
Gweithlu: Workforce:	No specific impact
Risg: Risk:	No specific impact
Cyfreithiol: Legal:	Compliance with statutory responsibilities
Enw Da: Reputational:	Provides assurance regarding governance
Gyfrinachedd: Privacy:	No specific impact
Cydraddoldeb: Equality:	No specific impact

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Professor Philip Kloer
Chief Executive
Hywel Dda University Health Board

Reference: HDUHB 2025-26

Date issued: 25 March 2026

Dear Philip,

Audit enquiries to those charged with governance and management

We write to make enquiries of both those charged with governance and management. The Auditor General's Statement of Responsibilities sets out that he is responsible for obtaining reasonable assurance that the financial statements taken as a whole are free from material misstatement, whether caused by fraud or error. It also sets out the respective responsibilities of auditors, management and those charged with governance.

This letter and the enclosed tables formally seek the documented consideration and understanding of a number of governance areas, which impact our audit of the financial statements.

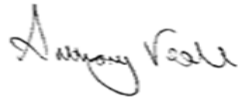
There is a section for management; one for 'those charged with governance' (the Board); and a section with background information.

The responses will inform our understanding of the Health Board and its business processes; and support our work in providing an audit opinion on your 2025-26 financial statements.

The completed tables should be formally considered and communicated to us, on behalf of both management and those charged with governance, by 31 May 2026. We have also included the 2024-25 responses for reference.

In the meantime, if you have queries, please contact David Williams on 02920 829326 and David.Williams@audit.wales or myself on 07896 271873 and Anthony.Veale@audit.wales.

Yours sincerely

A handwritten signature in black ink that reads "Anthony Veale". The signature is written in a cursive style with a large initial 'A'.

Anthony Veale

Engagement Director

CC Mr Huw Thomas, Director of Finance

Enquiries of management

General enquiries (including financial reporting) of management		
Question	2024-25 Response	2025-26 Response
<p>1. Are there significant matters and/or events that have occurred since April 2025 that could influence our audit approach or the Health Board's financial statements?</p>	<p>In 2024/25, the Health Board was unable to meet its statutory duties to breakeven over a rolling three-year period and to prepare a three-year Integrated Medium-Term Plan for approval by the Minister for Health and Social Services, in line with NHS Finance (Wales) Act 2014. Therefore, was not able to comply with both planning and finance statutory duties.</p> <p>However, the Health Board was allocated additional funding by Welsh Government (WG) in year. As a consequence, WG also set a revised Target Control Total of £31.55m. The Health Board has achieved the revised control total with a year-end deficit of £24.1m (subject to audit).</p> <p>Having placed the entire Health Board in 'targeted intervention' in January 2024, WG has de-escalated three areas to enhanced monitoring due to the progress seen. The three de-escalated areas are Child and Adolescent Health and Mental Health (CAHMS), Planned Care, and Leadership and Governance. While this is a positive step forward, it</p>	<p>In 2025/26, the Health Board was neither able to meet its statutory duties to breakeven over a rolling three-year period nor to prepare a three-year Integrated Medium-Term Plan for approval by the Minister for Health and Social Services, in line with NHS Finance (Wales) Act 2014. Therefore, was not able to comply with both planning and finance statutory duties.</p> <p>The Health Board submitted a deficit plan for £31.5m in March 2025 but was advised by Welsh Government (WG) that as a minimum that it would need to achieve the 2024/25 deficit of £24.1m. The Health Board committed to deliver this improved control total by increasing savings and reducing discretionary investments. Subsequent to providing funding for Welsh Risk Pool and Band 2 to 3 re-banding additional costs, WG issued the Health Board with a revised target control total of £22.1m. The Health Board has delivered a deficit of £22.1m (subject to audit).</p>

General enquiries (including financial reporting) of management

Question	2024-25 Response	2025-26 Response
	<p>is acknowledged that pressures remain across the organisation.</p>	<p>The entire Health Board was placed in ‘targeted intervention’ in early 2024. The escalation status set out improvements needed in six key areas. Progress continues to be made. The WG escalation assessment in February 2026 shows leadership and governance and performance related to cancer at level 1 meaning they are no longer escalated. Planned Care is at level 3. However, pressures remain with finance, strategy and planning and urgent and emergency care all at level 4.</p>
<p>2. What are your general views on the Health Board’s risk assessment process relating to financial reporting?</p>	<p>The risk assessment process for financial reporting follows the Health Board risk management framework.</p> <p>The Health Board has a ‘monitoring and review’ structure in place to ensure risks are effectively identified and assessed and that appropriate controls and responses are in place.</p> <p>The Sustainable Resources Committee* is responsible for scrutinising and seeking assurance on behalf of the Board that the risks relating to financial reporting on the Corporate Risk Register are being appropriately managed and mitigated in</p>	<p>The risk assessment process for financial reporting follows the Health Board risk management framework.</p> <p>The Health Board has a ‘monitoring and review’ structure in place to ensure risks are effectively identified and assessed and that appropriate controls and responses are in place.</p> <p>The Finance and Performance Committee is responsible for scrutinising and seeking assurance on behalf of the Board that the risks relating to financial reporting on the Corporate Risk Register are being appropriately managed and mitigated in</p>

General enquiries (including financial reporting) of management

Question	2024-25 Response	2025-26 Response
	<p>accordance with the risk management framework. The Audit and Risk Assurance Committee (ARAC) provide assurance on financial compliance on behalf of the Board.</p> <p>The Executive Team has approved the content of the Corporate Risk Register prior to this being discussed at both Board and Committee level. Risks have been identified via a top-down and bottom-up approach. The Sustainable Resources Committee* ensures that the risks assigned to it are being managed appropriately, taking into account gaps, planned actions and agreed tolerances, and to provide assurance regarding the management of these risks to the Board through Committee Update Reports.</p> <p>*Following a review of Committee structures the Sustainable Resources Committee will be disestablished from 31 March 2025 and a Finance and Performance Committee established from 1 April 2025 that will take over the scrutiny of the risks relating to financial reporting.</p>	<p>accordance with the risk management framework. The Audit and Risk Assurance Committee (ARAC) provide assurance on financial compliance on behalf of the Board.</p> <p>The Executive Team has approved the content of the Corporate Risk Register prior to this being discussed at both Board and Committee level. Risks have been identified via a top-down and bottom-up approach. The Finance and Performance Committee ensures that the risks assigned to it are being managed appropriately, taking into account gaps, planned actions and agreed tolerances, and to provide assurance regarding the management of these risks to the Board through Committee Update Reports.</p>

General enquiries (including financial reporting) of management

Question	2024-25 Response	2025-26 Response
<p>3. Are you aware of significant transactions that are outside the normal trading activities of the Health Board's business?</p>	<p>There are no significant transactions outside the normal trading activities of the Health Board's business.</p>	<p>There are no significant transactions outside the normal trading activities of the Health Board's business.</p>
<p>4. Are you aware of any transactions, events or changes in circumstances that would cause impairments of the Health Board's non-current assets (i.e. its fixed assets, such as land and buildings)?</p>	<p>Reinforced Autoclaved Aerated Concrete has been identified at Withybush Hospital and detailed surveys identified those planks which required urgent remediation work. A significant programme of capital works has completed in March 2025.</p> <p>The District Valuer has made an impairment assessment as of March 2025 for those capital works completed during 2024/25 which has been reflected within the Annual Accounts.</p> <p>Planks will continue to be monitored via annual surveys and assessments will be made whether there could be any additional impairments.</p>	<p>Reinforced Autoclaved Aerated Concrete has been identified at Withybush Hospital. A significant programme of capital works was undertaken to those planks which required urgent remediation work during 2023/24 and 2024/25. This resulted in an impairment.</p> <p>During 2025/26 affected planks were monitored via surveys with minimal remediation work required.</p> <p>They will continue to be monitored annually and assessments of additional impairments will be made if there is a significant deterioration.</p>
<p>5. Are you aware of any transactions, events and conditions (or changes in</p>	<p>Due to the timescale available to complete the accounts, significant estimates have been made for primary care expenditure where the actual</p>	<p>Due to the timescale available to complete the accounts, significant estimates have been made for primary care expenditure where the actual</p>

General enquiries (including financial reporting) of management

Question	2024-25 Response	2025-26 Response
these) that may give rise to recognition or disclosure of significant accounting estimates that require significant judgement?	amounts are not known prior to account submission. This includes – primary care prescribing, general medical services and community pharmacy. There is also an estimate for the Band 2 to 3 Healthcare Support Worker (HCSW) re-banding issue.	amounts are not known prior to account submission. This includes – primary care prescribing, general medical services and community pharmacy. There is also a further estimate for the Band 2 to 3 Healthcare Support Worker (HCSW) re-banding issue as the process has not concluded in 2025/26.
6. Does the Health Board have any new estimates in respect of the 2025-26 year of account?	The Band 2 to 3 Healthcare Support Worker (HCSW) re-banding issue.	No new estimates.
7. Have there been any issues that may impact the preparation of the 2025-26 financial statements?	None of which we are aware.	None of which we are aware.
8. Do you have knowledge of events or conditions beyond the period of the going	None of which we are aware. However, cash continues to be a significant issue. The Health Board is highly likely to utilise its cash allocation	None of which we are aware. However, cash continues to be a significant issue. The Health Board is highly likely to utilise its cash allocation

General enquiries (including financial reporting) of management

Question	2024-25 Response	2025-26 Response
<p>concern assessment that may cast significant doubt on the Health Board’s ability to continue as a going concern?</p>	<p>prior to financial year end with no line of sight at present as to how this shortfall will be managed without support from Welsh Government.</p>	<p>prior to financial year end with no line of sight at present as to how this shortfall will be managed without support from Welsh Government.</p>
<p>9. Are there any issues around the use of service organisations or common functions, including uncorrected misstatements from service organisations? This would include the NHS Wales Shared Services Partnership.</p>	<p>None of which we are aware. Details of the performance of the NHS Wales Shared Services Partnership are routinely reported through Board meetings.</p>	<p>None of which we are aware. Details of the performance of the NHS Wales Shared Services Partnership are routinely reported through Board meetings.</p>
<p>10. Please provide information on the status of the disclosed contingencies from the prior year.</p>	<p>The movement on contingent liabilities is disclosed within the 24/25 annual accounts.</p>	<p>The movement on contingent liabilities is disclosed within the 25/26 annual accounts.</p>

Enquiries of management - in relation to fraud

Question	2024-25 Response	2025-26 Response
<p>11. What is management's assessment of the risk that the financial statements may be materially misstated due to fraud? What is the nature, extent and frequency of management's assessment?</p>	<p>The Counter Fraud team is not aware of any incidents of fraud that would impact materially on the Health Board's financial statements. As such, the risk is deemed minimal.</p> <p>The Health Board has in place financial controls and standard operating procedures to mitigate the risk of financial misstatements. Furthermore, the Health Board's Counter Fraud strategy includes a series of proactive measures to mitigate this risk, which includes developing a counter fraud culture and raising awareness of the risks identified.</p> <p>The risk assessment process for financial reporting follows the Health Board risk management framework. The Health Board has a 'monitoring and review' structure in place to ensure risks are effectively identified and assessed and that appropriate controls and responses are in place. To date, no fraud themes have been identified and reported to the Local Counter Fraud Specialists (LCFS).</p>	<p>The Counter Fraud team has not identified any instances of fraud that would have a significant impact on the Health Board's financial statements and therefore considers the risk to be minimal. Robust financial controls and established standard operating procedures are in place to help prevent financial misstatements. In addition, the Health Board's Counter Fraud strategy incorporates a range of proactive measures, including a risk management approach and initiatives designed to foster a strong counter fraud culture throughout the organisation, addressing both current and emerging threats.</p> <p>The assessment of risks related to financial reporting aligns with the Health Board's risk management framework. A comprehensive 'monitoring and review' structure ensures that risks are appropriately identified and evaluated, with suitable controls and responses implemented to manage those risks effectively.</p>
<p>12. Do you have knowledge of any actual, suspected or</p>	<p>Yes, but nothing which would affect the materiality level. All cases are recorded on a national database, which is overseen by Counter Fraud Services Wales,</p>	<p>Yes, although nothing has occurred that would impact the materiality threshold. All cases are logged in a national database managed by Counter Fraud Services</p>

Enquiries of management - in relation to fraud

Question	2024-25 Response	2025-26 Response
<p>alleged fraud affecting the Health Board?</p>	<p>who review and approve all new referrals and case closures.</p> <p>All cases are reported to ARAC sessions, including any outcomes that pose a risk to the organisation.</p> <p>During 2024/25, the Counter Fraud Team has actively investigated and closed 56 reports of financial crime. 11 cases remain open and under review and will be carried over into the next financial year.</p> <p>Of the investigations that were closed, 4 criminal sanctions were applied, including 1 successful prosecution at Aberystwyth Magistrates Court and 3 Police Cautions. A further 12 civil sanctions were instigated, including the recovery of funds totaling £56,106. There were 8 internal disciplinary referrals, of which 2 members of staff resigned prior to the completion of proceedings and 4 members of staff received written warnings. This is in addition to the proactive activities undertaken and reported throughout the year. Given this work, it is reasonable to conclude the accounts have not been subject to a risk of material fraud.</p>	<p>Wales, who are responsible for reviewing and approving both new referrals and the closure of cases.</p> <p>Cases are reported at ARAC meetings, including those outcomes that present any organisational risk. In the 2025/26 period, the Counter Fraud Team carried forward 11 active cases from the previous year and registered 60 new referrals, all of which were investigated and subsequently closed.</p> <p>At the close of the financial year, 11 cases remain open and under review, to be carried forward into the next year. From the cases concluded, 7 civil sanctions were imposed, resulting in the recovery of funds totalling £99,627, as well as 2 internal disciplinary referrals. These outcomes are in addition to the proactive measures undertaken and reported throughout the year.</p>

Enquiries of management - in relation to fraud

Question	2024-25 Response	2025-26 Response
<p>13. What is management's process for identifying and responding to the risks of fraud in the Health Board, including any specific risks of fraud that management has identified or that have been brought to its attention?</p>	<p>The Health Board has a Counter Fraud Policy & Response Plan which includes the overall strategic aims of counter fraud work and operational response aligned to the NHS Counter Fraud Authority (NHSCFA) counter fraud, bribery, and corruption strategy. The Health Board Standards of Behaviour Policy incorporates professional behaviour with reference to fraud, corruption, and the Bribery Act 2010.</p> <p>To assist in the development of a robust CF culture within the organisation, the Policy is actively promoted within the Health Board's programme of awareness. In addition, a mandatory online ESR CF training package is in place for all staff.</p> <p>A top-down approach to maintaining professional scepticism, by way of collaborative working with directorates and the Director of Corporate Governance (Board Secretary), who is the Health Board's appointed Fraud Champion. This provides a level of support to the Counter Fraud function which is independent of the Executive Leadership and management of the Executive Director of Finance, who is responsible for the provision of the Counter Fraud Service.</p> <p>Collaborative work and sharing of information across Wales with both NHS and Non-NHS bodies is undertaken to appropriately identify known fraud and</p>	<p>The Health Board operates a Counter Fraud Policy and Response Plan, detailing both strategic objectives and operational procedures for tackling fraud, in accordance with the NHS Counter Fraud Authority's approach to fraud, bribery, and corruption. The Standards of Behaviour Policy further sets out expectations for professional conduct, referencing fraud, corruption, and the Bribery Act 2010.</p> <p>To foster a strong counter fraud culture, the Policy is actively promoted through the Health Board's awareness initiatives. Additionally, all staff are required to complete a mandatory online ESR Counter Fraud training package.</p> <p>A top-down method is applied to encourage professional scepticism, involving close collaboration with directorates and the Director of Corporate Governance (Board Secretary), who serves as the Health Board's designated Fraud Champion. This structure ensures that support for the Counter Fraud function remains independent from the Executive Leadership and the Executive Director of Finance, who oversees the Counter Fraud Service.</p>

Enquiries of management - in relation to fraud

Question	2024-25 Response	2025-26 Response
	<p>associated risks. This is supported by the National Fraud Initiative, which assists in identifying public sector fraud across multiple sectors.</p> <p>Risks identified at a service level or via the LCFS are assessed in line with Health Board procedure and where applicable they are recorded on Datix. Risks with a fraud theme can be raised by service users on Datix, which in turn get reported to the LCFS. Fraud risks identified will be reported to ARAC (in-Committee) and those applicable will be recorded on the Health Board’s Risk Register.</p> <p>In terms of proactive management, the LCFS are the primary point of contact for all economic crime concerns within the Health Board. They are professionally trained and accredited and equipped to respond to any concerns raised by staff.</p>	<p>Information sharing and collaborative efforts across Wales, involving NHS and non-NHS organisations, are undertaken to effectively identify known fraud cases and associated risks. The National Fraud Initiative supports these activities by helping to detect public sector fraud across various sectors.</p> <p>Risks discovered at the service level or through the Local Counter Fraud Specialist (LCFS) are evaluated in accordance with Health Board procedures and, where appropriate, documented on Datix. Fraud-related risks can also be reported by service users on Datix and are subsequently notified to the LCFS. Identified fraud risks are reported to ARAC (in-Committee) and, when relevant, recorded on the Health Board’s Risk Register.</p> <p>The LCFS are the main contact point for all matters relating to economic crime within the Health Board. They possess professional training and accreditation, equipping them to address any concerns raised by staff.</p>
<p>14. What classes of transactions, account balances and disclosures,</p>	<p>The cyber element of Mandate Fraud means that the risk of fraud in this area is ever evolving and present, although significant controls have been implemented</p>	<p>The risk assessment process for financial reporting follows the Health Board risk management framework. The Health Board has a ‘monitoring and review’</p>

Enquiries of management - in relation to fraud		
Question	2024-25 Response	2025-26 Response
<p>within the financial statements, have you identified as most at risk of fraud?</p>	<p>to mitigate its impact on the organisation. These controls have directly resulted in the identification of suspicious invoices prior to them being actioned.</p> <p>The risk assessment process for financial reporting follows the Health Board risk management framework. The Health Board has a 'monitoring and review' structure in place to ensure risks are effectively identified and assessed and that appropriate controls and responses are in place.</p> <p>To date, no fraud themes have been identified and reported to the Local Counter Fraud Specialists (LCFS), however, areas of risk have been identified internally and these centre around procurement of goods and services.</p>	<p>structure in place to ensure risks are effectively identified and assessed and that appropriate controls and responses are in place.</p> <p>From a Health Board perspective and reflecting common locally identified fraud risk themes (e.g., those consistently highlighted through LCFS work and counter-fraud reporting), the financial statement areas typically assessed as most at risk of fraud are:</p> <p>Non-pay expenditure (procurement and accounts payable): fictitious suppliers, invoice splitting to bypass controls, duplicate/altered invoices, conflicts of interest, contract leakage, overbilling, payments for goods/services not received.</p> <p>In response to these themes, relevant proactive work will be undertaken to assess and mitigate associated risks.</p>
<p>15. Are you aware of any whistleblowing or complaints by potential whistle-blowers? If so,</p>	<p>We are not aware of any whistleblowing or complaints of potential whistle-blowers relating to fraudulent activity.</p>	<p>There have been no reports or complaints from whistle-blowers regarding fraudulent activity that we are aware of. If any concerns are raised, the Health</p>

Enquiries of management - in relation to fraud		
Question	2024-25 Response	2025-26 Response
what has been the Health Board's response?	<p>Should a concern be received the Health Board would follow the process outlined in the All Wales Raising Concerns Policy.</p> <p>As stated, concerns of Fraud have been raised and these have been recorded and investigated. Please see question 12 for further information.</p>	<p>Board will adhere to the procedures set out in the All Wales Raising Concerns Policy.</p> <p>Instances of suspected fraud have been reported, documented, and investigated. For more details, please refer to question 12.</p>
16. What is management's communication to those charged with governance (the Board) regarding their processes for identifying and responding to risks of fraud?	<p>The steps undertaken are outlined in question 13.</p> <p>The LCFS attends all meetings of ARAC and regularly presents reports on counter fraud activity and any material changes to the annual work plan.</p> <p>Fraud risks / themes are recorded internally by CF and details are provided to relevant risk owners. Each risk is then assessed and where applicable, outcomes are reported in line with HB policy and in line with CF guidance, which includes, reporting each exercise as a piece of pro-active work on the counter fraud national crime recording system, Clue3.</p>	<p>The steps undertaken are outlined in question 13.</p> <p>The LCFS attends all meetings of ARAC and regularly presents reports on counter fraud activity and any material changes to the annual work plan.</p> <p>Fraud risks / themes are recorded internally by CF and details are provided to relevant risk owners. Each risk is then assessed and where applicable, outcomes are reported in line with HB policy and in line with CF guidance, which includes, reporting each exercise as a piece of pro-active work on the counter fraud national crime recording system, Clue3.</p>

Enquiries of management - in relation to fraud

Question	2024-25 Response	2025-26 Response
<p>17. What is management's communication to employees regarding their views on business practices and ethical behaviour?</p>	<p>The Health Board Standing Orders articulate the standards of behaviour expected by Board Members, Health Board Officers, and others as appropriate within the organisation. The Standards of Behaviour Policy sets out the Health Board's commitment to ensuring that its employees and Independent Members practice the highest standards of conduct and behaviour. The policy sets out the expectations and provides supporting guidance in delivering that requirement.</p> <p>Counter Fraud assisted in the review of this policy in quarter four 2024/25.</p> <p>The CF Team has an on-going work programme to develop an anti-fraud culture within the NHS as outlined in question 13.</p> <p>A programme of raising awareness exists where fraud risks impacting the organisation are reviewed and shared, highlighting key policies and processes currently in place to mitigate associated risks.</p>	<p>The Health Board Standing Orders define the expected standards of behaviour for Board Members, Health Board Officers, and other relevant individuals within the organisation. The Standards of Behaviour Policy affirms the Health Board's commitment to ensuring that all employees and Independent Members uphold exemplary levels of conduct and behaviour. The policy outlines the expectations and offers practical guidance to support these requirements.</p> <p>The CF Team maintains an ongoing programme aimed at fostering an anti-fraud culture within the NHS, as detailed in question 13. Additionally, there is an active awareness initiative, whereby fraud risks affecting the organisation are regularly examined and communicated, emphasising key policies and procedures currently in place to reduce these risks</p>
<p>18. For the Health Board's service organisations, have you reported any fraud or</p>	<p>To date, there has been no requirement to report fraud to any affected parties.</p>	<p>To date, there has been no requirement to report fraud to any affected parties.</p>

Enquiries of management - in relation to fraud		
Question	2024-25 Response	2025-26 Response
potential fraud to any affected parties?		

Enquiries of management – in relation to laws and regulations

Question	2024-25 Response	2025-26 Response
<p>19. What are the policies and procedures in place to identify applicable legal and regulatory requirements to ensure compliance?</p>	<p>The Health Board has taken reasonable endeavours to comply with identified relevant legislation and has a number of policies and procedures in place to comply with legislation relating to health and safety and employment matters, as well as specific Acts for example the Health and Social Care (Quality and Engagement) (Wales) Act 2020 which came into force on 1st April 2023.</p> <p>Legal implications are considered as necessary in all papers to the Board or its Committees. This is supported by internal and external and assurance testing by auditors/inspectors and regulators. Executive Directors also have delegated responsibilities which are captured in the Scheme of Delegation. The Health Board’s risk management framework places the responsibility for identifying, assessing and managing risks of potential areas of non-compliance with legislation and regulations with services and directorates.</p>	<p>The Health Board has taken reasonable endeavours to comply with identified relevant legislation and has a number of policies and procedures in place to comply with legislation relating to health and safety and employment matters, as well as specific Acts for example the Social Partnership and Public Procurement (Wales) Act 2023, which came into force on 1 April 2024, and the Health and Social Care (Wales) Act 2025, which came into force on 1 April 2026.</p> <p>Legal implications are considered as necessary in all papers to the Board or its Committees. This is supported by internal and external and assurance testing by auditors/inspectors and regulators. Executive Directors also have delegated responsibilities which are captured in the Scheme of Delegation. The Health Board’s risk management framework places the responsibility for identifying, assessing and managing risks of potential areas of non-compliance with legislation and regulations with services and directorates.</p>
<p>20. Are you aware of any instances of non-compliance with laws or regulations? Has the Health Board received any</p>	<p>In 2024/25, the Health Board received 2 new Fire Enforcement Notices in respect of The Regulatory Reform (Fire Safety) Order 2005: Article 30. The Health Board closed 2 Enforcement Notice issued</p>	<p>In 2025/26, the Health Board received no new Fire Enforcement Notices in respect of The Regulatory Reform (Fire Safety) Order 2005: Article 30. The Health Board continues to address the 3 outstanding</p>

Enquiries of management – in relation to laws and regulations

Question	2024-25 Response	2025-26 Response
<p>notice of any such known of possible instances of non-compliance?</p>	<p>by Mid and West Wales Fire and Rescue Service (MWWFRS) and continues to address the 2 outstanding Enforcement Notices (1 relating to GGH with a completion date of December 2027 and 1 related to WGH with a completion date of August 2027 – these dates have been agreed in principle with MWWFRS).</p> <p>There is also an issue of full compliance with the European Working Time Directive (EWTD), with switchboard staff working in the Finance, Digital and Performance directorate. Switchboard modernisation has been implemented which allows calls to be transferred to other sites for the break periods however the Health Board is looking to strengthen arrangements further by introducing double handed shifts on weekends and evenings, subject to consultation with staff and unions by March 2026.</p> <p>The Health Board has had contact with the Information Commissioner’s Office (ICO) in relation to four incidents during the year (self-reported by the Health Board). Incidents involved access to medical records by unauthorised individuals and information disclosed in error. One incident has been closed by the ICO with no</p>	<p>Enforcement Notices (1 relating to Cwm Seren with a completion date of April 2026, 1 relating to WGH with a completion date of July 2027 and 1 relating to GGH with a completion date of December 2027 - these dates have been agreed in principle with Mid and West Wales Fire and Rescue Service (MWWFRS)).</p> <p>There remains a risk relating to full compliance with the European Working Time Directive (EWTD) for switchboard staff within the Finance and Digital directorate. As an interim mitigation, the switchboard modernisation programme has been implemented, enabling calls to be transferred to alternative sites during mandatory break periods, which has reduced immediate operational pressure. The Health Board is now progressing further strengthening measures, including the introduction of double-handed cover for weekend and evening shifts and a reduction in the number of operating switchboard sites to improve resilience. These measures are intended to provide a more sustainable and EWTD-compliant staffing model. Engagement activity is underway to finalise and implement these changes, following confirmation of an appropriate solution for active alarm monitoring.</p> <p>The Health Board has had contact with the Information Commissioner’s Office (ICO) in relation to four</p>

Enquiries of management – in relation to laws and regulations

Question	2024-25 Response	2025-26 Response
	<p>further action required and three incidents are still being investigated by the ICO.</p> <p>The Health Board is in breach of its statutory duties relating to finance and planning as the Health Board has been unable to break even over a three-year period; and has been unable to submit a balanced three-year Integrated Medium-Term Plan.</p>	<p>incidents during the year (self-reported by the Health Board). Incidents related to unauthorised access to medical records and information disclosed in error. Two incidents were closed by the ICO, providing assurance regarding the adequacy of the Health Board’s response and remedial actions. Two incidents remain open with the ICO awaiting their review and decision.</p>
<p>21. Have there been any examinations or inquiries performed by licensing, tax, or other authorities/ regulators?</p>	<p>HMRC did not commence any new examinations or inquiries during the year. Communications with HMRC during the year related to matters routine in nature or related to matters which arose in prior financial years but which remain not settled at the start of the financial year.</p>	<p>The Health Board has not been subject to any direct examinations or inquiries by His Majesty’s Revenue and Customs (HMRC) during the year. Further to a request from HMRC, the Health Board has assisted HMRC as a witness in connection with its investigation into alleged fraudulent behaviour by an umbrella company supplying temporary workers to the NHS across England, Scotland and Wales.</p>
<p>22. Has there been any significant communications with regulators?</p>	<p>The Health Board accepted an invitation from HMRC to participate in a National Minimum Wage (NMW) Employer Support Programme. The programme offers an opportunity for the organisation to utilise HMRC’s expert advice and support to check that it is paying all workers in</p>	<p>There have been regular communications with all our regulators throughout 2025/26. This includes Healthcare Inspectorate Wales (HIW), in respect of off-site and on-site inspection activity which has resulted in areas of improvement for the Health Board to</p>

Enquiries of management – in relation to laws and regulations

Question	2024-25 Response	2025-26 Response
	<p>accordance with NMW regulations. This opportunity comes following a rapid increase in the NMW over recent years, which has brought more staff groups within its range. The programme commenced in January 2025 with an interactive face-to-face workshop hosted by HMRC. The Health Board will be working with HMRC over the coming months as the programme proceeds.</p> <p>There have been regular communications with all our regulators throughout 2024/25. This includes Healthcare Inspectorate Wales (HIW), in respect of off-site and on-site inspection activity which has resulted in areas of improvement for the Health Board to address and ensure lessons learnt are shared through the organisation.</p> <p>MWWFRS have provided 51 LOFSM (11 have been closed) throughout 2024/25 which have resulted in areas of improvement for the Health Board to address.</p>	<p>address and ensure lessons learnt are shared through the organisation.</p> <p>The Public Service Ombudsman for Wales provided a Public Interest Report (Case 202403251) which upheld the original complaint, identifying service failure, and made formal recommendations for urgent action.</p> <p>MWWFRS have provided 19 Letters of Fire Safety Matters (LOFSM) (2 have been closed and a further 9 are pending approval to close) throughout 2025/26 which have resulted in areas of improvement for the Health Board to address.</p>
<p>23. For the Health Board’s service organisations, have you</p>	<p>None of which we are aware. Details of the performance of the NHS Wales Shared Services</p>	<p>The Health Board notified HMRC during the year that it had overcharged VAT to a customer in respect of the</p>

Enquiries of management – in relation to laws and regulations

Question	2024-25 Response	2025-26 Response
reported any non-compliance with laws and regulations?	Partnership are routinely reported through Board meetings.	supply of pathology services. The position was corrected with no penalties issued. Details of the performance of the NHS Wales Shared Services Partnership are routinely reported through Board meetings.

