Date	**09/12/2025**
Time	**09:30 - 12:00**
Location	**Microsft Teams**

Virtual Audit & Risk Assurance Committee Meeting

HDD_Audit and Risk Committee

NHS Wales

Agenda - 9 December 2025

1 1 Introductions

09:30, 0 min

1.1 Apologies

09:30, 0 min
Rhodri Evans (Hywel Dda UHB - Independent Member)

1.2 Declaration of Interests

09:30, 0 min

2 Governance

09:30, 0 min

2.1 Minutes of the Meeting held on 14 October 2025

09:30, 0 min
Rhodri Evans (Hywel Dda UHB - Independent Member)

2.2 Table of Actions

09:30, 5 min
Rhodri Evans (Hywel Dda UHB - Independent Member)

2.3 Matters Arising not on Agenda

09:35, 0 min
Rhodri Evans (Hywel Dda UHB - Independent Member)

2.4 Escalation Status Update Report

09:35, 20 min
Philip Kloer (Hywel Dda UHB - Chief Executive), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Shaun Ayres (Hywel Dda UHB - Director of Delivery)

2.5 All Wales NHS Audit Committee Chairs' Meeting Update

09:55, 5 min
Rhodri Evans (Hywel Dda UHB - Independent Member)

2.6 Committee Self-Assessment

10:00, 5 min
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

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3 Audit Wales

10:05, 0 min

3.1 Audit Wales Update Report

10:05, 10 min
Anne Beegan, Urvisha Perez, David Williams

3.2 Structured Assessment 2025

10:15, 20 min
Anne Beegan, Urvisha Perez, Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

3.3 Review of the Management of Outpatients

10:35, 0 min
Anne Beegan, Urvisha Perez, Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Keith Jones (Hywel Dda UHB - Director of Operational Planning & Performance), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care), Lisa Humphrey (Hywel Dda UHB - General Manager)

3.4 Review of Urgent and Emergency Care - Patient Flow (Regional Report)

10:35, 20 min
Anne Beegan, Urvisha Perez, Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Gareth Cottrell (Hywel Dda UHB - Deputy Chief Operating Officer), Peter Skitt (Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine), Anna Chiffi (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality), Thomas Alexander (Hywel Dda UHB - Principal Programme Manager), Linda Jones

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3.5 Audit Fees Consultation 2026-27

10:55, 5 min
Anne Beegan, Urvisha Perez

BREAK

11:00, 10 min

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4 NWSSP – Audit and Assurance Services - Internal Audit

11:10, 0 min

4.1 Internal Audit Plan Progress Report

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

4.2 Medical Devices Regulations (Substantial Assurance)

11:20, 10 min
James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Gareth Rees (Hywel Dda UHB - Operations Directorate), Jan Bojanowski (Hywel Dda UHB - Head of Clinical Engineering)

4.3 Vaccination and Immunisation

11:30, 0 min
James Johns (NWSSP - Internal Audit), Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health)

4.4 Operational Governance Arrangements

11:30, 0 min
James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

4.5 Managed Practices

11:30, 0 min
James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

4.6 Level 3 and 4 Directorates

11:30, 0 min
James Johns (NWSSP - Internal Audit), Huw Thomas (Hywel Dda UHB - Director of Finance)

5 Financial Focus

11:30, 0 min

5.1 Financial Assurance Report

11:30, 10 min
Huw Thomas (Hywel Dda UHB - Director of Finance)

5.2 Counter Fraud Update

11:40, 10 min
Benjamin Rees (Hywel Dda UHB - Local Counter Fraud Specialist)

6 Assurance and Risk

11:50, 0 min

6.1 Risk Assurance Report

11:50, 10 min
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

7 For Information

12:00, 0 min

7.1 ARAC Workplan 2025/26

12:00, 0 min

8 Any Other Business

12:00, 0 min

9 Review of Meeting

12:00, 0 min

9.1 Matters and Risks for Escalation to the Board

12:00, 0 min

10 Date and Time of Next Meeting

12:00, 0 min

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09/12/2025 09:30 - 12:00

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09:30, 0 Mins

1 - 1 Introductions

1.1

09:30, 0 Mins

1.1 - Apologies

Rhodri Evans (Hywel Dda UHB - Independent Member)

For information

1.2 **09:30, 0 Mins**

1.2 - Declaration of Interests

All

For information

2

09:30, 0 Mins

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2 - Governance

2.1

09:30, 0 Mins

2.1 - Minutes of the Meeting held on 14 October 2025

Rhodri Evans (Hywel Dda UHB - Independent Member)