Enquiries of management – in relation to regularity

Question	2024-25 Response	2025-26 Response
24. What is your assessment of the risk of material irregularity, in respect of the 2025/26 financial statements?	Annual accounts are prepared in accordance with all relevant accounting guidelines including Manual of Accounts; the Treasury's Financial Reporting Manual (FReM); Standing Orders and Standing Financial Instructions. Therefore, the risk of material irregularity has been minimised to a low level.	Annual accounts are prepared in accordance with all relevant accounting guidelines including Manual of Accounts; the Treasury's Financial Reporting Manual (FReM); Standing Orders and Standing Financial Instructions. Therefore, the risk of material irregularity has been minimised to a low level.

Enquiries of management – in relation to regularity

Question	2024-25 Response	2025-26 Response
25. What is the process for responding to the risk of irregularity?	As per point 24, all available guidelines are followed to ensure the risk of irregularity is addressed and minimised to a low level.	As per point 24, all available guidelines are followed to ensure the risk of irregularity is addressed and minimised to a low level.
26. What is your knowledge of actual, suspected, or alleged irregularity?	We are not aware of any actual or suspected irregularity. Allegations of irregularity were made during the year which the Health Board investigations have not been able to substantiate.	We are not aware of any actual or suspected irregularity.
27. Where service organisations are used by the Health Board, have any irregularities been reported to any affected parties?	None of which we are aware. Details of the performance of the NHS Wales Shared Services Partnership are routinely reported through Board meetings.	None of which we are aware. Details of the performance of the NHS Wales Shared Services Partnership are routinely reported through Board meetings. The Welsh Government Independent Review outcome confirmed NWSPP's governance framework is fundamentally sound, setting out recommendations for strengthening and improvement.

Enquiries of management in relation to related parties

Question	2024-25 Response	2025-26 Response
<p>28. Have there been any changes to related parties from the prior year? If so, what is the identity of the related parties and the nature of those relationships?</p>	<p>Changes to related parties will be reflected in Annual Accounts disclosures. Likely change to related party note following changes to Board/Senior Management (key personnel).</p>	<p>Changes to related parties will be reflected in Annual Accounts disclosures. Likely change to related party note following changes to Board/Senior Management (key personnel).</p>
<p>29. What transactions have been entered into with related parties during the period? What is the purpose of these transactions?</p>	<p>As per point 28 above.</p>	<p>As per point 28 above.</p>
<p>30. What controls are in place to identify, account for and disclose related parties?</p>	<p>Register of Board Members Interests is maintained and reviewed by the Corporate Governance directorate.</p>	<p>Register of Board Members Interests is maintained and reviewed by the Corporate Governance directorate.</p>

Enquiries of management in relation to related parties

Question	2024-25 Response	2025-26 Response
<p>31. What controls are in place to authorise and approve significant transactions and arrangements:</p> <ul style="list-style-type: none">• with related parties; and• outside the normal course of business?	<p>Standing Orders, Standing Financial Instructions, Standards of Behaviour Policy together with declarations of interest forms are all in place.</p> <p>No transactions outside the course of normal business.</p>	<p>Standing Orders, Standing Financial Instructions, Standards of Behaviour Policy together with declarations of interest forms are all in place.</p> <p>No transactions outside the course of normal business.</p>

Enquiries of those charged with governance

Enquiries of those charged with governance		
Question	2024-25 Response	2025-26 Response
32. Do you have any knowledge of actual, suspected, or alleged fraud affecting the entity?	<p>Yes. The CF Team has actively investigated and closed 56 reports of Fraud or theft this financial year. All cases are recorded and managed with oversight from CFS Wales on the approved crime reporting system, Clue 3.</p> <p>All cases are reported to ARAC sessions, including any outcomes that pose a risk to the organisation.</p>	<p>Yes. In the 2025/26 period, the Counter Fraud Team carried forward 11 active cases from the previous year and logged 60 new referrals. Of these, 60 investigations were conducted and subsequently closed. Not all referrals related to criminal activity; some concerned issues or potential weaknesses within systems, which were reviewed and addressed as appropriate.</p> <p>All cases are documented and managed under the supervision of CFS Wales using the authorised crime reporting platform, Clue 3. Every case, along with any outcomes that may present a risk to the organisation, is reported at ARAC sessions.</p>
33. What is your assessment of the risk of fraud within the entity, including those risks that are specific to the Health Board's business sector?	<p>Overall, the risk of fraud can be described as low risk of individual high loss but an increased risk of high volume, low loss frauds. However, this can be mitigated by a strong emphasis on fraud prevention, which may reduce opportunities for fraud to take place, and fraud deterrence, which could persuade individuals not to commit fraud because of the likelihood of detection and punishment.</p>	<p>On balance, the risk of fraud is characterised by a low likelihood of significant individual losses, but a heightened chance of numerous instances of small-scale fraud. This risk can be addressed by placing a strong focus on fraud prevention, which serves to minimise opportunities for fraudulent activity, alongside robust deterrence measures that can dissuade individuals from engaging in fraud due to the</p>

Enquiries of those charged with governance		
Question	2024-25 Response	2025-26 Response
		increased probability of detection and subsequent consequences.
<p>34. How do you exercise oversight of:</p> <ul style="list-style-type: none"> • Management’s processes for identifying and responding to the risk of fraud in the Health Board; and • The controls to manage these risks? 	<p>Oversight is achieved by way of having in place an effective Counter Fraud, Bribery and Corruption workplan, which aligns itself to the Health Board’s Anti-Fraud, Bribery and Corruption Policy. The Health Board is required to demonstrate compliance with NHS Requirements of Government Functional Standard 013 Counter Fraud.</p> <p>Component 3 of the functional standards requires the Health Board to undertake comprehensive local risk assessments to identify fraud, bribery, and corruption risks in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology and record and manage risks in line with the organisation’s risk management policy and included on the appropriate risk registers where necessary.</p>	<p>Oversight is ensured by implementing a robust Counter Fraud, Bribery and Corruption workplan that is fully aligned with the Health Board’s Anti-Fraud, Bribery and Corruption Policy. The Health Board must evidence compliance with NHS requirements as outlined in Government Functional Standard 013 for Counter Fraud.</p> <p>Component 3 of these standards stipulates that the Health Board conducts thorough local risk assessments to identify risks of fraud, bribery, and corruption, following the Government Counter Fraud Profession (GCFP) fraud risk assessment methodology, and that all identified risks are documented and managed in accordance with the organisation’s risk management policy, including inclusion on relevant risk registers when appropriate. To that end, a Counter Fraud Risk Management strategy has been developed in 2025/26 with full roll out from 2026/27.</p>

Enquiries of those charged with governance

Question	2024-25 Response	2025-26 Response
<p>35. Are you aware of any non-compliance with laws and regulations that may be expected to have a fundamental effect on the operations of the Health Board?</p>	<p>In 2024/25, the Health Board was unable to meet its statutory duties to breakeven over a rolling three-year period and to prepare a three-year Integrated Medium-Term Plan for approval by the Minister for Health and Social Services, in line with NHS Finance (Wales) Act 2014.</p> <p>The Health Board has not been able to submit a balanced financial plan for 2025-26. Therefore was non-compliant with both planning and finance statutory duties. Also, as per response to Q20.</p>	<p>In 2025/26, the Health Board was unable to meet its statutory duties to breakeven over a rolling three-year period and to prepare a three-year Integrated Medium-Term Plan for approval by the Minister for Health and Social Services, in line with NHS Finance (Wales) Act 2014.</p> <p>The Health Board has not been able to submit a balanced financial plan for 2025-26. Therefore, was non-compliant with both planning and finance statutory duties. Also, as per response to Q20.</p>
<p>36. Are you aware of any instances of non-compliance with relevant laws and regulations?</p>	<p>As per response to Q20.</p>	<p>As per response to Q20.</p>
<p>37. What is the process for identifying and responding to the risks of fraud?</p>	<p>To effectively identify and respond to the risks of fraud, the LCFS actively undertakes inform and involve work to raise awareness of fraud in the NHS, empowering employees to identify and report their concerns.</p>	<p>To effectively identify and address the risks of fraud, the LCFS engages in proactive activities designed to increase awareness of fraud within the NHS, enabling staff to recognise and report any concerns. Employees are encouraged to report suspicions of fraud or associated risks directly to Counter Fraud, either via an</p>

Enquiries of those charged with governance		
Question	2024-25 Response	2025-26 Response
	<p>Employees can report concerns of Fraud or fraud risks direct to Counter Fraud, via an anonymous reporting hotline, online or via Datix or through the Working Together programme.</p> <p>The Health Board is required to demonstrate compliance with NHS Requirements of Government Functional Standard 013 Counter Fraud.</p> <p>The LCFS undertakes local assessments to identify fraud, bribery, and corruption risks in line with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology and records and manages risks in line with the organisation's risk management policy and includes on the appropriate risk registers where necessary.</p> <p>The CF workplan includes Preventative work, which is aimed at testing the effectiveness of existing controls and where applicable, develop new processes to further mitigate any identified risks. Such activities are known as Local Proactive Exercises and are recorded and reported to ARAC. Any recommendations are noted and where applicable tracked via the Audit Tracker function.</p>	<p>anonymous hotline, online platform, Datix, or through the Working Together programme.</p> <p>The Health Board must demonstrate adherence to NHS requirements outlined in Government Functional Standard 013 Counter Fraud. In accordance with Government Counter Fraud Profession (GCFP) fraud risk assessment methodology, the LCFS conducts local assessments to pinpoint risks of fraud, bribery, and corruption. These risks are recorded and managed in line with the organisation's risk management policy and, where necessary, included on the relevant risk registers.</p> <p>The Counter Fraud workplan and Fraud Risk Management Strategy features preventative measures, which involve evaluating the effectiveness of current controls and, where needed, developing new processes to further reduce identified risks. These activities, referred to as Local Proactive Exercises, are documented and reported to ARAC. Any recommendations arising from these exercises are noted and, where appropriate, monitored through the Audit Tracker function.</p>

Enquiries of those charged with governance

Question	2024-25 Response	2025-26 Response
	Fraud risks are also identified via the review of internal controls by internal audit, who will report to CF any emerging Fraud Risks.	Additionally, fraud risks may be highlighted through internal audit reviews of controls, with any new or emerging risks reported to Counter Fraud.
38. Are there any matters which those charged with governance consider require particular attention during the audit?	No	No
39. Are there any other matters which those charged with governance consider may influence the audit of the financial statements?	No	No
40. Are those charged with governance aware of any significant communications with regulators?	All significant communications with regulators are shared with the Board via its Committee structure in public/open session, who seek assurance that issues are being addressed.	All significant communications with regulators are shared with the Board via its Committee structure in public/open session, who seek assurance that issues are being addressed.

Enquiries of those charged with governance

Question	2024-25 Response	2025-26 Response
<p>41. What arrangements are in place to oversee the effectiveness of internal control?</p>	<p>The review of the system of internal control is informed by the work of the Internal Auditors, and the Executive Officers within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other reports.</p> <p>The Board and Committees rely on a number of sources of internal and external assurances which demonstrate the effectiveness of the Health Board’s system of internal control and advise where there are areas of improvement. These include:</p> <ul style="list-style-type: none"> • Feedback from WG and the specific statements issued by the Cabinet Secretary for Health and Social Care • Local Counter-Fraud and Post Payment Verification Activity; • Inspections by Healthcare Inspectorate Wales; • Delivery of audit plans and reports by external and internal auditors; • Feedback from statutory Commissioners; • Feedback from staff, patients, service users and members of the public; 	<p>The review of the system of internal control is informed by the work of the Internal Auditors, and the Executive Officers within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their audit letter and other reports.</p> <p>The Board and Committees rely on a number of sources of internal and external assurances which demonstrate the effectiveness of the Health Board’s system of internal control and advise where there are areas of improvement. These include:</p> <ul style="list-style-type: none"> • Feedback from WG and the specific statements issued by the Cabinet Secretary for Health and Social Care • Local Counter-Fraud and Post Payment Verification activity; • Inspections by Healthcare Inspectorate Wales; • Delivery of audit plans and reports by external and internal auditors; • Feedback from statutory Commissioners; • Feedback from staff, patients, service users and members of the public;

Enquiries of those charged with governance

Question	2024-25 Response	2025-26 Response
	<ul style="list-style-type: none">• Assurance provided by ARAC and other Committees of the Board;• AW Structured Assessment• Head of Internal Audit opinion	<ul style="list-style-type: none">• Assurance provided by ARAC and other Committees of the Board;• AW Structured Assessment• Head of Internal Audit opinion

Background information

Matters in relation to fraud

International Standard for Auditing (UK) and Ireland) 240 covers auditors' responsibilities relating to fraud in an audit of financial statements.

The primary responsibility to prevent and detect fraud rests with both management, and 'those charged with governance', which for the Health Board is the Board itself. Management, with the Board, should ensure there is a strong emphasis on fraud prevention and deterrence and create a culture of honest and ethical behaviour, reinforced by active oversight by the Board.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error. We are required to maintain professional scepticism throughout the audit, considering the potential for management override of controls.

What are we required to do?

As part of our risk assessment procedures, we are required to consider the risks of material misstatement due to fraud. This includes understanding the arrangements management has put in place in respect of fraud risks. The ISA views fraud as either:

- the intentional misappropriation of assets; or
- the intentional manipulation or misstatement of the financial statements.

We also need to understand how the Board exercises oversight of management's processes. We are also required to make enquiries of both management and the Board as to their knowledge of any actual, suspected, or alleged fraud and for identifying and responding to the risks of fraud and the internal controls established to mitigate them.

Matters in relation to laws and regulations

International Standard for Auditing (UK and Ireland) 250 covers auditors' responsibilities to consider the impact of laws and regulations in an audit of financial statements.

Management, with the oversight of those charged with governance, (the Board), is responsible for ensuring that the Fund's operations are conducted in accordance with laws and regulations, including compliance with those that determine the reported amounts and disclosures in the financial statements.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error, taking into account the appropriate legal and regulatory framework. The ISA distinguishes two different categories of laws and regulations:

- laws and regulations that have a direct effect on determining material amounts and disclosures in the financial statements; and
- other laws and regulations where compliance may be fundamental to the continuance of operations, or to avoid material penalties.

What are we required to do?

As part of our risk assessment procedures, we are required to make inquiries of management and the Board as to whether the Fund is in compliance with relevant laws and regulations. Where we become aware of information of non-compliance or suspected non-compliance, we need to gain an understanding of the non-compliance and the possible effect on the financial statements.

Matters in relation to related parties

International Standard for Auditing (UK and Ireland) 550 covers auditors' responsibilities relating to related party relationships and transactions.

The nature of related party relationships and transactions may, in some circumstances, give rise to higher risks of material misstatement of the financial statements than transactions with unrelated parties.

Because related parties are not independent of each other, many financial reporting frameworks establish specific accounting and disclosure requirements for related party relationships, transactions, and balances to enable users of the financial statements to understand their nature and actual or potential effects on the financial statements. An understanding of the Health Board's related party relationships and transactions is relevant to the auditor's evaluation of whether one or more fraud risk factors are present as required by ISA (UK and Ireland) 240, because fraud may be more easily committed through related parties.

What are we required to do?

As part of our risk assessment procedures, we are required to perform audit procedures to identify, assess and respond to the risks of material misstatement arising from the Health Board's failure to appropriately account for or disclose related party relationships, transactions or balances in accordance with the requirements of the framework.

Regularity

Regularity is the concept that transactions that are reflected in the financial statements must be in accordance with the Health Board's framework of authorities.

Frameworks of authorities are external frameworks, specific to an audited entity, with which the audited entity's transactions must conform. These frameworks are set up by bodies able to issue and/or enforce the authorities for that entity and might include, for example:

- authorising legislation;
- regulations issued under governing legislation;
- parliamentary authorities; and
- government or related authorities (for example Managing Welsh Public Money, issued by the Welsh Government).

Further information is available in [Practice Note 10](#).

What are we required to do?

The Practice Note includes an overview, from page 56 of the Practice Note, of what we are required to do.

4.6

11:25, 5 Mins

4.6 - Draft Performance Overview

Huw Thomas (Hywel Dda UHB - Director of Finance), Alwena Hughes Moakes (Hywel Dda UHB - Communications and Engagement Director), Fiona Hancock (Hywel Dda UHB - Senior Communications Officer)

| For approval

Attachments

[4.6 SBAR Annual Report Performance Section .pdf](#)

[4.6 DRAFT-Performance-Report-29Apr26.pdf](#)

[4.6 Performance Report IIA ARAC 7 May 2026.pdf](#)

**PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	07 May 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Draft Performance Report Chapter of the Hywel Dda University Health Board Annual Report 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Alwena Hughes Moakes, Communications and Engagement Director

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 Committee is asked to recommend the Performance Report chapter of the Hywel Dda University Health Board (HDdUHB) 2025/26 Annual Report for approval by the Board.

In recommending the report, it ensures that it reflects an analysis of the main business, performance and accountabilities, key achievements and successes of the organisation between April 2025 and March 2026, in line with guidance in the NHS Wales Manual for Accounts 2025/26.

Cefndir / Background

All NHS bodies are required to publish, as a single document, the Annual Report and Accounts following strict guidance set out by Welsh Government in the NHS Wales Manual for Accounts 2025/26 (Chapter 3). The Annual Report and Accounts is a suite of reports and includes:

- a **Performance Report** is to provide information on the Health Board, its main objectives and strategies and the principal risks that it faces. It must provide a fair, balanced and understandable analysis of the entity's performance, in line with the overarching requirement for the annual report and accounts to be fair, balanced and understandable;
- an **Accountability Report** which must include a Corporate Governance Report, Governance Statement, a Remuneration and Staff Report and a Senedd Cymru/Welsh Parliament Accountability and Audit Report; and
- a full set of **Audited Accounts** to include the primary financial statements and notes.

The above suite of documents is ratified independently through the University Health Board and its committees. The final publication comprises the entire suite of documents and must be made available for distribution at the Health Board's Annual General Meeting, which will be held no later than 31 July 2026.

Asesiad / Assessment

Our health and care system is currently facing unprecedented challenges due to multiple, simultaneous events impacting our way of life. As a health board, we encounter pressures in several key areas:

- Workforce availability, including social care
- Affordability and inflationary pressures
- Population health and demand for healthcare

These pressures result in backlogs and delays in patient care, excessive strain on staff, reduced system efficiency, and significant financial challenges. Additionally, we are at the start of a long-anticipated demographic shift, with many people living longer. In Hywel Dda, it is well known that we have an ageing estate and an unsustainable model of care.

Addressing these challenges will require sustained and co-ordinated efforts. Our focus is on improving access to services for our patients while balancing the need for financial sustainability and adhering to our control total.

The Health Board's performance for 2025/26 has shown some improvements, driven by the Ministerial priorities outlined in the 2026/26 Planning Framework, our planning objectives, the 'accountability conditions' issued in September 2025, and the Targeted Intervention process.

We continue to work towards our refreshed strategy, 'A Healthier Mid and West Wales: Healthier Lives, Well Lived,' prioritising objectives aligned with the Planning Framework, Ministerial priorities, and essential initiatives. This includes progressing our Clinical Services Plan to address current operational challenges and provide a roadmap for our service provision in the short and medium term.

Details of our approach and progress against these priorities are included in the Performance Overview and the Annual Report.

The Chair, Executive Directors, and the Chairs of the Finance and Performance Committee (FPC) and the Quality, Safety and Experience Committee (QSEC) have reviewed this first draft of the Performance Report virtually.

Please note that some performance data will be updated once the latest data becomes available, as noted in the document's review comments. The draft report is also subject to design changes and a final proofread once feedback from ARAC members, Welsh Government, and Audit Wales has been received and incorporated.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to **RECOMMEND** the Performance Report chapter of the 2025/26 Annual Report for approval by the Board.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference:
Cyfeirnod Cylch Gorchwyl y Pwyllgor:

3.2 In particular, the Committee will review the adequacy of:
3.2.1 all risk and control related disclosure statements (in particular the Accountability Report and the Performance Report), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	NHS Wales 2025/26 Manual for Accounts
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	The Performance Report has been reviewed by the Chair of HDdUHB, Executive Directors, including the Director of Finance, and the Chairs of FPC and QSEC.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not applicable
Gweithlu: Workforce:	Not applicable
Risg: Risk:	Associated risk is non-compliance due to unforeseen circumstances and tight deadlines. The process has been actively managed to minimise risks.

Cyfreithiol: Legal:	Associated legal impact is non-compliance with statutory duty to produce Annual Report and Accounts in time for the Annual General Meeting due to unforeseen circumstances and tight deadlines. The process is being actively managed to minimise risks.
Enw Da: Reputational:	Potential for media interest once the Annual Report is published. Integrated Impact Assessment completed
Gyfrinachedd: Privacy:	Not applicable – statutory requirement
Cydraddoldeb: Equality:	Not applicable – statutory requirement

Pre-design draft version

V2-29Apr26

NB: images will change for final design

cover image

2025/2026

Annual Report

Hywel Dda University Health Board

hduhb.nhs.wales

Ewch i dudalen xx am Gymraeg

Our Annual Report explains what we do as a health board, the care we provide, how we plan, deliver, and improve your local healthcare services. It describes our achievements and challenges throughout 2025/26 across a range of areas:



How to contact us

Publications in print or alternative formats and languages are available on request by contacting us.

- **Write to us at:** Hywel Dda University Health Board, Second Floor, Block C, Government Buildings, Picton Terrace, Carmarthen, SA31 3BT
- **Phone us on:** 01267 239554 / 07464 523370
- **Visit us at:** <https://hduhb.nhs.wales/>
- **Follow us on:**
 - Facebook: HywelDdaHealthBoard
 - Instagram: HywelDdaUHB
 - LinkedIn: hywel-dda-university-health-board
 - YouTube: hywelddahealthboard1

Hywel Dda University Health Board is a local health board established under section 11 of the National Health Service (Wales) Act 2006.

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Our Financial Accounts 2025-2026

Foreword

Welcome to our 2025/26 Annual Report. It looks back on a year that was tough at times but also productive for Hywel Dda University Health Board.

It reflects the pressures we faced, the progress we made, and the work underway to improve care for people across Carmarthenshire, Ceredigion and Pembrokeshire.

Firstly, thank you to our staff, volunteers, partners and local communities. Your hard work, resilience and support have been vital as we managed high demand for services, especially urgent and emergency care, alongside financial and workforce pressures. We also thank patients and families for their patience where waits have been long. We know how frustrating this can be, and improving timely, reliable care remains our priority.

In January 2026, pressure in our hospitals peaked, especially at Withybush and Glangwili. Our teams showed professionalism and commitment, always putting patient safety first. We are extremely grateful for their efforts during this challenging time.

Despite these pressures, we made real progress. In January 2026, the Board approved our refreshed long-term strategy: 'A Healthier Mid and West Wales – Healthier lives, well lived'. The strategy sets out our plans to 2040, reflecting changing needs, digital advances and lessons from COVID-19.

The strategy is available to read here:  <https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2026/board-agenda-and-papers-29-january-2026/>

As a new urgent and planned care hospital is still some years away, subject to future funding, we must strengthen services under pressure now. Take a look at our Clinical Services Plan here: <https://hduhb.nhs.wales/about-us/healthier-mid-and-west-wales/clinical->

[services-plan/](#) The plan focuses on nine priorities, shaped by feedback from over 4,000 people who shared their views during consultation.

Listening to our communities remains essential. This year, we engaged with people on primary and community care, Prince Philip Hospital's Minor Injuries Unit, and specialist learning disability services.

We saw positive developments, such as:

- Leri Cancer Unit official opening at Bronglais Hospital
- growth in volunteering
- new technology supporting pregnant women with Type 1 diabetes, and
- a fully restored paediatric service at Bronglais

We continued our vaccination programmes for flu, COVID-19, HPV, meningitis and routine childhood immunisations. We put in place measures to reduce the spread of infection, such as flu or norovirus.

Our research activity continues to grow, with many staff receiving well-deserved local and national recognition. We value strong partnerships and signed the Social Model for Health and Wellbeing Charter. We continue to work with Welsh Government, with good progress recognised in children's mental health and cancer services.

As always, there is more to do. We remain focused on improving care, supporting our staff and delivering safe, sustainable services for the people of west Wales.

 **Neil Wooding**
Chair

Professor Phil Kloer
Chief Executive

About us

Our mission - Healthier Lives, Well Lived - is anchored in four strategic objectives: Thriving Teams, Healthier Communities, Great Care, and Positive Futures.

To deliver our mission, we will need to make progress if we are to move towards our aspiration of healthier lives, well lived. We have termed these goals our 'strategic objectives' and they are the foundation of our strategy.

We believe good healthcare starts with **thriving teams**. In a people-centred service like the NHS, staff who feel supported are better able to care for others. These teams help build **healthier communities** by focusing on prevention and strengthening primary and community care. When people need specialist help, they should be able to access **great care** that is safe and high quality, without delay. Together, this helps build **positive futures** where people start life well, live and age well, and receive dignified care at the end of life.

Our population

We have a population of 382,800 people across Carmarthenshire, Ceredigion and Pembrokeshire. The population is ageing, with the number of people aged 65 and over expected to increase by 20 per cent by 2043. This will significantly increase demand for health and care services.

Many older people in the area live well, but overall health is below national averages. Around one third of people aged 65 and over are a healthy weight. Just over half report good general health. Fewer than half are free from a limiting long-term illness, showing that many live with ongoing health needs.

Health inequalities are more pronounced in later life. People living in the most deprived areas can expect to live almost five years less, spending around seven fewer years in good

health, than people in the least deprived areas. Long-term conditions such as dementia, heart and lung disease and falls place growing pressure on health services, especially for people aged 75 and over. As our population ages, preventing illness, reducing inequality and supporting people to live independently will become even more important. (Data source: ONS 2024)

Our Board

Governance across the organisation is managed by our executive directors and independent board members.

Our Board meets publicly every two months and is supported by committees and advisory groups. This year, there have been several changes in our Board and Executive, detailed in the **Directors' Report**.

Read more about our Board here:

<https://hduhb.nhs.wales/about-us/your-health-board/board-members/>

Our structure

We plan and provide NHS healthcare services for people living in Carmarthenshire, Ceredigion, Pembrokeshire, and bordering counties.

With over 13,000 staff we provide primary, community, acute (in-hospital), mental health and learning disabilities services.

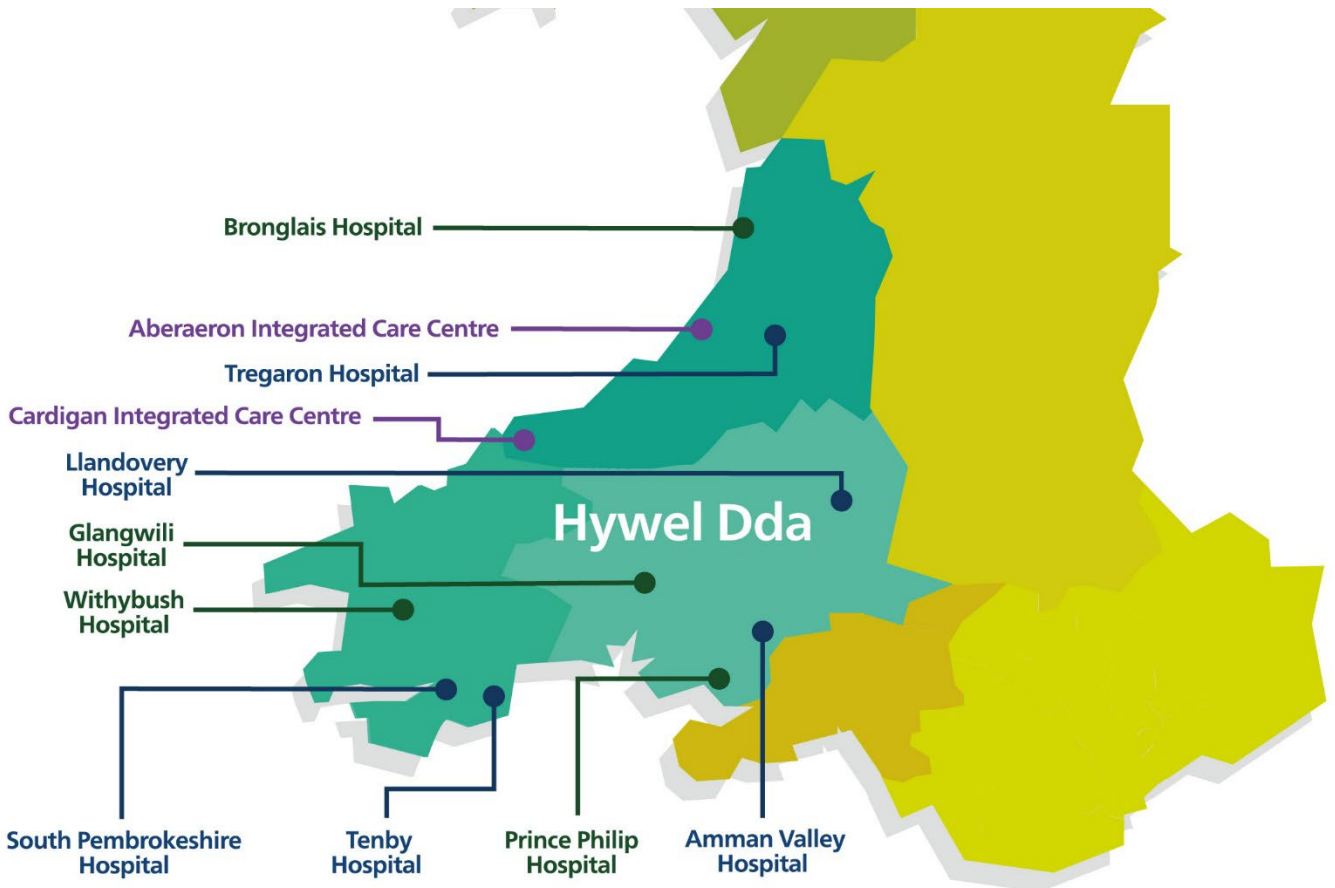
We provide specialised services commissioned by the Joint Commissioning Committee, and Sure Start services with local authorities. As part of the South West Wales Regional Joint Committee (RJC), we provide joint leadership for the planning, commissioning and delivery of

health services across Swansea Bay and Hywel Dda university health boards.

We work in partnership with local authorities, as well as public, private and third sector colleagues, including our valued volunteers.

Our services are provided in:

- Four main hospitals:
 - Bronglais Hospital in Aberystwyth
 - Glangwili Hospital in Carmarthen
 - Prince Philip Hospital in Llanelli, and
 - Withybush Hospital in Haverfordwest
 - Five community hospitals:
 - Amman Valley and Llandovery hospitals in Carmarthenshire
 - Tregaron Hospital in Ceredigion, and
 - Tenby and South Pembrokeshire hospitals in Pembrokeshire
- Two integrated care centres in Aberaeron and Cardigan in Ceredigion, and several other community settings
 - 47 general practices (six of which are Health Board managed practices)
 - 38 dental practices (including four orthodontic)
 - 97 community pharmacies
 - 43 general ophthalmic practices and 8 ophthalmic domiciliary providers
 - Numerous mental health and learning disabilities services



Part 1: Our Performance

Insert chapter cover image

An overview of our performance

This overview explains the challenges we have faced and how we have addressed them, as well as our achievements and progress.

It also includes a summary of how we have performed against Welsh Government targets, our actions to improve and how we have kept a focus on safety and quality.

The Health Board considers the adoption of the going concern basis to be appropriate and will continue to operate its business for the near future. We are not aware of any circumstances that would call this into doubt.

Statement from the Chief Executive Officer

The past year has been one of the most challenging we've faced as a health and care system. Like the rest of NHS Wales, our Health Board continues to work under intense pressure from rising demand, workforce shortages and significant financial constraints. Despite this, I'm proud of the determination and professionalism shown by our staff across all services, every day.

Our biggest challenges are still staff availability, rising costs and inflation, population health needs, and sustained pressure on urgent and emergency care. Thanks to the hard work of our teams, we've started to reduce some delays and improve access for patients, but I'm clear there is still much more to do.

Getting our finances back on track remains a key priority. Welsh Government allowed for a short-term deficit, and with extra funding we significantly reduced our year-end shortfall. While this is good progress, we are not yet financially sustainable. Improving this will remain a major focus in the years ahead.

In January 2025, it became clear that we could not give a balanced three-year Integrated Medium-Term Plan (IMTP). Instead, we produced a one-year plan – read our Annual Plan for 2025/26 here:

[https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2026/board-agenda-and-](https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2026/board-agenda-and-papers-26-march-2026/board-agenda-and-papers-26-march-2026/8-annual-plan-2026-27-pdf/)

[papers-26-march-2026/board-agenda-and-papers-26-march-2026/8-annual-plan-2026-27-pdf/](https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2026/board-agenda-and-papers-26-march-2026/8-annual-plan-2026-27-pdf/)

This focused on maintaining safe, high quality services within our financial limits. To do this, we reduced the number of objectives to those that mattered most and aligned them closely with Welsh Government priorities.

Our priorities for 2025/26

In 2025/26, our work focused on three key priority areas, outlined below.

Better care when you need it: Improving day-to-day NHS services

Urgent and emergency care - We are improving care for people who need help quickly, including those attending A&E or needing urgent hospital treatment.

Planned care, tests and cancer services - We are working to reduce waits for operations, diagnostic tests and cancer treatment.

Mental health services - We are improving access to mental health support for adults, children and young people.

These services are where demand is highest and where timely care makes the biggest difference to people's lives.

Digital and technology-enabled care - We are using digital tools to improve access, communication and the patient experience.

Improving population health - We are focusing more on prevention and helping people stay well for longer.

Our population is ageing and demand for services is growing. These changes help make sure the NHS can meet future needs.

2 Strong foundations: Making sure our NHS is sustainable and supported

A happy, healthy workforce - We are supporting our staff's wellbeing, promoting equality and inclusion, and creating a culture where people feel valued and supported to do their best work.

Living within our budget - We are improving how we manage our finances so we can protect essential services and make best use of the money available to us.

Our staff and our finances are the foundations of safe, reliable care. Getting these right supports everything else we do.

Together, these aim to strengthen the NHS today, improve care for patients, and help build a healthier future for our communities.

We've strengthened how we track progress, with clear accountability and regular reviews as part of Welsh Government's Targeted Intervention (TI) support. Through the year, this has helped drive improvement. We've been de-escalated in several areas, including cancer services, children and young people's mental health services, and leadership and governance. While we are still at higher escalation levels for finance, planning and urgent care, we are making progress.

Workforce stability has improved through international recruitment and reduced reliance on agency staff. Some services, including mental health, are consistently exceeding performance targets. We've seen improvements too in infection prevention and control.

Alongside immediate operational pressures, we've also taken important steps to look ahead. During the year, the Board approved a refresh of our long term strategy. A Healthier Mid and West Wales – Healthier lives, well lived is available to read here:

<https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2026/board-agenda-and-papers-29-january-2026/board-agenda-and-papers-29-january-2026/board-agenda-and-papers-29-january-2026>

3 Building a healthier future: Changing how care is delivered over the long term

Strengthening hospital services - We are making changes to some services to improve safety, quality and long-term sustainability.

More care closer to home - We are developing primary and community services so more people can receive care locally.

Better buildings and facilities - We are investing in hospitals and community sites to create safe, modern environments for care.

[papers-29-january-2026/11-1-refreshing-the-a-healthier-mid-and-west-wales-strategy-pdf/](#)

This builds on our original 2018 vision but reflects what’s changed since then, such as:

- the impact of COVID19
- an ageing population
- pressures on our buildings, and
- the growing importance of digital and community based care

Through public and staff engagement, we’ve listened to what matters most to our communities.

The strategy reinforces our commitment to prevention, early intervention and delivering care closer to home. It recognises that hospitals will always be needed for specialist and emergency care. Looking ahead to 2040, we know change must happen at pace if we’re to meet future demand and improve population health.

Linked to this is our Clinical Services Plan which is available to view at: <https://hduhb.nhs.wales/about-us/healthier-mid-and-west-wales/clinical-services-plan/>. It was developed to address the fragility of several services in the medium term. The plan focuses on nine services where staffing pressures, access issues or clinical risks are greatest. More than 6,000 people responded to our questionnaire in the first phase of engagement, and more than 4,000 people took part in our public consultation in the third phase.

In February 2026, the Board confirmed decisions for most services, balancing what can be delivered now with what may be possible over time, subject to approval. These changes aim to improve safety, standards and access, while making best use of our workforce and facilities. For stroke services, further engagement is planned before any final decision is made.

Read more about the Board decisions and next steps here: <https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2026/extraordinary-board-agenda-and-papers-18-and-19-february-2026/>

We also reflected on the future roles of our four acute hospitals. All continue to play a vital part in a single Hywel Dda hospital network, without changing how people access emergency or minor injury care. Clarifying these roles helps us plan services more effectively until our longer-term strategy is fully realised.

We are producing a ‘Community by Design’ Strategic Plan because strong primary care and community services are vital for better health and a sustainable NHS. Most care already happens in local settings. When these services work well, people stay healthier, receive help earlier and rely less on hospital care. Evidence shows that high quality and accessible community care improves outcomes, reduces inequalities and makes better use of public funds. With over £1 billion invested each year in primary care across Wales, it is essential this investment is used in a co-ordinated way that helps our communities. View our ‘Community by Design’ Strategic Plan at:

<https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2026/board-agenda-and-papers-29-january-2026/board-agenda-and-papers-29-january-2026/11-3-community-by-design-strategic-plan-pdf/>

The plan sets out a shift towards prevention, early support and keeping people well. It recognises that health is shaped by wider factors such as housing, income and education, and that improving health needs partnership working across the entire system. Aligned with national and local strategies, including ‘A Healthier Mid and West Wales’ it focuses on six priorities:

- prevention
- partnerships

- access
- digital services
- estates and infrastructure and
- workforce sustainability

Together, these will support more joined-up care closer to home and help reduce health inequalities.

There's no doubt that we still face major challenges. But we have a clearer plan, stronger grip, and committed staff and partners who want to deliver better care.

My priority is still supporting our workforce, improving patient experience, and building safe, sustainable services for the people of mid and west Wales.

Thank you for your continued support.

Professor Philip Kloer
Chief Executive





An overview of our performance

This section looks at how well we delivered healthcare services in 2025/2026.

It describes our focus on delivering safe, high quality care and our vision for urgent and emergency care. It also explains our performance in relation to key priorities, including the challenges we've faced and the risks we have addressed.

Delivering safe and quality care

Providing safe and high quality care is of paramount importance to us and remains a constant focus for improvement. During 2025/26, we have continued to carefully review how we work. We've focused on where we can do better to meet our Duty of Quality and deliver the best possible care for our patients.

This Performance Report shows the steps we have taken to continue improving the safety and quality of our services for the communities we serve.

You can find more detail about how we oversee and manage quality in the **Accountability section** of this Annual Report.

Our annual reports on quality, Duty of Candour and Putting Things Right will be published and available to view on our website at:

<https://hduhb.nhs.wales/quality-and-engagement-act/>



Our patients and staff are benefiting from a new digital system to streamline prescribing in secondary services.

The electronic Prescribing and Medicines Administration (ePMA) system is being rolled out across the Health Board. It will reduce the risk of medication errors by ensuring prescriptions are clear, legible and complete, with built-in safety checks for allergies and dosage accuracy.

ePMA is part of a national Digital Medicines Programme, led by Digital Health and Care Wales (DHCW)

Read more about the ePMA project here: <https://dhw.nhs.wales/news/latest-news/hospital-patients-set-to-benefit-from-digital-prescribing-in-hywel-dda-university-health-board/>

Together, these three reports describe the improvements we have made to ensure our services are safe, timely, effective and efficient. They show how improvements are guided by evidence and put people at the centre of their care in line with our Duty of Quality which can be viewed here: <https://hduhb.nhs.wales/duty-of-quality/>

We remain committed to listening to people who use our services. We learn from their experiences and respond with compassion and openness. Feedback from patients, families and carers is a vital source of insight, helping us to understand what matters most and where we can do better.

Over the year, we have improved how we use people's feedback to help us learn, improve quality, and make changes to our services.

In the coming year, the introduction of the new Listening to People arrangements across Wales will strengthen this work even further. These changes will help us respond faster and show how feedback is used. We will use our learning to make improvements, so people feel heard and change happens. Read more about the Listening to People framework here: <https://hduhb.nhs.wales/healthcare/services-and-teams/patient-support-services-complaints-feedback/>

Urgent and emergency care

Our vision for urgent and emergency care is simple. We want people to be able to access care easily, receive it quickly, and feel that their needs are at the centre of every decision. This work is guided by the Welsh Government's National Six Goals for Urgent and Emergency Care, which shape how we plan and deliver services. Read more about the national Six Goals here: <https://www.gov.wales/six-goals-urgent-and-emergency-care-policy-handbook-2021-2026>

During 2025/26, we've continued to experience significant pressure across the entire system. Demand for urgent and emergency care has increased by around five per cent compared to the previous year. We have faced ongoing challenges with ambulance response times and patient flow through our hospitals. Even so, we have made meaningful progress. For example, we have significantly improved hospital handover times and strengthened partnerships across urgent and emergency care services.

We developed and gained approval for our seven-day working business case. This will extend access to essential clinical and diagnostic services across the full week. Moving to a seven-day model will help reduce delays to assessment and treatment. It will improve continuity of care and support earlier discharge. Most importantly, it will help patients move through their care more smoothly, whatever day of the week they attend hospital. It will also support timely decisions and better outcomes.

We have also worked closely with our operational teams to improve the A&E environment. Changes have been made to reduce the risk of deconditioning, improve privacy and dignity, and better support patients with nutrition and hydration. We introduced Learning Disability Packs to make emergency hospital visits less stressful and more accessible for adults with learning disabilities. Alongside stronger clinical oversight, these improvements have had a noticeable positive impact on patient experience. This is particularly the case for patients in A&E longer while awaiting admission.

Glangwili Hospital's paediatric waiting area has been fully refurbished. This includes a new neurodivergent sensory room for children and adults. Designed to provide a calm, low stimulus space, the room helps reduce anxiety and supports emotional regulation. It minimises

overstimulation for people with autism, Attention Deficit Hyperactivity Disorder (ADHD) or sensory processing needs. In addition, we've begun major refurbishment work to improve the Same Day Emergency Care building, thanks to £2m of Welsh Government funding.

A dedicated room has been created in Prince Philip Hospital. This provides a private, calming space for sensitive and confidential conversations, including discussions about treatment, safeguarding concerns, and emotional wellbeing.

At Withybush Hospital, new comfortable, brightly coloured seating has been added to the A&E reception area. This increases capacity during busy periods, improving patient comfort, reducing congestion. It also helps create a more organised and efficient waiting environment.

Existing space at Bronglais Hospital has been altered to create an additional Emergency Nurse Practitioner (ENP) room. This increases capacity and helps manage minor injuries and illnesses more efficiently.

Together, these improvements reflect our continued commitment to making urgent and emergency care safer, more responsive, and patient-centred.

Due to its success, the pioneering Women's Health Psychology Service has been rolled out to Tywi/Taf and North Ceredigion areas. Originally, launched by Hywel Dda in 2023, it helps women experiencing emotional and psychological distress linked to pelvic health conditions.

During 2025/26, the Health Board partially met its planned objectives. We made demonstrable progress in areas including cancer performance, mental health services, infection prevention and control, and workforce stability. However, we did not meet expectations in urgent and emergency care flow, planned care waiting times in some specialties, and financial sustainability. These areas remain subject to targeted improvement actions and continued Welsh Government oversight. The reasons for under-delivery and the actions being taken to address them are set out in the Delivery and Performance Analysis section of this report.

Our performance against key improvement measures

The table below shows how we performed against our key improvement measures in 2025/26. This includes areas under extra monitoring by Welsh Government (TI), actions in our Annual Plan, and the Minister for Health and Social Care’s priorities.

- Variation - how are we doing over time**
- Improving variation
 - Usual variation
 - Concerning variation
- Assurance - performance against target**
- Always hitting target
 - Hit and miss target
 - Always missing target

Topic	Metric	Latest period	Target	Actual	Variation	Assurance
Cancer	% patients on single cancer pathway within 62 days	Feb 2026	75%	60%	●	■
Delayed discharges	Number of pathways of care delayed discharges	Mar 2026	n/a	220	●	n/a
Diagnostics	Patients waiting eight weeks+ for specified diagnosis	Mar 2026	0	3,308	●	■
Finance	Financial in month deficit	Feb 2026	n/a	£2,014,000	●	n/a
Infections	E. coli: Number of confirmed cases (in-month)	Mar 2026	21	23	●	■
Infections	S. aureus: Number of confirmed cases (in-month)	Mar 2026	6	10	●	■
Infections	C. difficile: Number of confirmed cases (in-month)	Mar 2026	8	7	●	■
Mental health (includes neuro)	% adult psychological therapy waits <26 weeks	Feb 2026	80%	56.1%	●	■
Mental health (includes neuro)	% child neurodevelopment assess waits <26 weeks	Feb 2026	80%	23.3%	●	■
Mental health (includes neuro)	% MH assess within 28 days (age 0-17)	Feb 2026	80%	88.4%	●	■
Mental health (includes neuro)	% MH assess within 28 days (age 18+)	Feb 2026	80%	88.9%	●	■
Mental health (includes neuro)	% therapy interven post LPMHSS assess (age 0-17)	Feb 2026	80%	83.3%	●	■
Mental health (includes neuro)	% therapy interven post LPMHSS assess (age 18+)	Feb 2026	80%	98.6%	●	■
Planned care	Waits over 52 weeks: new outpatient appointment	Mar 2026	0	0	●	■
Planned care	Patients waiting 104 weeks+ RTT	Mar 2026	0	3	●	■
Planned care	Patients waiting over 52 weeks RTT	Mar 2026	0	10,102	●	■
Planned care	Follow-up appts – delayed > 100%	Mar 2026	0	15,182	●	■
Planned care	% R1 eyecare patients waiting within 25% delay to target date	Feb 2026	95%	41.5%	●	■
Population health	% uptake of flu vacc – 65+ years	Mar 2026	75%	70.1%	n/a	n/a

Primary and community care	% of practices achieving National Access Standards	Mar 2025	100%	95.7%	n/a	n/a
Primary and community care	Dental: % of Welsh resident children accessing NHS primary dental care treatment within 12 months	Sep 2025	n/a	40.7%		n/a
Primary and community care	Dental: % of Welsh resident adults accessing NHS primary dental care treatment within 24 months	Sep 2025	n/a	28.5%		n/a

Primary and community care	Consultations delivered through PIPS	Jan 2026	n/a	2,647		n/a
Primary and community care	Patients 12yrs+ with diabetes receiving all eight NICE care processes	Feb 2026	n/a	44.2%		n/a
Therapies	Patients waiting 14 weeks+ for specified therapy (exc. Audiology)	Mar 2026	0	2,423		
Urgent and emergency care	Median time ambulance arrest category calls	Feb 2026	8	6	n/a	n/a
Urgent and emergency care	Median time ambulance emergency category calls	Feb 2026	8	10	n/a	n/a
Urgent and emergency care	Ambulance handover > 45 minutes Hywel Dda	Mar 2026	0	610		
Urgent and emergency care	Ambulance handovers > 1 hour Hywel Dda	Mar 2026	0	514		
Urgent and emergency care	Ambulance handover > 4 hours Hywel Dda	Mar 2026	0	117		
Urgent and emergency care	% patients spending < 4 hours in A&E/MIU Hywel Dda	Mar 2026	95%	75.1%		
Urgent and emergency care	Patients spending > 12 hours in A&E/MIU Hywel Dda	Mar 2026	0	1,206		
Workforce	% sickness absence rate of staff	Mar 2026	6.60%	6.70%	n/a	n/a

Urgent and emergency care (including the national six goals)

Standard response time for ambulance arrest (purple) and emergency (red) calls

The purple arrest category includes all incidents where a person is in cardiac or respiratory arrest. The red emergency category includes incidents where a person is at high risk of cardiac or respiratory arrest. Both the purple arrest and red emergency categories are equally prioritised, and an ambulance response dispatched in time order.

During 2025/26, we wished to meet the national targets of eight minutes for both call types. At the end of February 2026, purple arrest calls' standard time was six minutes and red emergency calls were ten minutes. Challenges were caused by:

- not having a vehicle available at the approved standby point and therefore unable to respond. This included vehicles held at hospital sites, waiting to handover patients

- having a vehicle at the nearest standby point but the incident was not practically reachable within eight minutes

To manage and mitigate the challenges, the Welsh Ambulance Service NHS Trust (WAST) constantly reviewed demand. They highlighted any pressures as they arose and clinically screened patients pre-hospital to avoid any unnecessary admissions.

Ambulance patient handovers over 45 minutes, one hour and four hours

Patients waiting in Accident and Emergency (A&E)/Minor Injury Unit (MIU) for less than four hours and more than 12 hours

When ambulances take patients to hospital, it's essential that patients are released quickly from the vehicles to receive the best care in the right environment. A swift patient handover also ensures that the ambulance crew can continue to provide a safe and efficient service to the local community. Delays in ambulance patient handover are often related to blockages in patient flow across the whole health and social care pathway. To address this, health boards need to ensure that staffing arrangements and patient flow systems are safe, efficient and effective.

To ensure people spend less than four hours in A&E, we must deliver efficient services and help people understand which NHS service best meets their needs.

To avoid patients waiting over 12 hours, we have to continuously improve the flow of patients through A&E, while maintaining effective and safe services.

Performance over the past 12 months shows an improving trend and less ambulance handover delays over 45 minutes, one hour and four hours.

We met our plan to reduce ambulance handovers over one hour to 840 monthly by

March 2026. Handovers taking over four hours were reduced to 177 monthly by March 2026.

The number of patients waiting in A&E/MIU for less than four hours improved from 69 per cent in March 2025 to 75 per cent in March 2026.

12 hours patient waits decreased from 1,412 in March 2025 to 1,206 in March 2026.

Common challenges faced at all our hospitals include:

- physical space constraints limiting our ability to treat and diagnose patients in a timely manner due to overcrowded A&Es. As a result, patients are delayed in being handed over to hospital
- staff shortages and recruitment challenges across NHS Wales, without enough clinical staff and senior decision-makers available
- delays due to onward patient flow through the health and social care pathway

Recovery improvements have been made through:

- two 'winter sprints' focusing on early and weekend discharges, and supporting more patients being looked after in their local communities. This also involved better collaboration between the Health Board and local authorities. Learning was used to support more improvements. These 'sprints' were a co-ordinated effort across all hospitals, strengthening resilience across both health and social care

Working with our partners, including local authorities, is crucial in improving patient outcomes and experience, reducing harm from delays, and ensuring beds are available for those needing them most

- clinical streaming hubs assess all medical referrals from GPs into A&Es. They review ambulances on their way to our hospitals to avoid unnecessary admission where

possible. This supports patient experience, patient flow through the pathway, reduces ambulances delayed at our hospitals, and provides prompt release of ambulances back into our community

Number of patients in hospital with a pathway of care delay

A pathway of care delay is when an inpatient occupying an NHS hospital bed is ready for the next stage of care, but this is prevented for one or more reasons. The revised definition for recording a delay is: “any patient post 48 hours clinically optimised”. The ‘next stage of care’ covers all appropriate destinations/transfers out of the NHS hospitals.

Daily internal reviews take place to understand the reasons for patient discharge delays and to try and mitigate these wherever possible. A monthly census count takes place of patients that have a delay to their pathway of care discharge (POCD). While POCD patient census numbers have varied during 2025/26, the main reason for delay is awaiting an assessment. The lowest number was 204 in December 2025 and 220 in March 2026.

To ease this, the number of Trusted Assessors roles has been increased. The assessors aim to help patient discharge from hospital to the next stage of care, preventing delays.

We meet weekly with local authorities to consider and monitor actions where a patient’s discharge from hospital is delayed. We also focus on patients with a longer than expected length of stay.

We continue joint working with colleagues from local authorities, third/independent sector and the Welsh Ambulance Services University NHS Trust (WAST) to enable patient flow, safe patient transfer and enhance community care. Welsh Government funding was used by local authorities to increase social work, reablement,

and domiciliary care capacity across the system.

Cancer Services

Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)

An early diagnosis and treatment of cancer increases a person’s chance of survival and reduces the likely harm to their health and quality of life. Diagnosis and treatment of patients with cancer is needed as quickly as possible.

Performance showed a steady improving trend over the last year. For the past **XX months** it was above 60 per cent, in line with Welsh Government’s Targeted Intervention de-escalation criteria. However, more work is needed to achieve the 75 per cent national target. The challenges in meeting this target during 2025/26 mainly related to fragility within some of our key diagnostic services. These are critical to ensuring the timely investigation of patients with suspected cancer.

We undertook in-depth examination and analysis for each tumour site. This informed our improvement plans for patients with suspected cancer waiting more than 28 days for a diagnostic test.

Meeting the 28-day diagnostic target requires the diagnostic testing part of the pathway to be provided within 7 days. Some key actions were taken to help address this:

- Contracted private suppliers to provide extra Computed Tomography (CT) scans for our patients until March 2026. This equates to 260 more CT scans a month, reported within seven days
- Investment in radiology to secure improvements across all pathways.