For approval

Attachments

2.1 Unapproved ARAC Minutes 14 October 2025.pdf

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

Date of Meeting: **09:30, Tuesday 14 October 2025**
Venue: **Microsoft Teams Meeting/ Ystwyth Boardroom**

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

In Attendance:
Ms Anne Beegan, Audit Wales (VC)
Ms Urvisha Perez, Audit Wales (VC)
Mr David Williams, Audit Wales (VC)
Mr James Johns, Head of Internal Audit, NWSSP
Mr Gareth Heaven, Internal Audit, NWSSP
Mr Murray Gard, NWSSP Specialist Estates Services (VC) (part)
Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary
Ms Claire Bird, Assurance and Risk Officer, deputising for Miss Charlotte Wilmshurst, Assistant Director of Assurance and Risk
Mr Huw Thomas, Executive Director of Finance
Mr Ben Rees, Head of Counter Fraud
Mr Andrew Carruthers, Chief Operating Officer (part)
Mr Gareth Cottrell, Deputy Chief Operating Officer (VC) (part)
Mr Peter Skitt, Clinical Care Group Service Director - Community and Integrated Medicine (VC) (Part)
Ms Anna Chiffi, Assistant Director of Nursing (VC) (part)
Mr Tom Alexander, Principal Programme Manager (VC) (part)
Mr Mark Henwood, Executive Medical Director (part)
Mr Ian Bebb, Clinical Audit Manager (part)
Mr James Severs, Executive Director of Allied Health Professions and Health Science (VC) (part)
Mr Craig Baker, Cellular Pathology Service Manager (VC) (part)
Ms Anne Simpson, Head of Strategic Commissioning (VC) (part)
Ms Eldeg Rosser, Head of Capital Planning (VC) (part)
Mr Dafydd Bebb, Board Secretary, Health Education and Improvement Wales (HEIW) (observing)
Ms Clare Moorcroft, Committee Services Officer (minutes)

Minutes Ref.	Item	Action
AC(25)159	**Introductions and Apologies for Absence**	

Cllr. Rhodri Evans, Audit and Risk Assurance Committee (ARAC) Chair, welcomed everyone to the meeting, thanking Mr Winston Weir for chairing the previous meeting in his absence. Apologies for absence were received from:

- Ms Sophie Corbett, Deputy Head of Internal Audit, NWSSP
- Professor Phil Kloer, Chief Executive
- Mr Lee Davies, Executive Director of Strategy and Planning

- Mr Shaun Ayres, Director of Delivery
- Dr Jon Arthur, Deputy Director of Health Science

AC(25)160 Declaration of Interests

No declarations of interest were made.

AC(25)161 Minutes of the Meeting held on 12 August 2025

Decision: RESOLVED – the Minutes from the meeting held on 12 August 2025 were approved as an accurate record.

AC(25)162 Table of Actions

An update was provided on the Table of Actions from the meeting held on 12 August 2025 and confirmation received that outstanding actions had been progressed. In terms of matters arising:

AC(25)103 – Mrs Joanne Wilson advised that this action has been closed, as the Chair of the People, Organisational Development and Culture Committee (PODCC) has requested that a detailed discussion take place at the next PODCC meeting.

AC(25)108 – it was agreed that queries in relation to Discharge Planning would be addressed during discussion of the Audit Wales report on this topic, which appears later on the agenda.

AC(25)163 Matters Arising not on Agenda

There were no other matters arising.

AC(25)164 Escalation Status Update Report

Members were informed that those due to present this item were unavoidably absent from the meeting, and that Mrs Wilson and Mr Huw Thomas would present the report in their absence. Mrs Wilson indicated that the Escalation Status Update Report outlines changes to the escalation criteria, noting that all of those aligned to ARAC remain on track. The Escalation Framework has evolved, and the chronology of this is described within the report. The most significant change is that involving the financial target. Building on this, Mr Huw Thomas reminded Members that the escalation criteria for finance has changed to reflect the Welsh Government expectation of a £24.1m deficit position, with this originally having been the Target Control Total of £31.5m deficit. He has made his concerns regarding this change clear, whilst recognising that the long-term ambition is one of financial balance and sustainability.

Cllr. Evans enquired whether this change is one which might be challenged. In response, Mr Thomas indicated that there have been discussions in this regard with Welsh Government. The Health Board is, however, not in a strong negotiating position, or a sustainable position. It needs to 'own' its financial trajectory, which necessitates a complex balancing of various factors. Next year's financial allocation is also likely to be challenging. Once the organisation has its Financial Roadmap in place, it will be in a stronger position. Mrs Wilson advised that she has been in

discussion with Ms Olivia Shorrocks from Welsh Government regarding the escalation criteria and governance around this. Cllr Evans noted it is important to establish how and why the criteria was changed outside the normal process. Members heard that a Tripartite meeting is due to take place in December 2025, which will require the Health Board to submit supporting evidence in the next six weeks. However, scheduled Joint Executive Team (JET) and Escalation meetings with Welsh Government have been stood down, due to the public accountability meetings.