Significant improvements in the lower gastrointestinal and urology pathways

- Introduction of Faecal Immunochemical Testing (FIT) within primary care reduced the traditional referral pathway wait by between 14-21 days. This was achieved through streamlining the referral process, prioritising patients for timely investigation, and reducing unnecessary colonoscopies and waiting times. Early signs show positive progress with reducing patient volumes for outpatient and CT scan appointments
- The Urology Service focused on ensuring stable outpatient capacity through an improvement measure for access to Magnetic Resonance Imaging (MRI) scans. This was through the prostate cancer rapid diagnosis (PROSTAD) pathway
- Outsourcing MRI scans for prostate patients started in November 2025. This equates to 20 patients per week, reporting within three days
- Pilot of Galeas Bladder non-invasive urine test from March 2026
- Introduction of 'one stop' gynaecological clinics to streamline the diagnostic service, double the number of 'see-scan-biopsy' slots available and reduce delays. Post-menopausal bleeding hysteroscopy was implemented at Glangwili and Wityhush hospitals in summer 2025
- Nurse-Delivered Local Anaesthetic Transperineal Prostate (LATP) was implemented in September 2025. This enabled clinical nurse specialists to independently deliver LATP biopsies and will increase procedures by over 210 per year
- Nurse-led support and pathology clinics were introduced to improve patient experience and reduce anxiety

- Introduction of Capsule Sponge pilot delivering 25 procedures per month. This minimally invasive test is used to detect conditions of the oesophagus, especially Barrett's oesophagus, without needing a traditional endoscopy. Welsh Government funding was used to support temporary extra nursing for the nurse-led pilot between January and March 2026



We've launched a personalised Cancer Therapies Service offering virtual, tailored support to people with a highly suspected or confirmed cancer diagnosis.

Delivered by a multi-disciplinary therapy team, the service supports patients before, during and after treatment, helping them feel informed, empowered and supported.

Patient feedback highlights the service's holistic, compassionate approach and positive impact on wellbeing.

Read more about the Cancer Therapies Service here:

<https://hduhb.nhs.wales/news/press-releases/supporting-you-through-cancer/>

Planned care, diagnostics and therapies services

Number of patients waiting over 52 weeks for a new outpatient appointment, over 52 weeks and over 104 weeks from referral to treatment (RTT)

Patients receiving timely access to high quality elective treatment and care should experience improved outcomes. Reducing the time that a

patient waits for treatment reduces the risk of the condition deteriorating and eases the patient's symptoms, pain and discomfort sooner.

Performance over the past 12 months is showing an improving trend. Over 99 per cent of our patients waited less than 52 weeks for a new outpatient appointment and 104 weeks for RTT throughout 2025/26.

At the end of March 2026, zero patients were waiting longer than 52 weeks for a new outpatient appointment. Three patients waited longer than 104 weeks and 10,102 patients waited longer than 52 weeks for RTT.

There were challenges through the year:

- staffing in some services
- prioritising urgent and cancer cases, and
- patient suitability for day case procedures or treatment needed by providers outside of the Health Board area.

However, the following recovery actions helped to keep steady performance throughout 2025/26:

- Our outpatient transformation programme, aligned with national planned care programme priorities, provided targeted actions to each specialty. These related to referral management and maximised use of See on Symptoms (SOS) and Patient Initiated Follow Up (PIFU) pathways to use resources efficiently
- Extra recovery funding for outpatients was prioritised in Ear, Nose and Throat (ENT), Neurology and Rheumatology and for treatments in ENT and Ophthalmology
- Demand and capacity modelling was undertaken regularly, optimising capacity, providing performance forecasting and directing funding resources to specialties as needed

- A theatre optimisation workstream was put in place to improve productivity and meet Getting It Right First Time (GIRFT) standards across specialties. This provided guidance on the right staffing levels and cutting variation between sites

Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100 per cent

The number of patients waiting for a follow-up outpatient appointment has increased year-on-year, while capacity has not been able to meet demand. NHS organisations need to improve service planning and clinical pathways to deliver sustainable planned care and reduce waiting lists to a manageable level, supported by PIFU and SOS pathways.

Performance over the past 12 months is showing an improving trend, with delayed follow-ups reducing from 16,504 in March 2025 to 15,182 in March 2026. However, the Targeted Intervention de-scalation target of 11,368 was not achieved.

The key challenges to our performance were:

- staffing challenges
- discreet patient groups needing ongoing face-to-face follow-up appointments
- initiatives to reduce new outpatient waits increased follow-up waits, as more patients progress through their pathways
- prioritisation of urgent and cancer cases, affecting routine activity

Improvements were made through:

- our outpatient transformation programme, which checked non-attendances and maximised the use of PIFU and SOS pathways for efficient use of resources
- working closely with colleagues in digital services, using available systems

- national clinical leadership and Clinical Implementation Network (CIN) guidelines to support our aims to achieve the Targeted Intervention de-escalation criteria. Our improvement programme priorities include:
 - monitoring non-attendance rates for every outpatient clinic and adjusting scheduling for services with rates above five per cent
 - fully implementing CIN follow-up criteria, both prospectively and for established follow-up waiting lists
 - further expanding PIFU and SOS approaches
 - careful evaluation of community health pathways to better manage patient demand
- all specialities now working on exclusions to PIFU/SOS that require ongoing face-to-face appointments

Percentage of ophthalmology high clinical risk (R1) patients waiting which were within their clinical target date or within 25 per cent beyond their clinical target date

For particular eye conditions, patients need regular reviews and ongoing treatment to ensure improved sight and minimised risk of avoidable blindness. A patient target date for new and existing appointments was introduced in 2018. The aim was to reduce the number of ophthalmology R1 patients waiting 25 per cent over their agreed clinical appointment date.

Performance over the past 12 months is showing a concerning trend and did not meet the national target of 95 per cent. However, we are closely following our recovery target to achieve the Targeted Intervention de-escalation criteria of 65 per cent by September 2026. Our performance in March 2026 was xx per cent.

The challenges we faced were:

- balancing requirements to deliver the referral to treatment target and the eye care measures targets with limited resources
- staffing challenges
- consultant and associate specialist doctor vacancies contributing to the reduced clinical workforce, affecting outpatient appointment capacity
- limited clinical workforce across all Health Board sites provided challenges in trying to increase clinic delivery. It also presents difficulties in supporting clinical staff development

The following initiatives took place:

- Extra clinics were introduced as protected capacity to increase R1 appointments
- Intravitreal injections (IVT), supported by an outsourcing contract, to increase delivery
- Regional solutions were explored, including for Age Related Macular Degeneration (AMD), glaucoma, cataract and vitreoretinal sub-specialties. Recruitment processes began to help stabilise the service

Number of patients waiting eight weeks and over for a specified diagnostic

Diagnostic tests and investigations are used to identify a patient’s condition, disease or injury. Diagnostic testing provides essential information to enable clinicians and patients to make the right clinical decisions. Early detection and diagnosis can prevent the patient suffering unnecessary pain and reduce the scale and cost of treatment.

Patients waiting longer than eight weeks are referred to as ‘breaches’ and the national target is to have zero breaches. Performance improvements were made in 2025/26 across the wider diagnostic service. Radiology was the key driver for this improvement. In March 2026,

the diagnostic services with the highest number of patients waiting over eight weeks were:

Specialty	March 2025	March 2026
Radiology	4,587	2,564
Cardiology	150	533
Endoscopy	72	127
All Diagnostics	4,851	3,308

The challenges in meeting this overarching target during 2025/26 related to service fragility within Radiology.

Performance challenges:

- Radiology - experienced higher levels of demand than capacity, mainly within Non-Obstetric Ultrasound (NOUS), MRI and CT. To address this, a staffed mobile MRI van was purchased in January 2025 and another van in August 2025. Staffing shortages affected the provision of obstetric ultrasound services
- Endoscopy - demand was greater than capacity for Gastrointestinal and Cystoscopy at times, due to unplanned outpatient insourcing clinics. An increase in Endoscopy nursing staff was approved in June 2025. Outpatient referrals exceeded internal capacity for diagnostic procedures
- Cardiology - experienced higher levels of demand than capacity, with staffing capacity gaps in CT Coronary Angiography and Exercise Tolerance Tests (ETT) and Dobutamine Stress Echocardiograms (DSE)

The following recovery actions were undertaken in 2025/26:

- Radiology - locum CT radiographers and NOUS sonographers hired to bridge staffing gaps and cover staff absence. We brought in a new radiology IT system in December

2025. This led to decreased activity that month due to installation and staff training. Urgent suspected cancer and emergency activity were unaffected. Continued internal and external (Welsh Government) resources and staffing solutions (insourcing) were implemented to reduce the number of patients waiting

- Endoscopy - a third party contract to deliver more endoscopies on our hospital sites started in February 2026 to support increased referrals. The Urology Service is also testing a urine-based test to replace the need for flexible cystoscopy for some patients. This trial will continue through 2026 and is expected to reduce demand further
- Cardiology - insourcing solutions were implemented to boost capacity. Echocardiograms, Myocardial Perfusion Imaging, Transoesophageal Echocardiograms and Ambulatory Echocardiogram monitoring faced increased waiting list pressures. Despite insourcing, re-triaging and cross-site collaboration, we used outsourcing (third-party staffing) and overtime to address capacity deficits and minimise breach position

Number of patients (all ages) waiting more than 14 weeks for a specified therapy

Patients receiving timely access to a specified therapy should experience improved outcomes. Reducing the time that a patient waits for a service reduces the risk of the condition deteriorating and eases the patient’s symptoms sooner.

Performance over the past 12 months is showing a concerning trend and has not met the national target of zero. It deteriorated from 2,216 in March 2025 to 2,423 in March 2026. This trend has been seen within four out of the seven services, namely Physiotherapy

Musculoskeletal (MSK), Podiatry, Occupational Therapy (paediatrics) and Dietetics.

We have not achieved our Targeted Intervention de-escalation criteria of 90 per cent of patients waiting less than 14 weeks for a specified therapy.

Specialty	March 2025	March 2026
Physiotherapy	1,192	1,333
Occupational therapy	322	452
Podiatry	570	444
Dietetics	78	161
All therapies	2,216	2,423

The key challenges were:

- an increased demand for musculoskeletal (MSK) physiotherapy led to a high percentage in waiting times. Changes to community health and other national pathways caused a shift from primary and secondary care to community MSK services
- an increase in demand for podiatry services, and patient complexity, resulting in appointments taking longer and contributing to the waiting list backlog
- Occupational Therapy has a large backlog of paediatric patients, compounded by increasing demand for services
- Dietetics had an increase in paediatric selective eating demand

The following recovery actions took place in 2025/26:

- Full national Physiotherapy MSK Service review undertaken
- Development and implementation of a telephone triage system for signposting physiotherapy patients to supported self-management resources piloted. Ongoing work underway to broaden its scope

- In-depth demand and capacity new patient tool in podiatry, with recommendations for three more staff to increase capacity
- In-depth demand and capacity new patient tool in Occupational Therapy, and exploring options to increase capacity. For example, reducing clinician travel time, increasing clinics and sensory workshops for parents, to improve flow within the service
- A review of access criteria and a service review carried out within Dietetics

Other actions implemented across all services include waiting list validation, staff skill mixing, exploration of group-based interventions.

Mental Health and Learning Disability Services

Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within 28 days from the date of receipt of referral

This shows compliance with Part 1 of the Mental Health (Wales) Measure 2010. The measure places duties on Local Primary Mental Health Support Services to assess a patient’s mental health needs within 28 days from receiving the referral. A readily accessible assessment (provided when needed) is essential if interventions and treatments for mental health problems are to be delivered as early as possible.

Performance over the past XX months for people aged under 18 years has been above 85 per cent. We have consistently met the planned target of 80 per cent.

Performance over the past XX months for adults aged 18 years and over has been above 90 per cent. We met the planned target of 80 per cent for eleven months out of twelve.

The Health Board was de-escalated for Targeted Intervention in relation to Children and Adult Mental Health Services.

Risks to meeting our targets related to:

- workforce challenges due to short and long-term sickness
- increased referrals
- more complex patients, meaning increased assessment time and the need for follow-up appointments
- tight timescales to achieve the target (patients unable to attend the first assessment could result in the follow-up appointment falling outside the given time period)

Risks were addressed and our targets were achieved by:

- ensuring effective administration processes and support were in place to enable the service to achieve its target. A review of assessment timeslots was undertaken to support complex patients
- continued cross-cover between county LPMHSS teams to support demand
- recruitment to vacancies to address an increase in referrals. We're currently recruiting mental health practitioners in Carmarthenshire and Ceredigion to support increased referrals and complex patients. We recruited a nurse under the 'Grow Your Own' scheme in September 2025

A pilot of the 'One at a Time' approach is planned, with support from NHS Wales Performance and Improvement. This is a structured intervention that provides meaningful support in one session.

Percentage of therapeutic interventions started within 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS)

As with the above assessment, all Local Primary Mental Health Support Services are to provide early and accessible therapeutic

interventions (delivered on an individual or group basis). This will enable more people to recover from mental illness and maximise their quality of life.

Performance over the past XX months for people aged under 18 years has been above 75 per cent. We met the planned target of 80 per cent for eleven months out of twelve.

Performance over the past XX months for adults aged 18 years and over has been above 90 per cent. We have consistently met the planned target of 80 per cent.

We were de-escalated for Targeted Intervention in relation to Children and Adult Mental Health Services.

Risks to meeting our targets related to:

- workforce challenges due to a spike in short and long-term sickness
- an increased number of patients being referred limiting the number of treatment sessions available and access to rooms. This continued to be challenging across the three counties

Risks were mitigated and targets were achieved by:

- working with our Primary Care Liaison Service across Carmarthenshire, Ceredigion and Pembrokeshire as a preventative measure
- developing offers of group interventions in therapies for patients. We continue to learn from this to inform future work
- success in recruiting mental health practitioners, as well as a nurse under the 'Grow Your Own' initiative
- roll-out of the SilverCloud digital platform for therapies referrals for 11 to 15 year-olds. Other supportive intervention options from third sector to help manage demand and increase choice

We're working with NHS Wales Performance and Improvement to pilot the 'One at a Time' initiative in Carmarthenshire. It tests a new approach in Mental Health and Learning Disabilities inpatient services. The focus must be on the person's biggest concern at that moment and should prioritise strengths and recovery.

Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health Service

Providing timely access to specialist psychological therapies in the Adult Mental Health Service is a key priority of the 'Together for Mental Health' Delivery Plan. It aims to bring psychological therapy waiting times for 'referral to assessment' and 'assessment to treatment' in line with recommended times for treatment for physical health domains.

Performance over the past XX months for this performance metric was between 51 and 58 per cent. We did not achieve the 80 per cent target. Performance in March 2026 was XX compared with 59.8 per cent in March 2025.

Challenges in meeting the target were due to:

- patients declining the offer of group therapies, despite being assessed as clinically appropriate
- increasing administrative workload for clinical staff resulting in a reduction in one-to-one activity
- a growing demand for highly specialist complex assessments requiring therapeutic input due to an increase complex trauma and behaviour
- a large geographical area and workforce challenges, particularly in Ceredigion and Pembrokeshire, could delay access where a client needed face-to-face intervention
- challenges in other services. For example, in Learning Disability services, complex

Court of Protection work, workforce pressures and changes in other services, such as Social Services, has limited the service's ability to respond to other referrals in a timely manner

Performance recovery actions included:

- introducing group therapies to clinically-appropriate patients to support an increase in demand. This significantly reduced waiting times with a 92 per cent acceptance rate. These are supported by high intensity interventions to patients where needed. Development of group work in Learning Disabilities Services is underway to support this where appropriate
- implementing digital options with treatment groups for childhood trauma, Obsessive Compulsive Disorder (OCD), stabilisation programme and self-esteem now in place
- support groups specific to treating post-traumatic stress disorder
- recruitment processes, including 'Grow Your Workforce' plans to reduce the impact of key clinical staff obtaining new posts
- new roles and extra training for all staff in the Community Team for Learning Disability (CTLD) to help with Court of Protection work
- new pathways around Memory Clinic and Behaviour that Challenges to upskill wider CTLD team members. This provides earlier intervention without relying on highly specialist input from Psychology and Behaviour Services
- development of the Memory Clinic and the Behaviour That Challenges pathways. These aim to upskill staff to provide earlier intervention and reduce lower-level demands on psychology and behaviour specialists

Neurodevelopmental Services

Percentage of children and young people waiting less than 26 weeks to start an Attention Deficit Hyperactivity Disorder (ADHD) or Autism Spectrum Disorder (ASD) neurodevelopment assessment

There has been an increase in demand for autism and ADHD diagnostic assessments. This has led to lengthy waiting lists for children and young people waiting for a neurodevelopmental assessment.

A national independent review has been conducted to better understand the increased waiting times and pressures on neurodevelopmental services, and to find options for improvement.

Building on this and the Together for Children and Young People Programme (which closed in September 2022), a wider neurodevelopment approach is being developed. This is part of Welsh Government's Neurodivergence Improvement Programme looking at building sustainable neurodevelopmental services across Wales.

Performance over the past **XX months** for children and young people waiting for a neurodevelopmental assessment has been between 18 and 27 per cent. We didn't achieve the 80 per cent target.

Performance in March 2026 was **XX compared** with 24.3 per cent in March 2025.

Challenges in meeting the target were:

- a continued increase in referrals resulting in a need to significantly increase capacity despite efficiency savings being made internally
- a lack of recurrent funding hindering planning to bring about sustainable change
- challenges in clinic room capacity
- staff vacancies

- sickness absence
- new legislative requirements requiring the development of pre and post-diagnostic support which has diverted resources from waiting lists management

Performance recovery actions included:

- a three-year improvement plan and re-design of the ASD service with value-based, person-centred approaches being implemented to improve efficiency
- a waiting list initiative for efficient diagnostic assessment, including a review and prioritisation of the existing waiting list
- an outsourcing contract to remove three-year waits by 31 March 2026
- working with Carmarthenshire County Council to explore the use of 'The Portsmouth Model' profiling tool. If the trial is successful, it will reduce delays in diagnosis and demand on qualitative behavioural tests for ADHD and ASD assessments
- implementing the use of Magic Notes AI scribe tool to support production of structured case notes and reduce administrative burden
- introducing a skill mix to support recruitment and promote a 'grow your own' culture

We're increasing clinic room capacity through Bandi Appeal fundraising and planned reconfiguration of Withybush Hospital's Puffin Ward for children with serious illnesses or injuries. The Appeal helps to provide necessary services for sick children and their families.

Infection Prevention and Control

Number of laboratory confirmed C. difficile infections and bacteraemia cases (in-month) for S. aureus and E. coli

Antimicrobial resistance (AMR) is a global problem that affects all countries and all people.

The scale of the AMR threat, and the need to contain and control it, is widely acknowledged and addressed in the UK AMR Strategy available to view here:

<https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2024-to-2029>

To protect people being cared for in hospitals, rigorous infection control procedures need to be in place.

Our aim is to remove all avoidable infections. Compared to 2024/25, the number of cases of *Clostridioides difficile* (*C. difficile*), *Staphylococcus aureus* (*S. aureus*) and *Escherichia coli* (*E. coli*) has decreased. Within Hywel Dda, we achieved reductions of 12.5 per cent in *C. difficile*, 5.3 per cent in *S. aureus* and 4.5 per cent in *E. coli* cases in 2025/26.

The Welsh Government TI targets for *C. difficile* and *E. coli* were met in March 2026. These need to be sustained for three consecutive months to be considered for de-escalation. TI is extra monitoring and intervention support from Welsh Government.

The de-escalation goals are:

- *E. coli* – 25 per cent reduction in hospital onset cases
- *S. aureus* – 33 per cent reduction in hospital onset cases
- *C. difficile* – 25 per cent reduction in hospital onset cases

Continuous monitoring and interrogation of our infection data suggests that the burden for *E. coli* and *S. aureus* bacteraemia infections is greater within the general population. It shows higher rates of community onset, meaning that cases primarily start in the community, rather than in hospital.

The high number of attendances in our A&Es presents challenges and impacts opportunities

for environmental decontamination, increasing the risk of cross infection.

Key actions supporting infection prevention and control performance within our hospital sites include:

- an emphasis on comprehensive cleaning policies, using modern disinfection technologies. For example, Hydrogen Peroxide Vapor (HPV) cleaning to prevent the survival of spores of *C. difficile* in the environment
- emphasising best practice, hand hygiene, and bare-below-the-elbow compliance. Assessment audits are also conducted regularly to check and maintain standards
- robust leadership, with healthcare acquired infections being checked and scrutinised monthly by our Infection Prevention Strategic Steering Group. This is supported by a dedicated Antimicrobial Management Group to oversee and provide strategic direction. Learnings and actions are shared to further mitigate infection outbreaks
- ongoing staff education and awareness about infection prevention and control practices. Aseptic non-touch technique training is in place also

Workforce

Percentage of sickness absence rate of staff (rolling 12 months)

Reducing sickness absence rates through effective management processes can create significant savings and improve the quality of services provided by NHS Wales.

Staff sickness absence remained stable throughout the year, but did not reduce against the March 2025 performance of 6.6 per cent. Lower sickness rates were reported in the summer months.

Absence rates related to anxiety, stress and depression were the top reasons for absences across the Health Board. Seasonal illnesses, including colds, coughs and flu accounted for the second highest reason for absence.

Ongoing support from our Workforce Team continues, in collaboration with senior managers, with a focus on hotspots across all Clinical Care Groups. Designated support from the Workforce Team continues to help address sickness absence related to employee relations matters:

- Bitesize training sessions were developed for managers and staff to improve the management of sickness absence, for example, the return to work process
- Designated support is ongoing to enable deep dives and data analysis into our most challenged areas and support given for employee relations matters
- To support staff back to work, an Occupational Health 'how to' guide was developed to help with more effective referrals
- Successful recruitment of two sickness absence advisors enabling more focused support for sickness absence management

End of year financial position

To follow in May

Primary and Community Services



We're improving care for patients with urinary catheters across west Wales through our Trial Without Catheter (TWOC) project.

We've introduced community TWOC clinics, moving care from hospitals to the community. This has resulted in quicker appointments, closer to home and more convenient.

Since its launch in 2024, waiting times have fallen from 120 days to just 17, an 86 per cent improvement. All patients received their TWOC within 28 days, and the success rate has reached 62 per cent.

Patient feedback has been excellent, with 100 per cent satisfaction for privacy, dignity, and overall experience.

Read more about TWOC progress here:
<https://hduhb.nhs.wales/news/press-releases/community-based-trial-without-catheter-clinics-helping-patients-across-hywel-dda/>

Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours

GPs are usually the first point of contact for the most people accessing health services.

During 2018-19, the National Survey for Wales reported that 40 per cent of respondents found it difficult to make a convenient GP appointment. Evidence shows that difficulties in accessing a GP appointment adds pressure to other health services, in particular A&E and Out of Hours.

Delivering better access to doctors, dentists and other health professionals is a key Programme for Government commitment. Phase 2 Standards were introduced in April 2022 to continue providing clarity around what should be expected for patients and professionals alike. The standards are based on an access commitment agreed through the General Medical Service Contract Agreement 2021/2022. They require practices to adopt a blended model of access, offering remote, face-to-face, urgent, on-the-day and pre-bookable appointments as decided by clinical need.

The Access Standards form the contractual foundation for how GP practices must provide timely, fair and transparent access.

This is measured on an annual basis. The Health Board achieved 95.7 per cent in 2024/2025, ranking fifth out of seven Welsh health boards.

Percentage of Welsh residents accessing NHS primary dental care treatment

Most oral and dental services are delivered within the primary care setting. Following the National Institute for Health and Care Excellence (NICE) guidance, statistics on adults treated are based on the previous 24-month period. Statistics for children refer to the previous 12-month period.

Each patient is counted only once in the 'total patients treated' statistics, even if they have received multiple episodes of care during the reference period. However, all courses of treatment are counted in the activity statistics, even if the same patient had multiple treatments. Patients may be treated outside of their resident health board and orthodontic patients are included.

Children - Access to NHS dentistry is currently below the Wales average. Poor oral health in children increases demand for urgent care and contributes to avoidable hospital admissions.

Early dental access prevents decay and reduces future treatment burden. Children under 18 years of age are exempt from NHS dental charges, so ensuring access delivers on the Welsh Government's commitment to universal, preventative services. We have seen an improvement of around 2 per cent in 2025/26 compared to the previous year. However, over half of our children did not access dental care treatment within 12 months. In September 2025, performance was 40.7 per cent and 38.9 per cent in September 2024.

Adults - Access to NHS dentistry is currently below the Wales average. Adult oral health strongly influences long-term wellbeing, chronic disease risk, and health inequalities.

Some adults are exempt from dental charges, including many on low incomes, pregnant adults, people with certain conditions. The system must ensure that those eligible for free or reduced-cost care can access it to reduce health inequalities linked to dental care.

The number of adults accessing dental treatment within 24 months decreased to below 30 per cent in 2025/26. In September 2025, performance was 28.5 per cent and 30.9 per cent in September 2024.

Read more information about NHS dental services here: <https://www.gov.wales/nhs-dental-services>

Number of consultations delivered through the Pharmacist Independent Prescribing Service

Pharmacies play a vital role in our communities in every part of Wales. Community pharmacies have been able to offer an extended range of services in Wales since the launch of the reformed contract on 1 April 2022. This reduced demand on GPs and supported access to treatment without the need to wait for an appointment.

From 1 April 2023, the following priority services were combined into a single national Clinical Community Pharmacy Service (CCPS):

- common ailment service
- emergency medicine supply
- seasonal influenza vaccination
- emergency, bridging and quick start contraception

Pharmacies must provide all four services or not at all. Since the reformed contract launched in April 2022, all pharmacies have been enabled to provide a new National Independent Prescribing Service. This involves a suitably qualified and competent pharmacist independent prescriber being available.

This is the UK's first nationally commissioned community pharmacy prescribing service. It provides increased access to services for the public and relieves pressures across the NHS.

In January 2026, 2,647 consultations were delivered across the Health Board area.

Patients aged 12 and above with diabetes receiving all eight National Institute for Health and Care Excellence (NICE) care processes

The majority of diabetes care can take place in primary care. People needing more specialist care are managed in secondary care services. To ensure good diabetes control, avoiding the risk of developing serious complications, clinical teams should monitor people with diabetes against the eight NICE care processes.

Diabetes is one of the largest and most costly health challenges. Ensuring that people with diabetes receive the full set of NICE recommended care processes is a core priority. This is because they underpin early detection of complications, prevention, cost-effectiveness, and improved long-term outcomes. The target of improvement compared to the same month in the previous year has been met throughout 2025/26. However, more than half of our

patients with diabetes aged 12 and above did not receive all eight NICE care processes.

Population Health - vaccination

Vaccines prevent many infectious diseases, protecting individuals, communities and wider health and social care services.

Percentage uptake of influenza vaccination amongst adults aged 65 and over

Percentage uptake of the COVID-19 vaccination for those eligible (Autumn Booster 2025)

Both the COVID-19 and influenza vaccination programmes are key public health initiatives. They aim to reduce the burden of flu-related illness, protecting the most vulnerable groups from serious illness and hospitalisations during the autumn and winter months.

The programme offers free flu vaccines to those most at risk, including people aged 65 and over. From spring 2025, a single COVID-19 booster dose is offered to:

- older adult care home residents
- adults aged 75 and over, and
- people aged 6 months and older who are immunosuppressed

Eligible people are contacted directly by their local health boards or primary care contractor for appointments.

Flu vaccination figures as of 24 March 2026 show an improvement from our 2024/25 campaign with an increase of 1.8 per cent to 70 per cent. However, the national target of 75 per cent was not reached. The end of the COVID-19 campaign uptake figures, as at 28 February 2026, show an improvement on all eligible people, to 57.4 per cent. This is an improving picture, but short of the 75 per cent target. We saw improved vaccination activity within immunosuppressed patients, with an increase of 21.7 per cent compared to the autumn 2024 campaign.

Delivery challenges include equity gaps between deprived and non-deprived population areas and variability of vaccination uptake. However, improvements were due to earlier joint working with primary care services, with increased opportunity to access vaccines through a hybrid delivery model. This included pharmacies, GPs and community pop-up venues, offering early opportunities. Invitation letters were sent to every eligible resident during the campaigns. We improved access through public engagement and joint working.

Percentage of children up-to-date with routine scheduled vaccinations by age five

Immunisation against childhood diseases by five years of age ensures that all new-born babies, infants and pre-school children have better health, ensuring a healthy start in life.

The childhood immunisation programme is achieved through integrated primary healthcare services and includes:

- a broad network of family planning services
- perinatal healthcare (based on essential technologies)
- promotion of child health
- prevention of childhood diseases and
- the appropriate treatment of sick children

As at December 2025, our performance data shows 88.2 per cent, a slight deterioration in trend over the past 12 months (December 2024, 90.4 per cent). The national target of 90 per cent was not reached.

Our key challenges included:

- persistent socioeconomic inequalities (uneven distribution of resources and opportunities within society)
- variability of vaccination uptake and missed opportunities caused by appointment non-attendance or reduced engagement with primary care services

A joint approach was set up between primary care services and the Health Board that increased opportunities to access vaccines through more clinics. We achieved this through:

- monitoring waiting lists of children needing vaccinations at a GP practice
- child health data and
- supportive proactive measures taken by the Health Board team providing additional clinics

We issued communication, through social media and posted mail, to encourage parents/carers to check their child's vaccination status and attend their appointments.

Percentage of children receiving Human Papillomavirus (HPV) by age 15 years

HPV immunisation in early teenage years ensures that young people enter adolescence with strong protection against HPV-related cancers and conditions, supporting long-term health and wellbeing.

The HPV vaccination programme is delivered mainly through school-based services. It provides a co-ordinated, fair and accessible approach that reaches nearly all learners in a familiar setting. This is supported by integrated public health and education partnerships. They promote adolescent health, prevent future HPV-related disease, and offer timely support and follow-up for those who missed the first sessions.

By embedding HPV immunisation within the wider school health services offer, the programme contributes to a healthier population and strengthens cancer prevention from an early age.

Latest data (December 2025) shows 77.1 per cent as an improving performance trend for the past 12 months (December 2024, 73.5 per cent). However, the national target of 90 per cent was not reached.

Delivery challenges include:

- persistent inequalities in uptake linked to socioeconomic factors
- variations in parental consent responses, and
- reduced attendance at school-based vaccination sessions

all of which appear to affect teenage vaccine uptake.

For 2026, the HPV programme has been brought forward to January-March in an attempt to improve uptake. This would also provide a longer time to catch-up before the exam period and end of school term.

School nursing teams are beginning to attend school assemblies and are encouraged to use Public Health Wales resources to help headteachers promote the vaccine programme. The nurse looking after home-educated children is encouraging all children to access vaccination through primary care or Health Board immunisation teams to address gaps in uptake.

Further detail on governance, risk escalation and mitigating actions is set out in the [Governance Statement](#).



The wellbeing of our future generations

Our wellbeing aims set out how we want to improve health and wellbeing, while meeting our duties under the Well-being of Future Generations (Wales) Act.

During 2025/26, we refreshed these aims to align with our updated strategy and reflect what we can realistically deliver. We worked closely with our staff, trade unions, partners and communities in developing these.

At the heart of this work is a strong commitment to a social model for health and wellbeing. This means focusing less on treating illness and more on prevention, early support and tackling the wider factors that shape people’s health, such as:

- poverty
- housing
- social connection and
- the environment

Reducing health inequalities and supporting people to live well must run through everything we do.

Our updated aims focus on four key areas and contribute to all seven national wellbeing goals. They are supported by practical work

programmes that track progress and focus on what matters most locally.

First, **prevention and early intervention**, helping people stay well for longer. This includes community-based services like the

South Carmarthenshire Rapid Access Multidisciplinary Service, which supports people



living with frailty to receive timely care at home and avoid unnecessary hospital stays.

The seven national wellbeing goals:

Second, **environment and climate change**, where we are working towards a low carbon future and building resilience to climate impacts. An example being innovations to reduce waste, including recycling schemes that divert clinical waste away from landfill.

Third, **our workforce**, by creating an inclusive culture, supporting staff wellbeing and developing skills for the future. We're inspiring the next generation through school engagement, work experience and apprenticeships, including supporting the Welsh language and recognising its vital role in patient care.

Finally, **collaboration and involvement**, working closely with communities and partners. This includes:

- using the arts to tackle health inequalities with Gypsy, Roma and Traveller communities, and
- strengthening local connections through community outreach work, such as health events delivered with local voluntary groups, faith organisations and community hubs

Our Wellbeing Objectives Annual Report 2025/26 can be read here:

<https://hduhb.nhs.wales/about-us/governance-arrangements/the-well-being-of-future-generations-wales-act/>

Working together

By working with partners such as local public service boards (PSBs) and West Wales Regional Partnership Board, we're taking a long-term, preventative approach that supports healthier communities. We believe our approach will give future generations in west Wales the best possible chance to thrive.

The current PSB plans are available to read:

- View Carmarthenshire PSB local assessment and wellbeing plan here: <https://www.thecarmarthenshirewewant.wales/the-board/>
- View Ceredigion PSB local assessment and wellbeing plan here: <https://ceredigion.gov.uk/your-council/partnerships/ceredigion-public-services-board/ceredigion-local-well-being-plan/>
- View Pembrokeshire PSB local assessment and wellbeing plan here: <https://www.pembrokeshire.gov.uk/public-services-board>

Ceredigion and Carmarthenshire PSBs will merge during 2026/27 and work is already underway to align priorities and work programmes. Pembrokeshire PSB will continue to run independently, while keeping strong strategic links with neighbouring PSBs.



People using our Early Intervention in Psychosis (EIP) service visited Brynteg Farm and Wellbeing Sanctuary in Llanelli as part of the Adventure Therapy programme.

Using animal-assisted activities helps to build confidence, resilience and support mental health recovery.

Reflecting on her experience, Emily said: "I was really nervous to ride the horse but the staff made me feel confident enough to try it... I felt very proud of myself and found it a very calming and fun experience."

Read about the programme here:

<https://hduhb.nhs.wales/news/press-releases/adventure-therapy-builds-confidence-in-young-people-facing-psychosis/>

Regional whole systems approach to healthy weight

We've taken a new, joined-up approach to tackle healthy weight across west Wales. Working with our PSBs and partners in Hywel Dda and Swansea Bay areas, we're focusing on the wider things that influence people's ability to live healthily.

Through earlier workshops and community engagement in 2024, partners agreed that access to food should be a key priority. In March 2026, organisations across Carmarthenshire, Ceredigion and Pembrokeshire agreed to focus on how public services buy and provide food, making healthier choices easier and affordable. This shared approach helps us tackle inequality and make lasting changes across the system.

Steps towards prevention and reducing inequalities

Health inequalities continue to affect many of our communities. This is made worse by pressures such as climate change, poverty, poor housing and social isolation. Improving health and wellbeing means working together to address these wider issues, not just treating illness.

Our 2025/26 Annual Plan placed a strong emphasis on prevention. This is reflected in our public health work and our Health Improvement and Wellbeing Strategic Plan 2024/27, which focus on helping people stay healthier for longer and reducing avoidable illness. The Plan can be viewed here:

<https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2024/board-agenda-and-papers-25-july-2024/board-agenda-and-papers-25-july-2024/5-4-report-of-the-strategic-development-and-operational-delivery-committee-pdf/>

Social Model for Health and Wellbeing

A key priority is embedding the Social Model for Health and Wellbeing in everything we do. This means working with communities and partners, and designing services around people's strengths, needs and circumstances.




The aim is to reduce health inequalities by giving people more control over their health, focusing on prevention, early support and timely care. Following last year's summit, we've set up a community of practice and an implementation plan to help turn this approach into everyday action.

Read more here about the Social Model for Health and Wellbeing:

<https://hduhb.nhs.wales/healthcare/services-and-teams/social-model-for-health-and-wellbeing/>

20four7 Prevention Model

The 20four7 Prevention Model puts prevention at the heart of our work. It helps us focus our efforts where they can make the biggest difference.

-  Supporting the 20 per cent most deprived communities
-  Tackling key risk factors: smoking, poor nutrition, alcohol and physical inactivity
-  Focusing on priority health areas, including mental health, cancer, heart disease, diabetes and children and young people

Over the coming year, we'll continue rolling out this model to support a shift towards better health and wellbeing for our population. More information about the 20four7 Model can be found in our Director of Public Health Annual Report 2025/26 at:

<https://hduhb.nhs.wales/about-us/performance->



Improving health through local partnerships

Working together with our partners and communities helps us deliver better care, tackle health challenges earlier, and create healthier, happier lives across west Wales. Here we share just a few examples of our partnership work and its benefits.

Our **Community Development Outreach Team** (CDOT) regularly engages with diverse communities and vulnerable groups across our three counties to understand and improve access to healthcare.

We aim to break down barriers and inequalities, serving as a bridge between communities and the Health Board. This includes:

- Gypsy and Traveller people
- people experiencing homelessness or housing insecurity
- people seeking asylum and refugees
- veterans
- unpaid carers, and
- people from Black, Asian and minority ethnic backgrounds

The Team shares health information in community languages, bringing in specialist teams to provide vaccinations to eligible people,

and engage with underserved communities to ensure inclusion in public consultations. The Team is visible across our communities, visiting events, residential sites and emergency accommodation, working in partnership with the local community, third sector and local authorities to strive for positive outcomes.

Our **Whole School Approach to Emotional and Mental Wellbeing Programme** shows how working in partnership can make a real difference. By teaming up with the Scarlets and Carmarthen Quins, we've reached children and young people in their community where they feel safe and supported, not just in classrooms. Bringing health, education and sport together has helped build a shared understanding of trauma and emotional wellbeing. It's given teachers and coaches the skills to spot when someone is struggling and respond with care.

As part of their commitment to becoming Health Promoting Schools, children from Tavernspite and Templeton schools in Pembrokeshire are championing activities that encourage healthy habits such as:

- physical activity
- nutritious eating
- personal safety
- environmental care
- hygiene, and
- positive relationships

The schools also set up a pupil-led emotional and mental wellbeing group. They are the first parkrun schools in the UK, showing their innovative approach to promoting active lifestyles.

People across Carmarthenshire are accessing free, expert mental health support over the phone through the **Active Monitoring** project funded by Tywi Taf GP group. Delivered by professionals from mental health charity Pembrokeshire and Carmarthen Mind, it offers early intervention support for a range of mental health issues.

A new health and wellbeing centre, Atriwm, in Carmarthen, is due to open in early 2027.

The development, led by Carmarthenshire County Council, with UK and Welsh Government funding, brings together council services, healthcare, education and leisure in one central location. The Health Board will deliver several community health services from the building. It will include training facilities for staff and clinics run by the University of Wales Trinity Saint David. Atriwm is a key step forward in delivering healthcare at the heart of the community. It brings a range of health and wellbeing services into one place for people to access support more easily, improve outcomes and support healthier lives.

The opening of the **new Sexual Assault Referral Centre (SARC)** hub in Aberystwyth

shows the real value of partnership working. By bringing partners together, we've created a safe, confidential place where victims and survivors of sexual violence can access medical care, forensic support, counselling and advocacy close to home. Joint funding and shared leadership have made this possible, ensuring services are compassionate, trauma-informed and centred on people's needs. This collaboration across health, policing, local authorities and the voluntary sector, strengthens support across the Dyfed-Powys area. It shows what can be achieved when organisations work together with a shared purpose.



Local people now have access to four new defibrillators on each of Hywel Dda University Health Board's main hospital sites.

This has been made possible by collaboration between the Health Board and Save a Life Cymru to install public access defibrillators for use in the community.

We're the second health board in Wales to engage with Save a Life Cymru to provide public access defibrillators. This will be a great development for the health of our communities and will save lives.

Read more about the public access defibrillators here:

<https://hduhb.nhs.wales/news/press-releases/new-defibrillators-for-public-use-in-local-hospitals/>

Our partnership with **Blue Horizons Adaptive Surf** shows how creative collaboration can transform rehabilitation. Through the BrainWaves Programme, people with neurological conditions take part in supported adaptive surfing sessions at Broad Haven, Pembrokeshire. They are guided by specialist instructors and NHS therapy staff. The six-week programme helps build strength, balance and confidence, while also boosting mood and wellbeing by reconnecting people with activities that matter to them. Patients, families and clinicians have seen powerful physical and emotional progress. To understand the personal impact, read Neil’s journey here:

<https://hduhb.nhs.wales/news/press-releases/brainwaves-neurorehabilitation-group-making-waves/>

The **Pembrokeshire Strengths-Based Collaborative Communication Programme** is changing how health, social care and voluntary organisations work together. Instead of focusing on problems, it encourages positive, person-centred conversations that help people build on their strengths and live the lives that matter to them. Over 200 staff have taken part in shared training and mentoring, improving teamwork, reducing burnout and supporting more sustainable care. The programme has made a real difference for people. It’s now being shared more widely, offering a practical model for integrated, compassionate care across Wales.

Working with community partners, our **Early Intervention in Psychosis service** supported young people to take part in animal-assisted therapy at Brynteg Farm and Wellbeing Sanctuary in Llanelli. The initiative used local resources to support recovery, build confidence and promote wellbeing in a welcoming, community-based setting.

We continue to work closely a range of national and regional organisations, including:

- Health Education and Improvement Wales
- Digital Health and Care Wales
- Aberystwyth University, Swansea University and the University of Wales Trinity St David
- the multi-agency Dyfed Powys Local Resilience Forum.



We introduced targeted interventions to address the rising use of image and performance enhancing drugs (IPEDs) .

Working with partners such as Dyfed Drug and Alcohol Service and Choices, we delivered educational workshops for young people and enhanced harm reduction support for those engaged in fitness culture.

The initiatives provide access to testing, tailored advice and confidential support, alongside outreach in community fitness settings.

The team has also joined forces with leisure, sports, and fitness venues across the region, engaging directly with over 100 people.

Early feedback has been very positive, reflecting a compassionate, partnership-based approach to an emerging public health challenge.

Read more about the initiatives to tackle drug abuse here:

<https://hduhb.nhs.wales/news/press-releases/new-initiatives-to-tackle-rise-in-image-enhancing-drug-use/>



Involving our communities in better healthcare

Better health starts with listening. Across our communities, people have told us what matters most to them when it comes to staying well and accessing care.

This year, we strengthened our commitment to collaborating with staff, patients, communities and partners. We've been hearing about lived experience, understanding local needs, and shaping services together.

By building meaningful relationships and creating opportunities for open conversation, we're helping to design care that's more inclusive, responsive, and better suited to our communities.

In addition to consulting and engaging on our strategy, Clinical Services Plan, primary and community services, we've also been hearing what people think about other services.

For example, we've worked on solutions together with local people to ensure safe, high quality care in Prince Philip Hospital's Minor Injuries Unit in Llanelli.

To help shape local primary care services for the future, we've engaged with patients and the

wider community about Meddygfa Sarn GP practice in Pontyates. During the summer, we listened to patients about their experiences of changes to general medical services across the St David's peninsula, including Meddygfa Penrhyn.

We've been working with the local community to understand how the temporary change to non-urgent adult mental health referrals in North Ceredigion are affecting people. The changes aim to reduce patient waiting times and workforce pressures. We also gathered wider views to understand what the impacts and potential mitigations could be if this temporary change was rolled out across Hywel Dda.

We've also engaged with our communities about their views on local community pharmacy services to support the re-writing of our Pharmaceutical Needs Assessment.

Community outreach

Our Community Development Outreach Team regularly engages with diverse communities and vulnerable groups across our three counties to understand and improve access to healthcare.



Community events

We've held a weekly **learning disability health drop-in service** in Carmarthen, offering accessible, friendly support for adults with learning disabilities. The sessions are run by a group of nurses and support workers with experience of communicating, and supporting adults, with learning disabilities.

Our **South Ceredigion Cluster Frailty Team** has been helping older people live well, independently and with confidence. At local summer events in Cardigan and Llandysul, the team connected with people and offered vital preventative care. This included free health checks, such as blood pressure and BMI testing, and advice about one-to-one support in the home.

Liver disease is the third biggest cause of death and fastest growing cause of cancer-related deaths. Since July 2025, our **Ceredigion Hepatology Team** conducted 17 liver health events in Ceredigion, scanning around 1000 members of the public. Each event picked up

between 11 and 15 per cent of people with varying levels of liver disease.

People received advice about prevention and lifestyle changes and, where needed, referred for further health management. These events help to improve people's health and ultimately save lives.

The Team also work with our Value-Based Healthcare Team, testing out a tool to capture patients' health and wellbeing over a 12 month period.

We attended **The Royal Welsh Show** in July and **Pembrokeshire County Show** in August. These popular events gave us the opportunity to talk with people and share information about our services.

Staff from a range of healthcare services were on hand at the Pembrokeshire show and gave advice and support about:

- health and wellbeing, lifestyle changes
- diabetes
- vaccinations
- school nursing
- local GP and community health projects
- community outreach and support
- our Clinical Service Plan consultation

People also had an opportunity to have a health check and get involved in other fun wellbeing activities.

How you can get involved

If you are interested in taking part in future engagement activities or you would like to keep up-to-date with the Health Board's work, you can join our Hywel Dda engagement scheme Siarad Iechyd/Talking Health here:

<https://hduhb.nhs.wales/healthcare/services-and-teams/siarad-iechyd-talking-health/>



Advancing care through research and innovation

Throughout 2025/26, we continued to support research, development and innovation to improve patient care, service quality and value. Our new Research and Innovation Plan for 2025-2030 sets the way ahead for patient benefit, service improvement and value-based healthcare.

Research and innovation continue to play a vital role in improving care for our patients. Over the year, more people have had the chance to take part in clinical research. This has given them access to new treatments, equipment and ways of working.

This growing research activity has also brought in more external funding, helping us invest more in local services. Commercial research has continued to grow too, supporting innovation while strengthening our financial sustainability.

Our work through the TriTech Institute has also moved forward. We agreed a new business plan outlining how TriTech will test new health technologies in real-life settings and support their safe use in everyday care.

Alongside this, we made progress in improving cancer research pathways. We helped to make sure patients across Hywel Dda and Swansea Bay areas have fairer and more consistent access to research opportunities.



Our podiatry clinics play a vital role in detecting hidden heart conditions that can lead to stroke. This pioneering approach uses a small mobile device to identify atrial fibrillation (AF), a common heart rhythm disorder and major cause of stroke. It was highly commended in the Digital and Technology Innovation category at the Advancing Healthcare Awards Cymru 2025.

The initiative is a collaboration between Hywel Dda's Podiatry Service, Arrhythmia Service, and Value-Based Healthcare Team, supported by digital teams across the health board.

Read more about the AF initiative here:

<https://hduhb.nhs.wales/news/press-releases/highly-commended-podiatry-service-helps-detect-stroke-risk/>

Strong partnerships are still central to our success. We continued to work closely with universities, industry and voluntary organisations to make sure research and innovation are shaped by local needs. During the year, we signed agreements with regional universities and helped launch a new Centre for Social Innovation with the University of Wales Trinity Saint David.

We continue to explore digital technology to improve healthcare and make services work better for people. Examples of digital tools we've introduced in Hywel Dda over the last year include:

- A new patient flow and e-observation system that tracks patients in real time, reduces delays and duplication. We plan to rollout the electronic observations by summer 2026
- A Radiology Information Systems Procurement (RISP) system that xxx was launched on 1 December 2025
- An electronic Prescribing and Medicines Administration (ePMA) to reduce the risk of medication errors. It ensures prescriptions are clear, legible and complete, with built-in safety checks for allergies and dosage accuracy

We kept good oversight through our Research and Innovation Sub-Committee, which checked performance, risks and funding. However, we also faced challenges. Funding pressures, operational demands and workforce gaps slowed some projects and highlighted the need to better support and develop our researchers.

Overall, 2025/26 was a year of steady progress. We've put strong foundations in place, and our focus for the year ahead is on building these further:

- growing research partnerships
- supporting our researchers
- delivering the TriTech business plan, and
- continuing to improve outcomes for patients, staff and communities

Read our Research and Innovation Strategic Plan 2025-2030 here:

<https://tritech.nhs.wales/wp-content/uploads/2025/06/REF26368-Hywel-Dda-RIS-2025-Doc-ENG-Digital-STP.pdf>



Our people, making the difference

Our staff are at the heart of everything we do. During 2025/26 we continued to focus on supporting, valuing and developing our workforce during a challenging period for health and care services.

We were pleased to recognise and celebrate staff achievements throughout the year. Our Hywel's Applause staff awards returned as an engaging in-person event. Long service awards also remained important, with staff recognised for milestones ranging from 25 to an exceptional 60 years of service.

Simple initiatives like Employee Appreciation Day continued to grow, showing how much colleagues value recognising each other.



Staff engagement remained stable, with improved participation (22 per cent) in the 2025 NHS Wales Staff Survey and positive

movement across most areas. 71 per cent of staff who responded showed a consistent level of commitment and connection to the organisation.

We've continued to encourage an open culture, supported by our Speak Up initiative. More staff raised concerns early through informal routes, helping to address issues sooner and more constructively.

Staff wellbeing stayed a priority. More than 250 colleagues received one-to-one psychological support, and 60 attended our Recovery in Nature Programme, helping to reduce stress and burnout. Leadership and development also continued to grow.

We saw strong demand for programmes like LEAP, Hywel Dda Manager and Foundations in Management, alongside an expanding network of 45 qualified coaches. Regionally, we now have 78 qualified coaches, enabling cross-organisational coaching support. Our Coach Approach Programme has now been delivered to 569 participants.

Workforce pressures are still a challenge, but there has been progress. We are proud to have the lowest nursing turnover of any NHS organisation in Wales since 2024.

Targeted retention work, including 'stay conversations' has helped teams understand what matters most to staff and where support can make a difference. We've reduced reliance on medical agency staff by supporting more people into bank or permanent roles.

We also strengthened recruitment pipelines and improved links between workforce planning and service delivery. We continued to promote equality, diversity and inclusion recognising that consistent and inclusive practise is still a long-term ambition.

language naturally. Staff at all skill levels are encouraged to practise and build confidence. This helps us deliver more personal, respectful care that meets people's needs.

We meet our legal duties under the Welsh Language Standards and aim to go further. We continued work with the National Centre for Learning Welsh to build staff confidence. Our progress will be reported in our Annual Welsh Language Report, due to be published in summer 2026.

More information about our Welsh language services is available here:

<https://hduhb.nhs.wales/healthcare/services-and-teams/welsh-language-services/>



Following a successful recruitment campaign, we were able to return to a fully operational children's services at Bronllais Hospital.

Recruiting six new children's nurses allowed Angharad Ward to return to normal after a temporary change to maintain patient safety.

During this period, the hospital continued to provide 24/7 care, treating around 400 paediatric patients locally, with minimal transfers required. The return of full services strengthens access to timely, high-quality care for children and families in the region.

Read more about the return of services to Angharad Ward here:

<https://hduhb.nhs.wales/news/press-releases/return-of-services-to-bronglais-childrens-ward/>

Staff language skills

The language skills of our staff, in accordance with Standards 116 and 117, are captured and recorded on ESR. As at 31 March 2026, 98 per cent of staff have recorded their Welsh language skills as follows:

Skill Level	0 - No Skills / Dim Sgiliau	1 Entry/ Mynediad	2 Foundation / Sylfaen	3 Intermediate / Canolradd	4 Higher / Uwch	5 Proficiency / Hyfedredd	Not recorded on ESR	Total
Hywel Dda UHB	5,195	2,737	1,107	914	922	1,400	251	12,526
%	41%	22%	9%	7%	7%	11%	2%	100%

In addition, 35 per cent of staff have recorded their skills as between levels 2 to 5, and 26 per cent between levels 3 to 5.

Welsh language related complaints

Four Welsh language service complaints were received during 2025/26. One investigation has been conducted by the Welsh Language Commissioner within the year under Section 71 of the Welsh Language Measure. [Full details are available in our annual Welsh Language report](#) at: [Welsh language services - Hywel Dda University Health Board](#)

- 31 on Cwrs 10 awr (10-hour beginner course), and
- 32 on Cwrs Hunan Astudio (self-study course)

Other learning opportunities included:

- 32 staff taking part in Cyrsiau Blasu Ar-lein Cymraeg Gwaith (online taster courses)
- 2 in the Cynllun Dementia (Dementia Programme), and
- 2 on Cwrs Preswyl Nant Gwrtheyrn Iefel Canolradd (an intermediate-level residential course at Nantgwrtheyrn)

Vacant posts

During the year, 2,423 vacancies were advertised. Welsh was essential for 32 posts, desirable for 2,069 posts, and not needed for 322 posts. No posts required Welsh to be learnt after appointment.

From these vacancy adverts, 2,482 posts were offered. Of those appointed, 499 people already had Welsh language skills at levels 3 to 5.

Learning Welsh

During the year, 319 staff took part in Welsh language learning. This included:

- 102 on the Cwrs Croeso (welcome course)
- 118 on Cwrs Codi Hyder (confidence-building course)

Developing our workforce

Working closely with Health Education and Improvement Wales, we now have 79 operational workforce plans in place. These are aligned with our Clinical Services Plan, helping ensure staffing, skills and future recruitment match changing models of care.

Regional and primary care workforce planning also progressed, particularly in GP out-of-hours, pharmacy, dental services. We continue to work with partners to address high-risk roles.

We have expanded simulation and digital learning, making training more practical and

accessible. One hundred educators were trained to deliver simulation sessions, reaching over 600 staff across hospital and community services. This has helped teams practise safely, build confidence and improve care.

Over the past year, we supported staff at all stages of their careers to learn, develop and progress. More than 1,000 staff applied for individual continuing professional development, with hundreds more taking part in group learning. Our Support Worker Development Programme helped 247 healthcare support workers build new skills and move into distinct roles. These were supported by recognised qualifications through our Agored Cymru accreditation.

Behind the scenes, we strengthened how we plan for the workforce of today and tomorrow.

- We invested in our future workforce, engaging with **8,500** pupils across all secondary schools in the region. **4,727** learners took part through the medium of Welsh, almost double the previous year
- Our health masterclasses supported **983** learners, alongside **234** students in work-based learning, including 'Day in the Life' experiences
- We also offered **124** clinical electives and **182** work-experience placements
- Our Becoming a Doctor Programme saw a **52 per cent** rise in applications, while our Pathway 4 Programme supported **13** young people with other needs
- Our volunteering community grew to **245** volunteers, and our Apprenticeship Academy now supports **141** apprentices

While our challenges remain, encouraging progress this year gives us a solid foundation to continue supporting our people and the quality care they provide.