Mrs Wilson suggested that an update be provided via the Table of Actions, following clarification of the above and agreement of the Escalation Framework. As outlined within the report, there are now two 'tests' to apply in terms of deterioration: no material deterioration against the previously agreed measure; and credible, sustained progress against the revised requirement. Finally, Mrs Wilson advised that all Targeted Intervention criteria are now included on the Audit Management and Tracking (AMAT) system. **PK/LD/ SA/HT**

Welcoming the comprehensive and clear report, Mr Maynard Davies expressed that the main issue is Welsh Government's changing expectations. He suggested that the letter sent to them by the Chief Executive yesterday sets out the Health Board's concerns well. Mr Davies also wished to highlight the potential financial liability to the Health Board of £4.2-5.2m associated with the Welsh Risk Pool (WRP). Whilst sharing concerns around the changes to financial outturn expectations, Mr Thomas suggested that it does not result in any fundamental change from a management perspective. He also emphasised that HDdUHB is being treated no differently from other Health Boards in this respect. Whilst accepting this, Mr Davies highlighted that every change to the financial expectation requires a 'refocus' by the Executive Team.

Mr Thomas indicated that the WRP issue presents a very current financial risk, which is outside the Health Board's control at this stage. He explained the reason for this liability arising, which was the increased number of court dates being made available this year, meaning that more clinical negligence cases are being heard. It was, however, important to recognise that such cases and any payments awarded relate to harm which has been done to patients, and redress for this.

Whilst acknowledging comments around the changed financial escalation criteria, Mrs Eleanor Marks was more pragmatic, given the Health Board's ultimate goal of financial sustainability. She also highlighted that Wales is entering an intensive political time, which influences the situation. Mrs Marks suggested that the organisation's focus should be on its medium- and long-term aims. Echoing a comment made by Mr Thomas, it is important to recognise that the Health Board is no longer an 'outlier' in terms of financial position.

Decision: The Committee:

- **NOTED** the documented movements to the Escalation Framework (clarified baselines, enabling actions/metrics, automatic de-escalation route) and their assurance consequences.
- **ACKNOWLEDGED** (Criterion 43) that where measures change in-year, progress will be judged on two tests: (i) no deterioration against the previous measure; (ii) sustained progress against the revised requirement within existing resources.
- **AGREED** to receive future Escalation Framework returns with a simple Change Note (old→new wording, date, baseline) and a compact Change Log, plus sustained-delivery flags where additional resources are going to be required or there is a material deviation to the annual plan.

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

AC(25)165 All Wales NHS Audit Committee Chairs' Meeting Update

Cllr. Evans drew Members' attention to the minutes and Annual Report from the All Wales NHS Audit Committee Chairs' (AWACC), provided for information. The Annual Report cites the HDdUHB Audit Tracker as an example of good practice. Cllr. Evans suggested that AWACC is an interesting forum, which highlights a number of common themes across Health Boards.

Ms Anne Beegan agreed that AWACC is a useful forum for sharing good practice, adding that the Chair is due to change imminently. Members also heard that AWACC had discussed the Audit Wales National Fraud Initiative briefing note, which appears later on the agenda.

Decision: The Committee **NOTED** the All Wales NHS Audit Committee Chairs' (AWACC) Update

AC(25)166 Audit Wales Update Report

Presenting the report, Mr David Williams advised that planning in relation to the Charitable Funds accounts audit work is being undertaken and the audit itself should be underway by the end of this month. With regard to performance audit, Ms Urvisha Perez indicated that the Discharge Planning Progress review is complete and included on today's agenda. The regional Patient Flow report is still in clearance and awaiting management response. It is hoped that this will be available for the next meeting. Audit Wales' other reviews are at various stages. The Outpatient Review and Structured Assessment are at reporting stage and field work is underway for the Investment in Digital Systems and Radiology reviews. The Estates Management deep dive and Local Council reviews are both in the latter stages of planning. As usual, Exhibit 3 in the report highlights relevant national reports published over the last six months, and Exhibit 4 provides information on corporate documents published since the previous meeting.