Our award-winning staff

Award wins at local and national level reflect the dedication, innovation and compassion our staff bring every day. Here are a few examples of our staff achievements throughout the year:

- Our **Community Dementia Wellbeing Team** won the Citizen and Third Sector Choice Award at the West Wales Regional Partnership Board Conference
- **Craig Baker, Cellular Pathology and Mortuary Service Manager** received the Biomedical Scientist of the Year award at the Advancing Healthcare Awards 2025
- **Bronglais Hospital** was presented with the 'Work in VTE Prevention' award during a ceremony at the House of Commons. It celebrated the achievements of Dr Annette Snell and her multidisciplinary team
- The **North and South Pembrokeshire Clusters** were nationally recognised at the 2025 NHS Wales Sustainability Awards for their innovative project 'Lessons in Asthma'. The project improves respiratory care for primary school children
- Our **Chronic Obstructive Pulmonary Disease (COPD) Team** won the top prize in the Excellence in Asthma COPD category at the Welsh Healthcare Awards 2025. This was in recognition of their innovative use of smart technology and remote monitoring to support patients from home
- **Angharad Hanbury, Lead Radiology Nurse** received a prestigious Nursing Excellence Award from Sue Tranka, Chief Nursing Officer (CNO) for Wales
- Our **Optometry Team** won the Health Board Support Award at the Optometry Wales Awards 2025. The award recognised its leadership in implementing the new national optometry contract

- Our **Pembrokeshire Diabetes Team** was awarded overall winner at the 2025 National XPERT awards. This was in recognition of their community-focused, culturally sensitive approach to Type 2 diabetes education, improving access and health literacy among underserved groups
- Our **Early Years Integration Team** was named West Wales Regional Partnership Board (RPB) Team of the Year. It was in recognition of their exceptional collaborative work supporting families and young children in the Gwendraeth Valley, Carmarthenshire
- **Anwen Butten, Head and Neck Cancer Clinical Nurse Specialist**, was awarded the prestigious Member of the Order of the British Empire (MBE). The 2025 King's Birthday Honour was awarded for her outstanding contribution to sport and to nursing and cancer care
- **Dr Ayman Wafy, Core Trainee in Psychiatry** was named as Hywel Dda's Trainee of the Year 2025. He was recognised for his outstanding contribution to clinical practise, education, and professional development
- **Ambia Haque** won the Rising Star award in the Celebrating Excellence in NHS Wales Finance. Her exceptional drive, initiative, and commitment marks her out as a future leader within NHS Wales Finance
- **Dr Tipswalo Day** won in the Public Services category of the St David Awards. Tipswalo, a consultant at Glangwili Hospital, is an inspirational obstetrician and gynaecologist dedicated to transforming maternity care for women in Wales and beyond
- Many more teams and services were accredited in our **Investors in Carers (IiC)** scheme. IiC promotes best practice in finding and supporting unpaid carers of all ages

We're incredibly proud of all our people, whatever their role across the organisation, for making quality health care possible every day. Their dedication, compassion and commitment continue to make a real difference to the health and wellbeing of our communities.



Caring for our planet and our people 🌱

Over the last year, we have continued to plan, scope and deliver opportunities to reduce carbon and bring sustainable practices into our day-to-day activities.

We have installed renewable energy generation and energy efficiency technologies to reduce our carbon footprint, contributing to Welsh Government's 2030 net zero public sector target. This included solar carports at South Pembrokeshire Hospital, Pembroke Dock and upgraded building management controls at Bronglais Hospital, Aberystwyth and Glangwili Hospital, Carmarthen.

Contractors have also found several future energy-saving opportunities for Bronglais Hospital and Withybush Hospital in Haverfordwest.

We continue to keep our performance and systems in line with ISO 14001 standards. Recent external audits of our waste management processes have highlighted areas for improvement. We have set clear goals to address these, which we check and review regularly.

Our approach to agile working is well-established, supported by an approved

plan and toolkit that help staff work from the right location for their role. We are making better use of our buildings to ensure they are fully used and work well.

We're working to cut emissions from our fleet vehicles and have a plan to switch to electric ones (EVs). We have secured EV charging infrastructure funding for 2026/27 to install EV charging stations for our fleet across Health Board sites to support this. We are also promoting the Health Board's lease car scheme with staff and encouraging the move to electric vehicles.



Cutting waste and increasing recycling continue to be top priorities for us. We're delivering the requirements of the Workplace Recycling Regulations to make sure we separate different types of waste for collection. These include paper, card, plastics, tins, food and glass on most of our sites.

We continue to increase ward recycling of absorbent hygiene products to lower carbon emissions and improve recycling rates. Since last year, we have diverted around 80 tonnes of hygiene products from landfill to be recycled.

The A&E in Withybush Hospital has achieved the Greener Emergency Department Framework bronze award status. We have tested reusable tourniquets in some wards in Prince Philip Hospital and we're changing from using plastic to paper medicine cups.

Other projects focusing on sustainable products, waste, single-use items, and plastics are also progressing. These include:

- laundering and reusing or recycling staff uniforms
- expanding our online Warp-It system to recycle and reuse more equipment to avoid waste
- implementing the Greener Emergency Department Framework to achieve bronze award status in our other A&E departments

Crown Commercial Services supplies electricity and gas to NHS Wales, including our Health Board. Although utility costs are still high, they have decreased due to lower unit prices following changes in the energy market.

We have developed a new Energy Performance Contract (EPC) with Vital Energi Ltd through the Re:Fit 4 Wales Framework. Vital Energi has carried out assessments at six sites to find opportunities to improve energy efficiency. These are: Bronglais, Glangwili, Prince Philip and Withybush hospitals, Hafan Derwen, and the Elizabeth Williams Clinic. Proposals include

upgrades to LED lighting, heating systems, insulation, building management systems, rooftop solar installations, air handling units, and chillers.



Work on the first phase is due to begin in April 2026, supported by a £10 million investment from the Welsh Government's Invest-to-Save Programme. Completion is expected during the 2026/27 financial year.

The Welsh Government NHS Decarbonisation Strategy has recently been updated and includes added initiatives. **Our Decarbonisation Delivery Plan** outlines our aim to meet those extra initiatives. This will be in areas like carbon management, buildings, transport, procurement, estate planning, land use, and clinical sustainability.

Training and development

Over the past year, our Environment Team has developed waste awareness training to help staff better understand each colour-coded waste stream used in healthcare settings. This also included the consequences of incorrect waste separation.

This training is now available through our online Electronic Staff Management System (ESR). Staff can also access e-learning modules on topics such as climate change, environmental sustainability, and achieving net zero.

Health Education and Improvement Wales (HEIW) provides Climate Smart Community training, which our staff are encouraged to take part in. The VAULT Sustainability Pages also offer guidance on efficiency opportunities and best practise examples from across NHS Wales.

For more detail, our full Sustainability Report for 2025/26 will be available on our website in June 2026: <https://hduhb.nhs.wales/about-us/governance-arrangements/board-committees/finance-and-performance-committee-fpc/>

Taskforce on Climate-related Financial Disclosure - Compliance Statement

This Climate-Related Financial Disclosure has been prepared following the requirements of Paragraph 3.41 of the Welsh Government Manual for Accounts. It is aligned with the four core themes of the Task Force on Climate-related Financial Disclosures (TCFD): Governance, Strategy, Risk Management, and Metrics and Targets.

This disclosure reflects the Health Board’s ongoing commitment and compliance to:

- environmental sustainability
- transparent financial reporting, and
- alignment with Welsh Government policy and NHS Wales strategic goals for net-zero emissions

We are committed to environmental sustainability and reducing carbon emissions, following the Environment (Wales) Act 2016 and The Climate Change (Wales) Regulations 2021. We continue to make positive progress towards net zero targets and climate adaptation planning. This is in line with the NHS Wales Decarbonisation Strategic Plan and the Climate Adaptation Strategy for Wales.

Our Climate Adaptation Plan was approved by the Health Board at its meeting in March 2026 and can be viewed here:

<https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2026/board-agenda-and-papers-26-march-2026/board-agenda-and-papers-26-march-2026/19-1-climate-adaptation-plan-pdf/>

The plan focuses on ensuring clinical and operational resilience, with adaptation integrated into service planning, business continuity, capital development and workforce planning.

Our governance around climate-related issues

We have conducted our own climate risk assessment and set up a governance structure to oversee the climate-related risks, issues and opportunities. Oversight rests with our Strategy and Planning Committee which is a formal sub-committee of the Board. Issues and risks are also checked and reported to Welsh Government through bi-annual qualitative reporting templates.

The Director of Public Health is responsible for embedding our climate and nature emergency response and resilience into:

- service planning
- capital development
- public health protection
- service delivery, and
- business continuity

Our Board’s oversight of climate-related issues

Our annual net zero reporting is overseen by our Corporate Performance Team and a robust process in place for completion and verification. This report is approved by our Strategy and Planning Committee before being sent to Welsh Government.

'Climate Change and Decarbonisation' is a formal scheme of delegation of the Public Health Directorate. They have developed a climate risk assessment and are expanding their portfolio of work to include delivery of the Health Board's new Climate Adaption Plan.

Our Hywel Dda Decarbonisation Delivery Plan includes 46 initiatives to meet Welsh Government's net zero targets. We track and report our climate mitigation efforts through:

- monthly Strategic Property and Environment Taskforce Group activity updates
- the Sustainable Transport Group
- the Estates and Energy Performance and Improvement Group
- the Value and Sustainability Group (Finance)
- an Annual Qualitative Report to Welsh Government
- Integrated Quality Planning and Delivery review meetings (as requested by Welsh Government)
- the Health Board's annual reporting process, including governance and wellbeing objectives
- annual quantitative net zero emissions reporting to Welsh Government
- an Annual Public Services Board report (as requested by the Public Services Board)

Management's role in assessing and managing climate-related issues

We support the ambition of NHS Wales to become a net zero health service by 2030. Climate-related issues are integrated into short, medium and long-term strategies through our Decarbonisation Delivery Plan and new Climate Adaptation Plan. This is in line with Welsh Government priorities and national policy.

Climate change is a priority affecting all parts of our organisation. Managers across several directorates contribute to net zero and environmental sustainability activities, as well as supporting the Environment Team to keep the ISO 14001 standard.

We've implemented an environmental sustainability impact assessment tool for managers and decision-makers to risk assess their activities on our route to net zero and climate ambitions. This will improve decision-making, compliance, risk management, consideration of equality/human rights, and socioeconomic factors.

Metrics and targets used to assess and manage relevant climate-related issues

Emission Reduction Targets: 16 per cent reduction by 2025; 34 per cent reduction by 2030 (from 2020 baseline). The Welsh Public Sector Net Zero Target Carbon Report tracks our data outputs and performance towards the 2030 and interim net zero targets. This is linked to the operational risk on the Health Board's risk register and updated in line with our risk management framework.

Our Decarbonisation Delivery Plan summarises the impact of our climate actions, aligning with the NHS Wales Decarbonisation Strategic Delivery Plan. It focuses on reducing carbon emissions from buildings, transport, procurement, and clinical areas like anaesthetic gases.

Emissions and the related risks

The table below shows our position in 2024/25 (measured in kgCO²e) and how it compares to 2023/24 and the trend.

Categories	2023/24	2024/25	Trend
Buildings, fleet and other assets			
Buildings	20,052,328	21,362,274	↑
Streetlighting	622	4294	↑
Fleet and equipment	676,043	563,624	↓
F-gases and anaesthetic gases	1,877,545	1,920,265	↑
Business travel, commuting and homeworking			
Business travel	2,200,851	2,084,307	↓
Commuting	16,282,868	15,733,933	↓
Homeworking	954,588	920,110	↓
Waste			
Organisational waste	501,733	460,656	↓
Supply chain - Tier 1 and Tier 2 combined			
Supply chain	111,192,247 (Tier 1 method)	113,436,849 (Tier 1 method)	↑
	96,075,696 (Tier 2 method)	17,766,625 (Tier 2 method)	↓
Land based emissions			
Total land-based emissions	-	-	n/a
Total emissions			
Total emissions	153,738,825 (Tier 1 method)	156,025,656 (Tier 1 method)	↑
	138,622,274 (Tier 2 method)	60,355,432 (Tier 2 method)	↓

Renewable energy (kWh)			
Onsite renewables - heat	6,836,205	3,893,750	↓
Onsite renewables - electricity	440,088	757,302	↑
Purchased renewables - electricity	10,194,208	0	↓

The Health Board’s net zero public sector results for 2024/25 show that overall carbon emissions have risen compared to 2023/24.

Emissions increased from 152,738,825 kgCO₂e (Tier 1 methodology) to 156,025,656 kgCO₂e (Tier 1) but reduced from 138,622,274 kgCO₂e (Tier 2 methodology) in 2023/24 to 60,355,432 kgCO₂e (Tier 2) in 2024/25.

This is because of a change in methodology used by NHS Wales Shared Services Partnership (NWSSP) on how they account for supply chain emissions compared to reporting in previous years.

Emissions from buildings, fluorinated/ anaesthetic gases, and streetlighting rose during the year. The increase in streetlighting emissions reflects the correction of an error, from Bronglais Hospital streetlighting data being omitted in previous years.

At the same time, emissions from the following areas have all decreased since 2023/24 and shown positive progress:

- fleet and equipment
- business travel
- staff commuting
- homeworking, and
- organisational waste

Impacts from climate change is included in the Health Board’s corporate risk register. The ability to meet the net zero targets and deliver the decarbonisation plan is included on the operational risk register. Risk management reports are reviewed by the Board and mitigation activities are updated regularly.

Our performance against targets to manage climate-related risks and opportunities

Climate-related risks are identified via the Climate Risk Assessment and Risk Register. The Public Health Directorate and the Risk Management Team, along with the relevant risk owners, regularly review and update these risks. They provide updates to relevant committees and senior responsible people.

Scenario analysis is used to assess the potential impact of climate-related threats such as extreme weather, energy price volatility, and supply chain disruptions. Further details on our climate emergency risks, responses and resilience planning are included in our Climate Adaptation Plan.

Biodiversity: Compliance Statement

What is the Biodiversity Duty?

Section 6 under Part 1 of the Environment (Wales) Act 2016 introduced an enhanced biodiversity and resilience of ecosystems duty (the S6 duty) for public authorities in the exercise of functions in relation to Wales. The S6 duty requires that public authorities (including all health boards and trusts) must seek to maintain and enhance biodiversity so far as consistent with the proper exercise of their functions and in so doing promote the resilience of ecosystems.

What do NHS Wales organisations have to do?

To comply with the S6 duty public authorities should embed the consideration of biodiversity and ecosystems into their early thinking and business planning, including any policies, plans, programmes and projects, as well as their day-to-day activities. To comply with the S6 duty, most public authorities must prepare and publish a plan setting out what they propose to do to maintain and enhance biodiversity and promote resilience. This plan can and should be an integral part of any planning document as part of the health board or trust business or corporate planning processes. A standalone plan is not necessarily required.

As a public body in Wales, Hywel Dda University Health Board (UHB) recognises its legal duty under Section 6 of the Environment (Wales) Act 2016 to seek to maintain and enhance biodiversity, and in doing so, promote the resilience of ecosystems, in the exercise of our functions.

We fully acknowledge the interdependencies between the natural environment, the health and wellbeing of our population, and our obligations under the Well-being of Future Generations (Wales) Act 2015. In line with the sustainable development principle, we aim to ensure that our decisions and operations meet today’s needs without compromising the ability of future generations to meet theirs.

Our approach and achievements

In 2025/26, Hywel Dda UHB has continued to build on its commitment to biodiversity and ecosystem resilience through a range of activities that align with our environmental and health objectives. These actions contribute directly to the following national wellbeing goals:

- **A Resilient Wales** – by supporting healthy, functioning ecosystems and managing our estate with nature in mind
- **A Healthier Wales** – by creating greener spaces that support physical and mental wellbeing
- **A Globally Responsible Wales** – by minimising ecological harm and fostering sustainable practises across our services and infrastructure

Key actions include:

- **Sustainable estate management:** We have continued to implement nature-positive practises across our sites where opportunities arise, including habitat conservation, native tree and wildflower planting, and active development of green spaces
- **Green space enhancements:** Projects such as biodiversity corridors, pollinator-friendly planting, and wildlife-friendly landscaping have been expanded across various community and hospital locations
- **Capital schemes and design standards:** We increasingly factor biodiversity and climate resilience into capital developments, and infrastructure upgrades where opportunities arise
- **Staff and community engagement:** The Health Board has partnered with organisations to improve green spaces and raise the profile of biodiversity

Maintaining our commitments and moving forward

To further embed our statutory duties under the Environment Act and Future Generations Act, we will:

- develop and publish a Biodiversity and Ecosystem Resilience Plan aligned with both Acts, setting clear priorities

- work with Natural Resources Wales, local authorities, and Public Health Wales to ensure coordinated approaches to nature recovery at a regional level
- enhance green infrastructure across our estate to support biodiversity net gain, carbon reduction, and better patient environments where opportunities arise
- incorporate biodiversity principles into our climate response planning (adaptation), recognising the link between environmental quality and health outcomes
- monitor and report our biodiversity actions through our climate response activity aligning with our broader climate response and adaptation ambitions

By taking these actions, Hywel Dda UHB contributes meaningfully to Wales' nature recovery agenda while ensuring that our operational activities support the long-term wellbeing of the communities we serve.

Reflecting and looking ahead

2025/26 has been a challenging year for Hywel Dda University Health Board, with extremely high demand, staffing pressures and financial constraint. These pressures have at times been difficult for patients, staff and communities. Despite this, our focus has remained on keeping people safe, supporting our staff and improving care wherever possible.

This annual report shows a mixed picture. There have been areas of progress, including improvements in cancer services, mental health care, infection prevention and workforce stability. At the same time, too many people are still waiting too long for care, particularly in urgent and emergency services and planned treatment. Financial sustainability is still a major challenge.

Alongside managing day-to-day pressures, we have continued to look ahead. Our refreshed strategy, 'A Healthier Mid and West Wales – Healthier lives, well lived' gives us a clear direction to 2040.

Our work on the Clinical Services Plan and the developing 'Community by Design' approach will continue into 2026/27. These programmes aim to improve safety, quality and sustainability. They have been shaped by extensive engagement with staff, patients and communities, and listening to these voices will remain essential as changes progress.

Looking ahead to 2026/27, our Annual Plan focuses on a small number of clear priorities. These include:

- maintaining safe services
- improving access and patient flow
- supporting and stabilising our workforce
- reducing reliance on agency staff, and
- improving quality and patient experience

Financial recovery will remain a central focus, supported by continued close working with

Welsh Government. While we are not yet financially sustainable, we have a clearer understanding of the actions required and the pace of improvement needed.

Partnership working will be increasingly important. Improving health and wellbeing cannot be achieved by the NHS alone. Working with local authorities, voluntary organisations and communities, we will continue to embed a social model for health and wellbeing. This will focus on prevention and reducing health inequalities.

Our commitments to sustainability, research and innovation, digital transformation, bilingual services and meaningful involvement remain central to how we work.

Above all, our future depends on our people. The professionalism, resilience and compassion shown by our staff and volunteers throughout 2025/26 has been exceptional. Supporting their wellbeing, development and ability to deliver high quality care remains our priority as we build safer, sustainable services for our communities.





Integrated Impact Assessment Tool	Y/N	Evidence & Further Information	Completed By	Evidence (Insert)
Financial/Service Impacts				
1. Has the new proposal/service model been costed? If so, by whom?				
2. Does the budget holder have the resources to pay for the new proposal/service model? Otherwise how will this be supported - where will the resources/money come from i.e. specify budget code or indicate if external funding, etc?				
3. Is the new proposal/service model affordable from within existing budgets?				
4. Is there an impact on pay or non pay e.g. drugs, equipment, etc?				
5. Is this a spend to save initiative? If so, what is the anticipated payback schedule?				
6. What is the financial or efficiency payback (prudence), if any?				
7. Are there risks if the new proposal/service model is not put into effect?				
8. Are there any recognised or unintended consequences of changes on other parts of the system (i.e. impact on current service, impact of changes in secondary care provision on primary care services and capacity or vice versa, or other statutory services e.g. Local Authorities?)				
9. Is there a need for negotiation/lead in times i.e. short term, medium term, long term? If so, with whom e.g. staff, current providers, external funders, etc?				



10. Are capital requirements identified or funded?				
11. Will capital projects need to be completed in time to support any service change proposed?				
12. Has a Project Board been identified to manage the implementation?				
13. Is there an implementation plan with timescales to performance manage the process and risks?				
14. Is there a post project evaluation planed for the new proposal/service model?				
15. Are there any other constraints which would prevent progress to implementation?				
Quality/Patient Care Impacts				
16. Could there be an impact on patient outcome/care?				
17. Is there any potential for inequity of provision for individual patient groups or communities? E.g. rurality, transport.				
18. Is there any potential for inconsistency in approach across the Health Board?				
19. Is there are potential for postcode lottery/commissioning?				
20. Is there a need to consider exceptional circumstances?				
21. Are there clinical and other consequences of providing or delaying/denying treatment (i.e. improved patient outcomes, chronic pain, physical and mental deterioration, more intensive procedures eventually required?				



22. Are there any Royal College standards, NICE guidance or other evidence bases, etc, applicable?				
23. Can clinical engagement be evidenced in the design of the new proposal/service model?				
24. Are there any population health impacts?				
Workforce Impact				
25. Has the impact on the existing staff/WTE been determined?				
26. Is it deliverable without the need for premium workforce?				
27. Is there the potential for staff disengagement if there is no clinical/'reasonable' rationale for the action?				
28. Is there potential for professional body/college/union involvement?				
29. Could there be any perceived interference with clinical freedom?				
30. Is there potential for front line staff conflict with the public?				
31. Could there be challenge from the 'industries' involved?				
32. Is there a communication plan to inform staff of the new arrangements?				
33. Has the Organisational Change Policy been followed, including engagement/consultation in accordance with guidance?				



34. Have training requirements been identified and will this be complete in time to support the new proposal/service model?				
Risk Impact				
32. Has a risk assessment been completed?				
33. Is there a plan to mitigate the risks identified?				
Legal Impact				
34. Has legal compliance been considered e.g. Welsh Language: is there any specific legislation or regulations that should be considered before a decision is made?				
35. Is there a likelihood of legal challenge?				
36. Is there any existing legal guidance that could be perceived to be compromised i.e. Independent Provider Contracts, statutory guidance re: Continuing Healthcare, Welsh Government Policy etc?				
37. Is there any existing contract and/or notice periods?				
Reputational Impact				
38. Is there a likelihood of public/patient opposition?				
39. Is there a likelihood of political activity?				
40. Is there a likelihood of media interest?	Y	Potential for media interest once the Annual Report is published.	Fiona Hancock	
41. Is there the potential for an adverse effect on recruitment?				
42. Is there the likelihood of an adverse effect on staff morale?				



43. Potential for judicial review?				
Privacy Impact				
44. Have the Information Governance Team been contacted about the project to assess whether a Data Protection Impact Assessment (DPIA) needs to undertaken?				
45. Has a full DPIA been undertaken – Please contact Information.Governance3@wales.nhs.uk for the template.				
Equality Impact (unless otherwise completed as part of the accompanying SBAR)				
46. Has Equality Impact Assessment (EqIA) screening been undertaken – follow link below? Equality, diversity and inclusion (sharepoint.com)				
47. Has a full EqIA been undertaken – follow link below? Equality, diversity and inclusion (sharepoint.com)				
48. Have any negative/positive impacts been identified in the EqIA documentation?				

4.7

11:30, 10 Mins

4.7 - Draft Accountability Report (To Follow)

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

| For approval

5 - Financial Focus

5.1

11:40, 10 Mins

5.1 - Financial Grip and Control

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

| For assurance

Attachments

[5.1 Financial Grip and Control Feb 2026 - Hywel Dda ARAC.pdf](#)

Financial Grip and Control measures across NHS Wales

Financial Planning and Delivery Directorate

Objective:

To provide organisations with a consolidated schedule setting out the core financial, workforce and procurement grip and control measures to safeguard financial stability during periods of significant financial pressure.

Background:

At M09 2025/26 six health boards in Wales report deficits totalling £206m, (1.9% of the reported Revenue Resource Limit).

Given the scale of the pressure, it is essential that the NHS Wales Finance Function can demonstrate that the financial governance and financial control environment mechanisms are robust and sufficient assurance is received on their effectiveness.

Scope:

The tool is designed to help organisations assess their financial grip and control. It is not an exhaustive list but is predicated on common themes and areas of risk identified through NHS Wales.

The key focus for the grip and control schedule is the practical controls, processes and actions that should be in place in year to avoid excessive or inappropriately approved financial commitments; reduce waste; and improve in year expenditure run-rates. The tool will help organisations to strengthen the underpinning financial governance and control measures that support improved financial performance.

As a first step, the focus has been placed on core financial, workforce and procurement processes and systems. There is more limited literature available on best practice grip and control within specific expenditure areas such as commissioning, CHC and prescribing systems and processes.

Preparation approach:

The schedule has been prepared by Financial Planning and Delivery by examining and consolidating examples from various sources including:-

- Grip and Control presentation report (Financial Planning and Delivery May 2022)
- Financial Grip and Control Checklist (NHS England December 2022)
- Establishment Control (HFMA May 2025)
- Budgetary Framework and Grip and Control Discussions (Directors of Finance Forum July 2024)

Structure of the document:

The schedule includes both **financial controls (in black)** that organisations should have in place and **grip actions (in blue)** that will support the reduction of expenditure run rates.

The financial grip and control measures are categorised across eight themes:- Framework and Guidance, Vacancies, Sickness and Leave, Rostering and Rotas, Bank and Agency, Other Staff Payments, Procurement and Other items.

The document includes both a summary schedule and a detailed schedule. The summary schedule identifies key thematic areas and the highest impact actions from the detailed schedule.

Other financial governance reference documents:

The checklist may be used in conjunction with:

- HFMA’s “Improving NHS financial sustainability: are you getting the basics right?” checklist tool [Improving NHS financial sustainability: are you getting the basics right? \(hfma.org.uk\)](http://hfma.org.uk) – focus on key overarching financial processes such as planning, budget setting, reporting, financial governance, training and development
- Financial Management Maturity Model (NAO January 2010)
- Model Standing Orders, Reservation and Delegation of Powers and Model Standing Financial Instructions – NHS Wales (issued by Welsh Government)
- The Finance Academy’s ‘Financial Control Procedures Governance Best Practice Principles Guide’ - available on the learning and development platform

All are valuable tools to support organisations to consider if they have the controls and processes in place to achieve best value for money.

Completion and next steps:-

Complete the checklist to consider whether the relevant policy or process exists and secondly to consider operational delivery and compliance. This may require input from representatives from several areas workforce, procurement, efficiency, finance and audit.

Agree priority issues and how proposed actions to address the issues identified will be taken forward. This may require assembling a working group including representatives from workforce, procurement, efficiency, finance.

Key findings from the exercise to be shared through the Director of Finance forum to identify any national areas of focus.

Update from Hywel Dda UHB:

The following sections will/have been completed by functional leads. Self-identified ‘gaps’ have been highlighted in **RED** text. Following the completion of the national benchmarking exercise across NHS Wales organisations, a consolidated list of gaps will be created and suggestions/recommendations made to update controls where appropriate. Critical gaps will be updated immediately.

Functional completion:

Framework and Guidance:	Finance
Establishment and Vacancies:	Workforce People Management
Sickness and Leave Management:	Workforce People Management
Rostering, Rotas and Job Planning:	Workforce People Planning and Effectiveness
Temporary Staffing:	Workforce People Planning and Effectiveness
Other Staff Payments:	Workforce People Planning and Effectiveness
Procurement:	Procurement
Other Items:	Finance

1. Summary Schedule

Framework and Guidance	Establishment and Vacancies	Sickness and Leave Management	Rostering, Rotas and Job Planning
<ul style="list-style-type: none"> • Clear and Up to Date Standing Financial Instructions and guidance. • Clear procedures & process notes. • Budget holders and all financial administrators have received up to date training on their roles & responsibilities • Clear governance process for new investment. • Delegation letters issued and signed. • Internal Escalation process in place. 	<ul style="list-style-type: none"> • Ensure robust budgeted establishments are in place and regularly reviewed and reconciled. • Regular vacancy control panel (VCP). • Automated weekly head count tracker. • Ensure managers notify HR of leaving dates. • Review all current vacancies with a view to remove or freeze posts. 	<ul style="list-style-type: none"> • Enforce compliance with the All Wales Sickness policy. • Adherence to the requirements of agreed attendance at work policies and the all-Wales Occupational Health minimum service levels. • Monitor absence and sickness on individual, service line, service and organisation level. • Monitor medical annual leave. • Policies to limit carry forward of significant leave balances 	<ul style="list-style-type: none"> • E-rostering fully deployed. • Rosters approved 12 weeks in advance (as per the Agency workforce reduction programme and control framework). • Contracted hours to be fully rostered. • Job planning policy implemented with > 90% of all Consultants having an agreed job plan in place at all times; and alignment of rota to job capacity plans.
Temporary Staffing	Other Staff Payments	Procurement	Other items
<ul style="list-style-type: none"> • Temporary Staffing Policy in place. • Clear process for booking, and compliance with process. • Review bank and agency authorisation levels – seniority and consistency across sites. • No off-contract agency & locum. • Auto enrolment for new starters onto the bank. • Review pay rates and consider weekly pay for bank as an incentive. • Ensure appropriate deduction for agency staff breaks. 	<ul style="list-style-type: none"> • Implement prior approval for overtime and enhanced payments. • A monthly 'audit' of the highest overtime earners and expenses claimants. • Non-clinical overtime controls in place. • Enhanced authorisation process for WLIs with clear demonstration that existing Programmed Activities (PAs) have been utilised before WLIs awarded. • Review process in place for additional sessions allocated. 	<ul style="list-style-type: none"> • Monitor use of Single Tender Waivers. • Consolidate a list of supplier discounts. • Robust contract management processes in place. • Enforce the 'No PO No Pay' policy. • Review and reduce those able to requisition and order. • Targeted approach for clinical preference variation (as identified by V&S procurement group). 	<ul style="list-style-type: none"> • Review and ensure all eligible VAT is being reclaimed. • Income management policies to minimise bad debt costs. • Stock management policies to minimise wastage. • Review all credit balances on the Balance sheet for potential over accrual. • Journals are based on latest relevant data and assumptions.

2. Detailed Schedule

1. Framework and Guidance	Controls / Processes in place	Assurance that processes are operational
<p>Clear and Up to Date Standing Financial Instructions</p> <ul style="list-style-type: none"> SFIs are up to date and readily accessible to all relevant officers. 	<p>Documented policies, Standing Financial Instructions and All-Wales frameworks are in place and approved by the Board. Operational procedures are supported by defined approval thresholds, system controls, segregation of duties and clearly assigned responsibilities. Controls are designed to prevent unauthorised activity, identify variance at the earliest opportunity, and enable timely corrective action.</p>	<p>Assurance is obtained through routine financial and workforce reporting, executive and committee oversight, exception reporting, internal performance reviews and periodic Internal Audit coverage. Compliance is monitored via dashboards, variance analysis and escalation through service and executive governance structures.</p> <p>Gap 1: Subsequent supporting principle documents are not accessible to relevant officers in the same location and are housed locally within functions, e.g. detailed examples of budgeting principles to support the Budgetary Control Financial Control Procedure.</p>
<p>Clear Process Notes</p> <ul style="list-style-type: none"> All Financial Control Procedures are up to date; accessible and minimum provision aligns with the Finance Academy best practice guide. (e.g. month end close down processes, financial reforecasts). All Financial Control Procedures are widely available to all relevant team members. Adequate training is provided to all relevant staff members to ensure awareness and understanding of relevant financial control procedures. 	<p>Documented policies, Standing Financial Instructions and All-Wales frameworks are in place and approved by the Board. Operational procedures are supported by defined approval thresholds, system controls, segregation of duties and clearly assigned responsibilities. Controls are designed to prevent unauthorised activity, identify variance at the earliest opportunity, and enable timely corrective action.</p>	<p>Assurance is obtained through routine financial and workforce reporting, executive and committee oversight, exception reporting, internal performance reviews and periodic Internal Audit coverage. Compliance is monitored via dashboards, variance analysis and escalation through service and executive governance structures. Audits are undertaken to assess management compliance; this can be utilised as a management tool to assess learning needs, compliance or wider system issues. Links to Gap 3</p>

Colour Key:-

financial controls are black

grip actions are blue

		<p>Gap 1: Subsequent supporting principle documents are not accessible to relevant officers in the same location and are housed locally within functions, e.g. detailed examples of budgeting principles to support the Budgetary Control Financial Control Procedure.</p> <p>Gap 2: Some training is offered to first time managers via the Managers Passport programme, but this does not systematically cover all employees that enter management posts. Systemic analysis required for grip & control gaps, as training may not be the solution in itself.</p> <p>Gap 3: Periodic refresher training is not currently available to continuously educate all relevant staff members of the controls in place that are to be adhered to.</p>
<p>Roles and Responsibilities</p> <ul style="list-style-type: none"> • Roles and responsibilities of budget holders clearly defined and clearly communicated, including responsibilities with respect to core budgets, cost reduction element of their budgets and procurement. • Delegation letters have been issued and have been signed. • All budget holders have objectives supporting the delivery of financial objectives in Performance appraisal process. • Budget holders receive training on their roles responsibilities and objectives at reasonable intervals and monitoring of this can be demonstrated. • Consider whether the number of budget holders is appropriate - reduced budget holders can improve control over expenditure. 	<p>Documented policies, Standing Financial Instructions and All-Wales frameworks are in place and approved by the Board. Operational procedures are supported by defined approval thresholds, system controls, segregation of duties and clearly assigned responsibilities. Controls are designed to prevent unauthorised activity, identify variance at the earliest opportunity, and enable timely corrective action.</p>	<p>Assurance is obtained through routine financial and workforce reporting, executive and committee oversight, exception reporting, internal performance reviews and periodic Internal Audit coverage. Compliance is monitored via dashboards, variance analysis and escalation through service and executive governance structures.</p> <p>Gap 1: there is not a consistent onward delegation of financial objectives via Performance appraisals as far as currently known.</p>

Colour Key:-

financial controls are black

grip actions are blue

	<p>Annual budget delegation Accountability Letters are issued to Executive Directors and Deputies; Functional Leads and Clinical Care Group Directors. This sets out responsibilities and reminds budget holders of the procedures in place that are to be adhered to.</p> <p>A scheme of delegation is in place, with changes approved by Board, and a consistent Oracle sub-scheme of delegation is in place with consistent approval levels and budget holders across all Revenue, Capital and Charitable Fund cost centres.</p>	<p>Gaps 2 and 3 from 1. Framework and Guidance – Clear Process Notes apply.</p>
<p>Investments and Business Cases</p> <ul style="list-style-type: none"> • Clear Business Case review procedures for reviewing and approving any new projects across the organisation. • The above includes a relevant committee structure where robust review and challenge take place. • Post implementation benefit realisation reviews process in place. • Review previous 12 months of business cases to ensure savings/benefits realisation. • Establish list of ongoing and planned projects and determine what can be ceased or delayed. 	<p>Documented policies, Standing Financial Instructions and All-Wales frameworks are in place and approved by the Board. Operational procedures are supported by defined approval thresholds, system controls, segregation of duties and clearly assigned responsibilities. Controls are designed to prevent unauthorised activity, identify variance at the earliest opportunity, and enable timely corrective action.</p> <p>All investment business cases are to be included on an annual basis within the annual financial planning cycle, with the exception of the Nurse Staffing Level reviews, which occur</p>	<p>Assurance is obtained through the annual financial planning cycle, routine financial and workforce reporting, executive and committee oversight, exception reporting, internal performance reviews and periodic Internal Audit coverage. Compliance is monitored via dashboards, variance analysis and escalation through service and executive governance structures.</p> <p>Gap 1: there is an absence of a medium-term plan to provide multi-year strategic direction to business cases.</p> <p>Gap 2: there is a lack of consistency across business cases, with financial benefits being ambiguous in a lot of cases. Further structure and consistency are required, with a regular</p>

Colour Key:-

financial controls are black

grip actions are blue

	<p>during a year and are submitted to Board for approval, with central reserve funding allocated to services if approved.</p> <p>Initially, the Financial and Performance Committee scrutinise business cases, before they are submitted to Board for final review and approval/rejection.</p>	<p>organisation process for capturing, reviewing, prioritising and scrutinising them before being submitted for formal scrutiny to the Finance and Performance committee. NB Business Cases do not routinely explore alternative workforce design; to optimise “value” in workforce models. Integration of VBHC as a model for integrated workforce planning may be possible here. Query further gap?</p> <p>Gap 3: Limited evidence of benefits realisation or systematic reviews on historic cases</p>
<p>Internal Escalation</p> <ul style="list-style-type: none"> Clear internal escalation processes in place for service areas that are not delivering their financial plans with appropriate financial or non-financial controls or remedial actions applied. 	<p>An internal escalation framework is in place, with four levels of escalation across seven domains. Procedures are supported by defined approval thresholds, system controls, segregation of duties and clearly assigned responsibilities. Controls are designed to prevent unauthorised activity, identify variance at the earliest opportunity, and enable timely corrective action.</p>	<p>Assurance is obtained through routine monthly performance reporting, executive and committee oversight, exception reporting, internal reviews and periodic Internal Audit coverage. Compliance is monitored via dashboards, variance analysis and escalation through service and executive governance structures.</p> <p>Gap 1: Repeated examples of continued escalation does not employ an appropriate and timely response to deliver impactful actions to achieve de-escalation. Level 4 is not available presently.</p>

2. People Costs – Establishment and Vacancies	Controls / Processes in place	Assurance that processes are operational

<p>Policy and Procedure</p> <ul style="list-style-type: none"> Criteria in place for annual and other leave (e.g. study and parental leave) to be notified to the organisation and signed off (where applicable) with sufficient notice to minimise impact on rotas. Processes in place to ensure compliance with the All-Wales Sickness policy - Rigorous sickness policy and procedure is in place and communicated to minimise absences (inc. return to work meeting). Consider increasing sign off levels for sick leave to ensure transparency. 	<p>Documented policies, Standing Financial Instructions and All-Wales frameworks are in place and approved by the Board. Operational procedures are supported by defined approval thresholds, system controls, segregation of duties and clearly assigned responsibilities. Controls are designed to prevent unauthorised activity, identify variance at the earliest opportunity, and enable timely corrective action.</p> <p>Carry Over of annual leave is defined in the Agenda for Change handbook. There is an annual leave carryover proforma on SharePoint. Internal process for communication and completion is handled within the People Planning pillar with communications being issued via Global/Viva Engage.</p> <p>The PowerBI dashboard has a tab for annual leave balances which managers have access to and is updated monthly.</p> <p>Functional leads are sent monthly absence reports by the Workforce Intelligence team in the People Planning pillar.</p> <p>There is an all-Wales Absence Management policy which identifies the key responsibilities of each manager in respect of absence.</p>	<p>Assurance is obtained through routine financial and workforce reporting, executive and committee oversight, exception reporting, internal performance reviews and periodic Internal Audit coverage. Compliance is monitored via dashboards, variance analysis and escalation through service and executive governance structures. Audits are undertaken to ensure compliance to policy; this can be utilised as a management tool to assess learning, compliance or system issues.(Links to Gap 3)</p> <p>Gap 1: Line managers are not consistently using the sickness and annual leave report that are available to them.</p> <p>Gap 2: Line managers are not consistently applying the all-Wales Absence Management policy as identified in the recent internal audit report on sickness absence.</p> <p>Gap 3: There is no process in place to provide assurance that annual leave balances are well managed within the target of 14.6% defined within the Rostering Policy.</p>
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2. People Costs – Establishment and Vacancies	Controls / Processes in place	Assurance that processes are operational
<p>Establishment (Establishment control HFMA)</p> <ul style="list-style-type: none"> • Workforce plans are in place, are of a sufficiently granular level of detail (for example, by service, workforce type and substantive/ temporary); and align to approved establishment levels and budget. • Workforce plans are regularly reviewed by service and service leads to ensure compliance with or action to move to compliance against both establishment and budget. • Reconciliation process in place to ensure that WTEs per financial and HR systems reconcile. 	<p>Holistic workforce planning is undertaken as part of the annual planning cycle, which focuses on clinical service and staff group.</p> <p>Establishment report in place from Workforce and Finance but not accessible to service users.</p> <p>Monitoring forms part of the WOD escalation framework meetings</p> <p>The Health Board established a Financial control group, and whilst this overarching group has been dissolved, Workforce and OD have retained their own Internal FCG (initially established in October 2025) as part of its own control mechanisms.</p>	<p>Assurance is obtained through routine financial and workforce reporting, executive and committee oversight, exception reporting, internal performance reviews and periodic Internal Audit coverage. Compliance is monitored via dashboards, variance analysis and escalation through service and executive governance structures.</p> <p>Gap 1: Executive Function planning to be undertaken consistently for all.</p> <p>Gap 2: Integration of financial establishment / budget to be included through a collaborative approach to planning with Service, Workforce and Finance, including formally sign-off for WTE plans compared to budgets. This needs to look beyond numbers to skill mix/workforce model design (VBHC may be a helpful mechanism here.</p> <p>Gap 3: Budget holder review of established budgets is inconsistent, with reactive resolution when posts are to be replaced and finance instigate a change due to mis-aligned budgets.</p> <p>Gap 4: Establishment report is not easily accessible to service users and budget holders combining Workforce actual WTE with Finance budgeted WTE.</p>

Colour Key:-

financial controls are black

grip actions are blue

2. People Costs – Establishment and Vacancies	Controls / Processes in place	Assurance that processes are operational
		<p>Gap 5: Not all services have a workforce plan in place however, there each CCG and corporate directorate is required to establish its own internal FCG controls before vacancies are approved, as part of the new arrangements from 1st April 2026. Not all arrangements are currently in place.</p> <p>Gap 6: Assurance is needed that the reporting of variable pay usage, previously reported into FSCG group, will be picked up in the new arrangements.</p>

2. People Costs – Establishment and Vacancies	Controls / Processes in place	Assurance that processes are operational
<p>Vacancy Review (Establishment control HFMA)</p> <ul style="list-style-type: none"> Establish a regular vacancy control panel (VCP) or equivalent to check and challenge recruitment to ensure all vacancies remain within authorised budgetary limits. Ensure the VCP terms of reference enable flexibility to avoid operationally delaying opportunities for savings and considering clinical need. Implement an automated weekly head count tracker (temporary and substantive). Assess the recruitment process and remove blockers/ bottle necks that may lead to higher agency & locum costs. Review all current vacancies with a view to remove or freeze posts. Focus on long term/ 6-month vacant posts – can these be removed or re-engineered? Review the establishment to remove partial posts not required and identify unfunded posts. Implement non-clinical recruitment freeze unless it can be evidenced that role is business critical or key for financial/ quality and safety improvement. 	<p>Documented policies, Standing Financial Instructions and All-Wales frameworks are in place and approved by the Board. Operational procedures are supported by defined approval thresholds, system controls, segregation of duties and clearly assigned responsibilities. Controls are designed to prevent unauthorised activity, identify variance at the earliest opportunity, and enable timely corrective action.</p> <p>Systematic approach to approval with vacancy's routed to Finance for approval or rejection depending on budget availability prior to recruitment episode commencing.</p> <p>Service management deploy internal vacancy panels prior to recruitment episodes being triggered.</p> <p>All Wales KPIs exist for “time to hire” and are included within the PODCC Metrics report for assurance of compliance and reported to the all-Wales Recruitment Modernisation Board.</p> <p>TRAC acts as the compliance tool here for financial authorisation.</p>	<p>Assurance is obtained through routine financial and workforce reporting, executive and committee oversight, exception reporting, internal performance reviews and periodic Internal Audit coverage. Compliance is monitored via dashboards, variance analysis and escalation through service and executive governance structures.</p> <p>The Health Board is consistently exceeding the all-Wales KPIs for “time to hire”.</p> <p>Gap 1: Management override can occur within the Service, Finance or Workforce for by-passing the control environment.</p> <p>Gap 2: Manual ESR changes from service managers without timely/appropriate Workforce and Finance review, i.e. re-banding, acting up arrangements.</p> <p>Gap 3: CCGs do not always have exit strategies in place to align with the on-boarding of new staff which results in higher agency and locum costs.</p>

<p>Leavers</p> <ul style="list-style-type: none"> Processes in place to ensure line managers notify HR of leaving dates and any other pay-impacting staff changes in a timely manner to reduce risk of overpayments. 	<p>Documented policies, Standing Financial Instructions and All-Wales frameworks are in place and approved by the Board. Operational procedures are supported by defined approval thresholds, system controls, segregation of duties and clearly assigned responsibilities. Controls are designed to prevent unauthorised activity, identify variance at the earliest opportunity, and enable timely corrective action.</p> <p>SMA tool assisting managers for an easy-to-use interface to instigate terminations and reduce overpayments.</p> <p>Payroll issues automated reminders to line managers regarding the monthly payroll cut-off dates, which highlights the importance of new starters, leavers and changes being processed in a timely manner. An example is given in the email of a mid-month leave and the importance of submission before the cut of date for that month.</p>	<p>Assurance is obtained through routine financial and workforce reporting, executive and committee oversight, exception reporting, internal performance reviews and periodic Internal Audit coverage. Compliance is monitored via dashboards, variance analysis and escalation through service and executive governance structures.</p> <p>To ensure monies can be claimed back Recruitment monitor exits of IENs or Medics recruited via the WG programme.</p> <p>Gap 1: Without positive confirmation of employees being marked as present on the ESR system (default assumes employees as present opposed to absent), management inconsistency gives rise to overpayments on a regular basis and lengthy financial disputes with no recovery occurring for a number of cases.</p> <p>Gap 2: HR does not get notified of leavers or pay impacting changes. The manager will input directly into ESR or the SMA App.</p> <p>Gap 3: Who is responsible for monitoring end dates (and then associated actions) for Fixed Term Contracts or Secondments – likely a cost pressure.</p> <p>Gap 4: Termination forms are still being completed late by Line Managers which gives rise to overpayments.</p>
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2. People Costs – Establishment and Vacancies	Controls / Processes in place	Assurance that processes are operational
		<p>Gap 5: Delays in termination forms can lead to lengthy financial disputes with no recovery occurring for a number of cases.</p>
<p>Workforce management monitoring (Establishment control HFMA)</p> <ul style="list-style-type: none"> • Process in place to review levels of poorly performing staff and consider options for more rapid improvement and/ or staff exit. • Periodical review of actual temporary staff rates against rates charged to identify and address issues (specific and themes). 	<p>Documented policies, Standing Financial Instructions and All-Wales frameworks are in place and approved by the Board. Operational procedures are supported by defined approval thresholds, system controls, segregation of duties and clearly assigned responsibilities. Controls are designed to prevent unauthorised activity, identify variance at the earliest opportunity, and enable timely corrective action.</p> <p>There is an all-Wales policy on Improving Performance at Work for A4C staff and UPSW for M&D staff.</p>	<p>Assurance is obtained through routine financial and workforce reporting, executive and committee oversight, exception reporting, internal performance reviews and periodic Internal Audit coverage. Compliance is monitored via dashboards, variance analysis and escalation through service and executive governance structures.</p> <p>Hywel Dda has been piloting the new Improving Performance at Work policy, and this has resulted in staff progressing through the informal and formal elements of the procedure. Since the pilot, staff have been progressed through the policy.</p> <p>New NHS policy comes into effect across Wales on 1st April 2026 and workshops are being held to roll-out to managers.</p> <p>Gap 1: A comprehensive and live temporary staff reporting is not available to service managers.</p> <p>Gap 2: Services do override rate cards on a daily basis to ensure gaps are filled.</p>

3. People Costs – Sickness and Leave Management	Controls / Processes in place	Assurance that processes are operational
<p>Monitoring and Reporting</p> <ul style="list-style-type: none"> • Monitor adherence to the requirements of agreed attendance at work policies and the all-Wales Occupational Health minimum service levels. • Monitor absence and sickness on individual, service line, service and organisation level. • Sickness is regularly reviewed at the board level, and problem areas identified and examined. • There is a set % target for staff off sick at any time and performance is measured against this target. • There is a set % target for staff on leave at any time and performance is measured against this target. • Monitor staff compliance with core organisational HR policies (e.g. annual leave requests, sickness absence) and ensure outliers are identified and addressed through appropriate routes. • Monitor medical annual leave. • Limits to the amount of annual leave, training and other influenceable absences that can be taken at any time. • Global policies for the management of leave to prevent excessive use of annual leave at the end of the year or carry forward of significant balances. 	<ul style="list-style-type: none"> • Clear policies in place for study, parental and sickness leave with notice periods. • Local processes in place (SOPs) for annual leave. • Limits on carry-forward i.e. up to 5 days but should more leave be carried forward due to absence or maternity leave, there is an escalation process to Exec Director level for approval. • Linkage of leave planning to e-rostering to ensure cover and minimise premium costs for staff on Allocate. • The Health Board provides monthly reports on its compliance with the all-Wales Occupational Health minimum service levels which is reported to PODCC. • The PowerBI dashboard has a tab for annual leave balances which managers have access to and is updated monthly. 	<p>Board-level review of sickness and leave KPIs by service and inclusion in Improving Together Executive Team led function reviews.</p> <p>Monthly reports indicate that the Health Board is fully meeting the all-Wales Occupational Health minimum standards.</p> <p>A deep dive into the specific reasons for absence e.g. Section 10 have been submitted to PODCC.</p> <p>Gap 1: Inconsistent application of concerns identified in the monthly functional sickness absence report are not being addressed by senior managers when the data indicates more than 5 days to enter sickness absence.</p> <p>Gap 2: There are a number of different routes to entering annual leave i.e. Allocate, ESR, Paper, Email. This inconsistent practice impacts on control measures which are available.</p> <p>Gap 3: Inconsistent monitoring of use of annual leave via PowerBI dashboard by Line Managers and senior leaders.</p> <p>Gap 4: Back-dated sickness or unrecorded leave transactions no escalated with no function lead approvals in place</p>

Colour Key:-

financial controls are black

grip actions are blue

		<p>Gap 5: Monitoring of some medical leave is difficult due to leave years being linked to date commenced in service and not financial year.</p>
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4. Rostering, Rotas and Job Planning	Controls / Processes in place	Assurance that processes are operational
<p>General rostering and rotas</p> <ul style="list-style-type: none"> • E-rostering is fully deployed • Rosters are approved 12 weeks in advance (as per the Agency workforce reduction programme and control framework), and minimal changes to rosters once approved, for all staff grades. • Processes to ensure contracted hours are fully rostered. • Clear timeline for submission of rotas. 	<p>The Health Board has a Rostering Policy and includes key performance indicators and a rostering approval process.</p> <p>Compliance with the rostering policy is monitored through:</p> <ul style="list-style-type: none"> - E-rostering system metrics (approval timelines etc). <p>Executive-level dashboards present:</p> <ul style="list-style-type: none"> - Roster approval compliance. - Use of bank, agency and locum by roster group. - Correlation between late rota approval and premium staffing costs. 	<p>Persistent non-compliance is escalated through:</p> <ul style="list-style-type: none"> - Workforce escalation forums. - Executive performance reviews. <p>Internal audit reviews are undertaken periodically to assess:</p> <ul style="list-style-type: none"> - Policy compliance. - Effectiveness of controls. - Reliability of reported data. <p>This is reported through Value & Sustainability and to Professional Leads for Nursing & Medical Workforce through appropriate forums including exception reports identifying rosters not approved within required timescales.</p> <p>Gap 1: There is no process in place to provide assurance that annual leave balances are well managed within the target of 14.6% defined within the Rostering Policy.</p> <p>Gap 2: SOP adherence for annual leave and training controls is inconsistent.</p> <p>Gap 3: Night shift gaps persist despite substantive establishment.</p> <p>Gap 4 Whilst significant progress has been made it is not being sustained and Job Planning compliance and transparency varies between services.</p>

4. Rostering, Rotas and Job Planning	Controls / Processes in place	Assurance that processes are operational
<p>Robust Nursing Rota Management</p> <ul style="list-style-type: none"> • Staff levels are matched to patient demand patterns to avoid waits and avoidable admissions. • Weekly monitoring for shift requests vs. shift fill rate and any associated care and safety issues. • Review staffing levels against patient ratios vs current guidelines (inc. safer staffing tools) and provide constructive challenge to clinical leads on achieving efficiency while maintaining quality. • Review specialising policy, approvals, and tracking process to ensure standardised approach linked to patient need/acuity. • Review nursing agency & locum use before, during and after school holiday periods (tests the strength of rota planning). • Review options for: <ul style="list-style-type: none"> ○ reduced handover periods; ○ back-to-the ward for nursing management staff for a number of shifts per week; and ○ specialist nurses to provide a number of clinical shifts on wards to reduce agency & locum bill, cover vacancies, and improve staff rotation. 	<p>As above</p>	<p>As above</p>

4. Rostering, Rotas and Job Planning	Controls / Processes in place	Assurance that processes are operational
<p>Robust Medical Job Planning Management</p> <ul style="list-style-type: none"> • Job planning policy implemented with > 90% of all Consultants having an agreed job plan in place at all times. • Process in place to ensure alignment of rota to job plans. • Monitoring in place to support Medical Director leadership track medical productivity for example: - <ul style="list-style-type: none"> ○ job plan delivery (individual and then team job plans); ○ PAs over 12. ○ % Direct Clinical Care; and ○ theatre/clinic throughput. • Review consultant job planning compliance (assess current level of rollout) to identify opportunities for greater productivity (review of low and high Professional Activity “PA” staff). • Improve transparency of medical workforce holiday planning to core planning teams, linking to theatre and clinic planning. • Review on-call run rate for utilisation trends. 	<p>Clear policies for study, parental and sickness leave with notice periods.</p> <p>Rollout of Allocate is progressing; to be completed by June 2026.</p> <p>Metrics/reporting being developed to test efficacy of system/protocols.</p> <p>During 2025/26 job planning was reported as part of the suite of WOD escalation measures.</p>	<p>Reports to Medical Workforce Planning & Stabilisation on progress.</p> <p>Gap 1: Not all Job plans align activity, management duties, education and clinical delivery to funded hours.</p> <p>Gap2: There are no consequences for individuals who do not positively engage in the annual job planning process.</p> <p>Gap 3: The Health Board is yet to agree the parameters of the 52-hours CPD for its staff.</p>
<p>Other Clinical Staff</p> <ul style="list-style-type: none"> • Review compliance with / introduce Clinical Nurse Specialist and Allied Health Professional job planning process to identify opportunities for greater productivity. 		<p>Gap 1: Not all Job plans align activity, management duties, education and clinical delivery to funded hours.</p>

5. People Costs – Temporary staffing including Bank and Agency & Locum	Controls / Processes in place	Assurance that processes are operational
<p>Policy, procedures, roles and responsibilities</p> <ul style="list-style-type: none"> • An organisation wide temporary Staffing Policy in place and up to date. • There is a clearly communicated process in place for bank / agency & locum booking. • Monitoring controls in place to monitor compliance with the process for bank / agency & locum booking. • Governance process exists to oversee temporary staffing with clear ToR (either at overall level or by key staffing group e.g. nursing, medical, corporate). • Limit who can authorise bank and agency & locum staff to increase transparency; follow up on all short notice use. • Review consistency of authorisation levels and approach across sites. 	<ul style="list-style-type: none"> • Nursing have a SOP which includes an escalation process for the booking of temporary staff e.g. bank and agency. • Auto-enrolment to bank for eligible staff; medical and A&C banks in place. • No off-framework/ off-contract engagements; self-imposed caps and rate controls. • Long-term agency policy with conversion pathways to substantive/bank. • Nursing have a full variable pay SOP covering all elements including escalation times. Work is on-going to formulate a SOP for medical teams in line with the medical e-rostering rollout. 	<p>Reporting through FCSG and Value & Sustainability.</p> <p>Specific Nursing & Medical Forums.</p> <p>Gap 1: Short-notice bookings without proper approval.</p> <p>Gap 2: Off-framework placements under exceptional justifications.</p> <p>Gap 3: Inconsistent authorisation approaches across sites.</p> <p>Gap 4: The Health Board does not have a consistent approach to the management of bank and agency staffing across different professional groups.</p>

5. People Costs – Temporary staffing including Bank and Agency & Locum	Controls / Processes in place	Assurance that processes are operational
<p>Bank utilisation</p> <ul style="list-style-type: none"> All relevant staff groups are auto enrolled on the bank. Review actual temporary staff rates against rates charged periodically to identify and address issues. Implemented and promoted a medical bank, and an Administration and Clerical bank. Promote bank staff as an alternative to agency & locum. Review pay rates and consider financial incentives for bank staff to increase bank usage, for example consider weekly pay as an incentive. 	<p>The Health Board uses STREAM which enables staff to draw down a proportion of pay as need arises during the month.</p> <p>Report due to be considered by the Executive Team on the withdrawal of the weekly payroll due to less than 70 staff members utilising this.</p>	<p>Gap 1: Inconsistent application of the rate cards due to management override for enhanced rates of pay that are not within policy.</p> <p>Gap 2: We run a weekly payroll for less than 70 staff which is inefficient and can lead to overpayments due to the speed of turnaround.</p>
<p>Agency and Locum controls</p> <ul style="list-style-type: none"> Robust controls over agency & locum usage for example: - <ul style="list-style-type: none"> self-imposed cap on agency & locum expenditure; senior sign off of agency & locum expenditure. senior sign off of off-framework expenditure; clear Board accountability defined and communicated across organisation. improved communication of planned clinic cancellations to agency/bank teams; and no direct approach for agency. Process in place to ensure non-framework or off-contract agency staff are not engaged. An organisation process in place for long term agency & locum use. Seek local agreement of agency & locum pay rates with surrounding trusts / explore use of a collaborative bank. Evaluate opportunities for moving from use of agency & locum to internal organisation resource and / or bank. 	<p>Medical Stabilisation group was established in 2025/26 and will continue in 2026/27. Significant progress made to reduce high cost locums.</p>	<p>Gap 1: Inconsistent application of the rate cards due to management override for enhanced rates of pay that are not within policy.</p> <p>Gap 2: there is no preventative control to ensure no direct approach to agencies occur.</p>

5. People Costs – Temporary staffing including Bank and Agency & Locum	Controls / Processes in place	Assurance that processes are operational
<p>Timesheet and expenses management</p> <ul style="list-style-type: none"> • Ensure breaks and hours claimed are accounted for correctly in timesheets (i.e. agency workers are only paid for time worked, in accordance with HB policies). • Ensure appropriate deduction for agency & locum staff breaks (lunch). • Ensure mileage claims are only for required intra-site travel. 	<p>Yes</p> <p>Yes</p> <p>Yes</p>	
<p>Restrictions on non-clinical temporary staff</p> <ul style="list-style-type: none"> • Review and implement exit strategies for all non-clinical temporary workers. • Temporary ban on usage of non-clinical agency staff, with exceptions authorised by executive director. 	<p>Yes</p> <p>N/A no non-clinical agency staff</p>	
<p>Effective monitoring</p> <ul style="list-style-type: none"> • Senior leads monitor weekly dashboard summaries of temporary staff usage, cost and trends to provide early warning signs and demonstrate progress with issues arising. • Track number of interims, termination dates, delivery of objectives, and daily rates. Focus on reducing number and costs. Consider options for contract terms that enables the organisation to offer substantive role after x months use: - e.g. offer locums a suitable package to convert from locum to substantive contracts. • Identify medical rotas with the highest use of temporary and bank staff and set out a plan to address • Hold weekly agency & locum meetings across all staffing groups with agency & locum overspends, attended by finance and key stakeholders, to review and control agency & locum expenditure. 	<p>Yes – Nursing</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Recruitment conversion processes in place:</p> <ul style="list-style-type: none"> • Temp to Perm • Agency to Perm • Bank to Perm <p>Weekly Recruitment ‘Hard to Fill’ meetings to ensure proactivity and innovation.</p> <p>Gap 1: There is no comprehensive physical reporting (WTE) of Medical shifts worked with the associated financial costs.</p> <p>Gap 2: clarity is lacking to articulate the nature of the requirement for temporary cover, where a number of issues are commonly conflated resulting in a lack of control surrounding the termination of a temporary worker.</p>

6. People Costs – Other Staff Payments	Controls / Processes in place	Assurance that processes are operational
<p>Overtime and enhanced payments controls</p> <ul style="list-style-type: none"> • Ensure breaks and hours claimed are accounted for correctly in timesheets. • Perform a monthly 'audit' of the top 10 highest overtime earners by division. • Implement prior approval for overtime and enhanced payments - monitor and reduce. • For non-clinical staff - implement non-clinical overtime controls to limit expenditure in this area (e.g. Exec director authorisation required). 	<p>Expenses system in place which is administered by Shared Services.</p> <p>For corporate teams there is a Time Off In Lieu (TOIL) policy.</p>	<p>Gap 1: No monthly audit of the top 10 highest overtime earners by CCG/Directorate is being undertaken.</p> <p>Gap 2: There is a lack of and inconsistent reconciliation of hours before paying bank or overtime to staff.</p> <p>Gap 3: Lack of understanding of whether the TOIL Policy is being applied before payment of bank or overtime rates.</p> <p>Gap 4: Levels of discretionary effort above contracted hours is not monitored.</p> <p>Gap 5: Compliance with Working Times regulations over a defined reference period i.e. 17 weeks/26 weeks is not undertaken. Documented “opt outs” for the 48-hour week may not be in place or monitored/reviewed.</p> <p>Gap 6: Inconsistent mileage and travel allowance across sites.</p>
<p>Expenses Monitoring</p> <ul style="list-style-type: none"> • Monthly monitoring of the highest mileage and expenses claimants. 		<p>To be introduced in May linked with other measures around high spend controls.</p>

Colour Key:-

financial controls are black

grip actions are blue

<p>Waiting List Initiatives (WLIs) controls</p> <ul style="list-style-type: none"> • Ensure consistent process across organisation including compliance with the WLI rate across the organisation. • Appropriate review process in place for additional sessions allocated. • Enhanced authorisation process for WLIs, with checks are undertaken before WLIs are awarded to ensure that :- <ul style="list-style-type: none"> ○ WLIs offer financial benefit or are operationally critical before approving, and ○ existing Programmed Activities (PAs) have been utilised. • Benchmark WLI rate against other Health Boards. 	<p>Yes</p> <p>Planned Care CCG</p>	<p>Gap 1: Management override occurs for rates above cap that are not within policy.</p> <p>Gap 2: Inconsistent mileage and travel allowance across sites.</p>
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7. Procurement	Controls / Processes in place	Assurance that processes are operational
<p>Procurement – Clarity of Roles</p> <ul style="list-style-type: none"> • Clear documentation and communication of roles between local managers, the procurement function and Shared Services. 	<ul style="list-style-type: none"> • Roles and responsibilities between local managers, the Procurement function, and NWSSP Shared Services are formally defined, version-controlled, and published on the HDdUHB intranet. 	<ul style="list-style-type: none"> • Intranet page link and version history showing last review date.
<p>Procurement - Tender process</p> <ul style="list-style-type: none"> • Approval limits are periodically and regularly reviewed where appropriate. • All new contracts awarded in compliance with Statutory Regulations and SFIs. • All new contracts (including agency & locum staff) are procured via appropriate tendering procedures to ensure best value for money is attained. • Single Tender Waivers controlled to minimise use. • Whole Life Costings are applied to evaluate tenders. • Appropriate SLAs and T&Cs are applied to ALL contracts to enable appropriate and effective contract management. • Breaches are reported to the relevant Executive Director and included in financial performance monitoring arrangements. 	<ul style="list-style-type: none"> • All procurements are run in accordance with Public Procurement Regulations, Standing Financial Instructions, and internal governance. • The Procurement SMT and Oracle Systems Team review compliance. • All awards go through the Health Board Financial Control Sub-Group (FCG). • Whole-Life Costing (WLC) is applied where appropriate. • Contract award packs with standard T&Cs are issued to named Contract Managers. • Single Tender Waivers (STWs) are tightly controlled, with none approved in the last 12 months due to strengthened scrutiny. • Breaches are escalated to the Deputy Head of Procurement and reported through ARAC. 	<ul style="list-style-type: none"> • SMT/Oracle compliance review logs and sample tender files • FCSG – Procurement agenda item • STW log confirming 0 STWs in the past 12 months. • Contract award pack samples with named Contract Manager acknowledgements. • ARAC papers noting any breaches and actions closed. • Internal audit outcomes on procurement compliance.

7. Procurement	Controls / Processes in place	Assurance that processes are operational
<p>Procurement – Call Off</p> <ul style="list-style-type: none"> Contract pricing is reviewed annually to attain any further increased banding cost advantages through life of contract. Product catalogues reviewed (both NHS Supply Chain and Local Catalogues) to remove duplicate items on catalogue (e.g. pens) to ensure value for money. Consolidate a list of supplier discounts and penalties for early / late payments (in alignment with contract register) - set out plans to recover / avoid these and share with accounts payable team to enact. 	<ul style="list-style-type: none"> Contract pricing is reviewed in line with contract mechanisms to secure banding advantages and value for money. Catalogue content is actively cleansed to remove duplicates and guide buyers to preferred lines. Procurement partners with Finance to ensure negotiated discounts are applied and to mitigate late-payment risks. 	<ul style="list-style-type: none"> Annual/biannual pricing review records and variation notices Enablement reports showing duplicate item removals and catalogue compliance rate Evidence of discounts applied on invoices AP on-time payment KPI trend where relevant to discount realization. <p>Gap 1: Catalogue usage not mandated and therefore is not adhered to consistently.</p>

7. Procurement	Controls / Processes in place	Assurance that processes are operational
<p>Procurement - Contract management</p> <ul style="list-style-type: none"> • Robust contract management processes are in place, including a complete and up to date contract register. • Regular contract reviews to ensure SLAs are being met - with specific focus on PFI contracts where relevant. • When contracts expire, these are retendered in accordance with the statutory regulations rather than rolled over and explore options for efficiencies/price reduction. • Contract terms are relative and proportionate to the contract matter and that there is a clear understanding of the risks transferred. • Service specifications are reviewed and ensure SLAs are being achieved or amend where suitable and do not directly affect patient care (e.g. reduce frequency of window cleaning etc.) 	<ul style="list-style-type: none"> • Contract register is maintained locally and aligned to All-Wales registers. • Contract management packs categorize contracts (e.g., critical/strategic/transactional) and set monitoring expectations. • Expiring contracts are proactively recommissioned; rollover is avoided unless justified. • PFI contracts are overseen by NWSSP Specialist Estates Services. • Service specifications and SLAs are reviewed to maintain quality while seeking efficiencies. 	<ul style="list-style-type: none"> • Contract register • Forward look of expiries (next 6–12 months) with sourcing plans • Sample completed contract review minutes/action logs • Evidence of SLA/KPI performance reports and remedial actions • Confirmation of PFI oversight by NWSSP SES and latest review output. <p>Gap 1: a live contract register is not easily accessible to service leads and does not afford proactive triggers to functional leads to highlight upcoming expiry of contracts.</p> <p>Gap 2: periodic and routine contract management reviews are not conducted to review contract KPIs and service compliance by all contract managers, overseen by Procurement.</p>

7. Procurement	Controls / Processes in place	Assurance that processes are operational
<p>Procurement – Purchase to Pay</p> <ul style="list-style-type: none"> Establish a robust purchase ordering (PO) system to enable the implementation of a 'no PO no payment' rule and no retrospective POs, in collaboration with Accounts Payable, to help control expenditure. Invoices that fail three-way match (PO, goods receipt, invoice) are rejected and returned. Source of error are identified and contract managed appropriately. Payments are only processed following sign off from the appropriate level. Sample audit batches for any possible out of policy expenditure. Continuous review of all open purchase orders that feed the monthly goods received not invoiced (GRNI) accrual for accuracy and appropriateness, ensuring any no longer valid items are removed/closed. Consider limiting and refining approval limits of requisitioners where appropriate. 	<ul style="list-style-type: none"> Robust P2P governance is in place via joint AP & Procurement working groups and All-Wales P2P forums. Three-way match is enforced; invoices failing match are returned per policy. 'No PO, No Pay' is embedded; retrospective POs are discouraged and tracked. Breaches are flagged by buyers and reported via ARAC. Requisitioner numbers and approval limits are being refined, with mandatory training for requesters and approvers. 	<ul style="list-style-type: none"> P2P dashboards Retrospective PO logged within ARAC report. Attendance/ competency records for requisitioner/approver training to be introduced ARAC reports including policy breaches and closures Working group minutes with actions completed. <p>Gap 1: Invoices that fail a three-way match are not rejected at source but are held by NWSSP pending service update.</p>
<p>Procurement - Other</p> <ul style="list-style-type: none"> Process in place to identify any "off contract" and consultancy expenditure. A strategy in place to review and market test costs to ensure best value. Contract pipeline clearly identified (and shared with NWSSP) to enable economies of scale. Ensure the number of purchasing cards in the organisation is right-fitted and balances the process efficiencies against the risk that the use of these bypasses' procurement processes. Targeted approach for clinical preference variation (as identified by V&S procurement group). 	<ul style="list-style-type: none"> Regular spend reviews identify off-contract and consultancy spend, enabling rapid short-term contracting and longer-term sourcing plans. Purchasing cards have been rationalised; Precision Pay is used to reduce risk and improve visibility. Work is progressing to better align CCGs with Procurement. A Regional Procurement Nurse is being recruited to lead clinical product standardisation and variation reduction with regional partners (e.g., SBUHB). 	<ul style="list-style-type: none"> Quarterly spend analysis highlighting off-contract spend; corrective actions and re-routing to contracts. P-card policy, cardholder list reductions, and Precision Pay usage reports; internal audit results on P-card control. Clinical variation baseline (e.g., top 10 categories) and standardisation roadmap; post-implementation savings/quality benefits. Regional collaboration team in place Regional workplan in draft

Colour Key:-

financial controls are black

grip actions are blue

7. Procurement	Controls / Processes in place	Assurance that processes are operational
<p>Procurement – Signalling</p> <ul style="list-style-type: none"> Organisation has considered placing a hold on certain items (e.g. external venue hire). Although the savings will be low, can act as a signalling mechanism. 	<ul style="list-style-type: none"> Non-essential expenditure (e.g., external venue hire) has previously been restricted to signal financial discipline and prioritise clinical operations. Catalogue expansion (e.g., Lyreco punchout; exploring digital tail-spend catalogue) steers staff to preferred products and controlled routes. 	<ul style="list-style-type: none"> Communications/policy notice implementing restrictions with effective date Before/after spend analysis for restricted spend Catalogue adoption metrics and % of tail spend routed through approved catalogues

8. Other Items	Controls / Processes in place	Assurance that processes are operational
<p>VAT recovery management</p> <ul style="list-style-type: none"> Review latest contracted out services guidance to ensure all eligible VAT is being reclaimed. 	<ul style="list-style-type: none"> Procurement buyers follow a defined internal process to verify VAT coding on all Purchase Orders, ensuring alignment with COS rules, contract status, and service category. Specialist VAT advisory support is in place via external partners (EY/KPMG), providing periodic review, challenge, and reclaim submissions to maximise recoverable VAT and ensure compliance with HMRC requirements. All covered by a VAT Financial Control Procedure. 	<ul style="list-style-type: none"> Sample audits of POs by Procurement /Finance demonstrate correct COS categorisation and VAT coding accuracy (e.g., % accuracy rate, exceptions log, corrective actions taken). Compliance and Tax team actively review spend to ensure all eligible VAT is being reclaimed. External VAT reclaim reports: Regular outputs and assurance letters from EY/KPMG confirming claims submitted, value recovered, areas reviewed, and compliance with HMRC COS guidance. Joint review meetings between VAT Leads, Finance, and Procurement to monitor reclaim rates, review missed opportunities and validate the accuracy of coding on high-risk categories (e.g., estates, IT, outsourced services). Ad-hoc re-reviews undertaken (by different advisors) to ensure no areas missed.

8. Other Items	Controls / Processes in place	Assurance that processes are operational
<p>Income and Debt management</p> <ul style="list-style-type: none"> • A NHS visitor and migrant cost recovery programme in place. • Bad debt cost management process in place e.g.: - <ul style="list-style-type: none"> ○ Ensure debtors categorised logically (e.g. NHS, Non-NHS, Private Patients, Overseas, Salary Sacrifice, Prescriptions, Salary Overpayments, etc.) with agreed risk based, proportionate approach to collection for each category. ○ Identify strategy for key debtors and set collection targets for team members. ○ Review processes in place to ensure invoices are issued in real time or as soon as possible. ○ Consider payment in advance/on delivery where appropriate or the use of pro forma invoices in areas such as private patients backed with settlement facilities available at point of delivery. ○ Identify and address internal issues that are preventing timely collections i.e. unresponsive / untimely resolution of queries by divisions. ○ Scrutinise requests to write-off salary overpayments (if historic practice shows these are material). ○ Ensure prompt referral to external debt recovery agencies where necessary. 	<ul style="list-style-type: none"> • Identification and Charging for Overseas Visitors for NHS Treatment Financial Control Procedure. • Designated Overseas Officer employed by Health Board. • Income and Cash Collection FCP – includes credit control and debt recovery approach for different categories of debtors and referral to debt collection agency as appropriate. • Income Risk Stratification FCP – covers area to consider for all employees who engage with companies to provide a service in return for payment to reduce risk of non-payment. 	<ul style="list-style-type: none"> • Regular training provided to frontline staff regarding use of policy. • Regular monthly reviews of overdue debts are undertaken. • All write-offs where uneconomical to pursue reported to ARAC. • Area of highest interest in relation to recovery of overpayments of salary. All Wales policy in place.

<p>Stock Management</p> <ul style="list-style-type: none"> • Ensure appropriate stock rotation processes are in place and being followed to minimise wastage. Agree process with suppliers to swap out short shelf-life items or use consignment. • Review stock level minimum and maximum thresholds in line with current usage to minimise wastage. • Review delivery charges, triggers and schedules and implement changes to reduce any carriage charges where possible (e.g. standing orders, minimum order values, 3 day delivery rather than next day). • Review controls on consignment stock. 	<ul style="list-style-type: none"> • Stock Financial Control Procedure in place. • Pharmacy has Standard Operating Procedures (SOPs) governing both stock maintenance and stock checking. These SOPs outline clear responsibilities, frequency of checks, documentation requirements, and investigation pathways for discrepancies. • Separate monthly checks of the central store areas are also conducted, which ensures all stores, fridges, and other specialist storage spaces are reviewed and signed off. • Stock within the robots undergoes monthly short-dated reviews, with expired items removed and destroyed, and short-dated items redistributed where possible. • Expiry date checks of stock held outside the robot are reviewed as part of the rolling stock check process mentioned above, and all items within three months of expiry are classed as “short-dated” and logged. • Robust stock rotation processes are in place across all storage areas to minimise waste and expiry. • A weekly minimum stock level report is generated and reviewed by procurement teams. • A system program reviewing stocks within the robots (KROB) is available. 	<ul style="list-style-type: none"> • <i>Functionality within the Pharmacy Stock Control System (WellSky/CareFlow) facilitates this, by generating randomised daily lines for validation. This happens at sites on a daily basis. Any identified discrepancies, expiry issues and stock rotation needs are investigated and actioned, and all documentation are stored locally in dispensaries.</i> • <i>The system generates a specific slow moving stock report (KLSOW) to identify slow moving items across the Health Board. This is reviewed centrally on a regular basis and stock redistributed across sites or returned to suppliers (if possible) to minimise stock destruction and wastage.</i> • Scan4Safety live tracking provides real-time visibility of stock levels, expiries, and usage patterns, enabling proactive identification of slow-moving or excess items and confirming compliance with rotation processes. • Physical stock count undertaken at least annually for areas not covered by an automated process. • <i>This reviews usage-based recommended minimum and maximum levels within the system, and these are adjusted as necessary by trained staff where</i>
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Colour Key:-

financial controls are black

grip actions are blue

<ul style="list-style-type: none"> • <i>At the Pharmacy Services Governance Group meeting, all procurement-related KPIs are presented and reviewed. This includes stock holding levels within each site along with other key indicators such as volume of ordering, receipting and invoicing.</i> • Minimum and maximum stock thresholds are reviewed regularly and adjusted in line with usage data, clinical demand, new pathways, and service changes to avoid over-stocking and obsolescence. • Delivery schedules, order triggers, and carriage charge structures are reviewed with suppliers to reduce unnecessary charges and optimise delivery frequency (e.g., consolidated weekly deliveries, minimum order values, standing orders, or 3-day delivery options instead of premium next-day services). 	<p><i>clinically and financially appropriate.</i></p> <ul style="list-style-type: none"> • <i>This process needs refinement to its functionality as currently it is very challenging due to the manual workload involved and needs resourcing and process support. The regular rolling stock checks mitigate this risk, but this could be more efficient if working appropriately.</i> • <i>Current rolling stock checks are held manually on paper within each separate pharmacy department. The team are working on a central electronic process to provide this oversight and improve assurance on the processes.</i> • <i>This enables identification of anomalies and opportunities for efficiencies.</i> • Carriage charge reduction project during financial year 2026/27. • Stock ownership and replenishment controls: The introduction of four dedicated stores staff ensures consistent delivery-to-ward processes, accurate stock rotation, and controlled top-up cycles. Compliance is evidenced through observed practice audits and supervisor sign-off.
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8. Other Items	Controls / Processes in place	Assurance that processes are operational
		<ul style="list-style-type: none"> Internal audit / peer review: Results from internal audits or stock spot checks, with actions tracked to completion. <p>Gap 1: operational stocktakes are not conducted on a regular and routine basis, resulting in the annual financial stocktake generating a higher volume of adjustments.</p>

<p>Estates</p> <ul style="list-style-type: none"> • Review outliers identified from benchmarking overall running costs for facilities and estates (inc. estates footprint use) (see the VAULT). • Ensure appropriate maintenance schedules in place to ensure asset kept in good working order. • Ensure an estates strategy is in place and regularly reviewed, to include estate rationalisation consideration to determine where savings might be delivered. • Establish list of ongoing and planned estates and maintenance projects and ensure it has been prioritised and has Board approval. 	<ul style="list-style-type: none"> • Data collected through the Estates & Facilities Performance Management returns are available for internal benchmarking purposes. • All Planned Preventative Maintenance Schedules (PPM) are routinely assessed in line with Welsh Health Technical Memorandum (WHTM) requirements and processed using our online Computer Aided Facilities Management (CAFM) system which offers dynamic reporting against benchmarks set for each maintenance schedule. This is reviewed monthly at the Estates Maintenance Operations Governance Group Meeting and again at the Estates Governance Group Meeting. Any concerns are picked up there. Specific disciplines e.g. Electrical Safety and Water Safety are picked up in those meetings are reported into the Health & Safety Compliance Group Meeting and then Health and Safety Committee. • A Property Asset Strategic Plan is in place and provides an overview of existing and planned changes to the HB's estate. • All contractual work in Estates team is tendered in line with procurement and SFIs and utilises framework contractors that have been vetted and approved e.g. Grounds 	<ul style="list-style-type: none"> • Data collection is undertaken in-house and reported annually via NWSSP Specialist Estate Services. • Day to day operational Maintenance & Engineering teams utilise CAFM for PPM schedules daily and report into governance groups for check and challenge as mentioned. • The strategy was endorsed by the Board in May 2023 and covers the period between 2023 to 2026. This strategy will be updated in 2026/27 to align with the HB's refreshed Clinical & Estate Strategic plan. • All Terms of Reference for the aforementioned boards and committees contain explicit purpose and instructions with minutes available to demonstrate compliance.
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Colour Key:-

financial controls are black

grip actions are blue

8. Other Items	Controls / Processes in place	Assurance that processes are operational
	<p>Maintenance and Lift Inspections. Other planned estates projects report through the Estates Governance Group, Capital Subcommittee and Strategy and Planning Committee for appropriate approvals. Any projects over £1m go to Public Board for formal approval following Executive Team sign off.</p>	
<p>Journal Approvals</p> <ul style="list-style-type: none"> Internal journal review process in place and regular accruals and prepayments have been reviewed to ensure they remain current and the method of calculation is based on up-to-date assumptions. Controls over journals are appropriate including posting authorisation levels, review and sign off process. 	<ul style="list-style-type: none"> Oracle E-Business Suite – System Access and Ledger Security FCP – includes General Ledger Input Procedures covering Journal processing, postings and approval. Oracle keeps an automated record of all journals posted which can be linked back to source. Feeders Control Sheet completed by Core Accounting Team for all external feed journals from outside the Oracle system. Quarterly extract of all manual and Application Desktop Integrator (ADI) journals selected at random for retrospective approval by the originator’s line manager. 	<ul style="list-style-type: none"> For all ‘actual’ journals automated posting is active within Oracle and scheduled to meet the organisation’s prescribed monthly closedown timetable. Due to the volume of journals and critical path required to meet timetable, Audit Wales has recognised that it is not practical to approve journals before posting and hence review our retrospective journal process as part of the Annual Accounts audit. All budget journals are posted by the Corporate Reporting Team.

8. Other Items	Controls / Processes in place	Assurance that processes are operational
<p>Fixed Assets and Capital</p> <ul style="list-style-type: none"> • Fixed asset register is in place and regularly updated including a fixed asset verification exercise. • Review capital programme for subsequent revenue affordability, deferring, reducing or stopping schemes as appropriate. • Asset lives regularly reviewed to ensure appropriate and that depreciation is consistent with consumption. • Consider reprioritising the capital programme to prioritise spend-to-save projects. • Review assets held on SoFP (buildings, equipment etc) and dispose of any no longer in use or needed. • Consider VfM of ownership options such as lease v purchase. 	<ul style="list-style-type: none"> • Capital Investment FPC – covers capital planning process; how to bid for capital; procedure for capital purchases; monitoring arrangements of capital programme and accounting arrangements for the Fixed Asset Register. • Yes, operated by the Finance Capital Team. • Revenue implications are considered as part of the prioritisation process for capital. It is not the only consideration taken into account when the programme is developed, clinical risk and patient impact are key considerations. • Reviewed annually by the Finance Capital Team as part of the Annual Audit process. • A spend to save allocation has been earmarked in the programme for 24/25, 25/26 and 26/27. • The UHB has an Estates Strategy that reviews estates assets that can be disposed as new projects complete. • The UHB currently has a mixed portfolio of capital developments some in the more traditional build and own category and a few where collaboration with local authority and WG has led to various lease options being developed. 	<ul style="list-style-type: none"> • Three-year cyclical asset verification process – current year (Ceredigion) with 70%+ response rate at 9/3/26. • Subject to Audit. • Large projects are considered by Executive Team, Capital Sub Committee and Strategy and Planning Committee prior to being presented to Board for approval. • Subject to audit. • The split of the UHB discretionary capital is considered by Executive Team, Capital Sub Committee, Strategy and Planning Committee prior to being presented to Board for approval. • All plans and major developments are reported through the Governance process described above.

8. Other Items	Controls / Processes in place	Assurance that processes are operational
<p>Balance Sheet Review</p> <ul style="list-style-type: none"> • Ensure all balance sheets are reconciled at appropriate intervals and action is taken to address historical balances. • Monthly assessment of existing provisions to determine whether these can be released during year as opposed to later in the year/year end. • Review all credit balances on the Balance sheet for potential over accrual (e.g. Annual Leave Accrual or GRNI balances). 	<ul style="list-style-type: none"> • Blackline system in place used to perform monthly reconciliations. • Balance sheet accounting principles implemented in year (and documented for clarity in Quarter 3 2025/26). Includes: <ul style="list-style-type: none"> ○ proactive assessment on a monthly basis of current provisions to determine whether they can be released in year as opposed to traditional year-end approach. ○ quarterly review of historic annual adjustments, recognising these are at a point in time and may not be indicative of year-end position. 	<ul style="list-style-type: none"> • Historic balances (particularly in CHC) reviewed and released where not required. • Wellsky balances were assessed as high at 2024/25 year end but due to time and staff constraints the erroneous over accrual was not addressed. • Balance sheet process is still bedding in but improving as staff are becoming more familiar with it. <p>Gap 1: a comprehensive aged balance sheet review does not currently exist.</p>

5.2

11:50, 40 Mins

5.2 - Draft Annual Accounts 2025/26 (To Follow)

Huw Thomas (Hywel Dda UHB - Director of Finance)

| For discussion

6

12:30, 0 Mins

6 - Any Other Business

All

| For information

7 - Date and Time of Next Meeting

9.30am, 23 June 2026

| For information