As mentioned earlier, a briefing note in relation to the National Fraud Initiative (NFI) is appended to the Audit Wales Update report. Members heard that the 2024/25 NFI exercise is now well underway, with participants actively reviewing their data matches. The briefing note is for information, and provides a national-level update on the current exercise and local data for the number of matches received. It also provides information around a high-level assessment of NFI governance and follow-up being undertaken over the next few months. This will be based on the Audit Wales NFI self-assessment checklist, and will assist in understanding the factors influencing outcomes across different bodies; explaining variation; identifying good practice and areas for improvement. The findings from this assessment will feed into Audit Wales' next national report on this topic, due to be published next autumn.

Cllr. Evans enquired whether Audit Wales felt that there were any issues requiring the Committee's attention, and requested assurance that reviews are on track to be delivered as planned. In response, Ms Perez indicated that there were no issues or concerns. Publication of the report from the Outpatients review has been delayed, and work on the Estates and Cancer reviews has not yet commenced.

With regard to the update on Charitable Funds audit work, Mr Davies noted that this is only at the planning stage and queried whether there will be sufficient time to complete audit work by the intended date of December 2025. Mr Williams confirmed that December 2025 is the target date for delivery and that resources are in place. Referencing her role on the board of a charity, Mrs Marks highlighted that fundraising is particularly challenging at present. Whilst not necessarily a question for ARAC, she enquired how and where this risk is accounted for in relation to Hywel Dda Health Charities and the potential impact on support which can be provided to projects. In response, Mr Thomas confirmed that this issue is considered by the Charitable Funds Committee (CFC). Whilst the Health Board should be cognisant of the sustainability of the charity, it must also be conscious of the distinction between the two bodies. The future and the sustainability of the charity itself would be a risk requiring consideration by CFC and the Board.

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

AC(25)167 **Review of Urgent and Emergency Care (Discharge Planning and Impact of Patient Flow)**

Mr Andrew Carruthers, Mr Gareth Cottrell, Mr Peter Skitt, Ms Anna Chiffi and Mr Tom Alexander joined the Committee meeting.

Ms Anne Beegan introduced the local Discharge Planning Progress Update, noting that (as mentioned earlier) the wider regional report remains in clearance. The report being considered today relates to a follow-up review of previous recommendations,

and Members will be familiar with certain of the areas involved. A high-level overview is provided on page 5 of the report, which identifies that there has been no progress against four actions. This relates to the Discharge Lounges, and Audit Wales has made a new recommendation in relation to these facilities. The other recommendations relate to implementation of the Discharge Policy. A recommendation in relation to training around the Policy has also been made. Whilst the local and regional reports do closely align, the focus in the report presented today is on the Discharge Lounges. There are a couple of areas where progress has been identified; in relation to the performance measurement and in implementing a digital platform.

Mr Andrew Carruthers thanked Audit Wales for the report, indicating that Members will be aware of the challenges in this area. The review's findings align with those of previous Internal Audits. Mr Carruthers noted that, whilst the previous report on this topic was 2017, the Health Board has probably only recently addressed certain of the recommendations therein. He felt that the new operational structure has assisted in this regard, facilitating a more consistent and Health Board-wide approach. It is recognised, however, that there is still much to do. Current work in relation to Discharge Lounges is a key component of this, and will have contributed to the improvements in ambulance handover times seen recently. Mr Peter Skitt advised that an 'In-hospital and Discharge Reset Week' is planned for December 2025. There is continued collaboration with Local Authority partners, along with a whole-team methodology. He agreed that the new operational structure is assisting in this whole-system approach. An increase in patient discharges prior to midday is being seen.

Members heard from Ms Anna Chiffi that there is a targeted exercise in relation to Discharge Lounges, where there have previously been inconsistencies across the region. There are now standard operating times for Discharge Lounges across three sites: 8.00am-6.00pm Monday to Friday. Patients identified for discharge are being moved to Discharge Lounges as early in the day as possible. Certain clinical tasks, such as final IV infusions and dressing changes are also being undertaken in the Discharge Lounges, which has increased the number of patients who can be moved to these facilities. Bronglais Hospital (BGH) does not currently have a provision for a Discharge Lounge; however, work is underway to identify a suitable space. In the meantime, patients deemed able to sit in day rooms within the ward area or away from their bed space are identified, to support patient flow.

In terms of the Discharge Policy, there is a new SharePoint page on the intranet containing a suite of information designed to support staff in the discharge process. This includes a link to online training, patient boarding guidelines, the care home of choice process and information around the community equipment service. It also includes a specific page on Discharge Lounges. Ms Chiffi advised that the team is also exploring a more robust process around criteria-led discharge, with greater specificity in

terms of actions required for patients to be discharged. This will facilitate a more continuous seven day discharge process, allowing clinicians, nurses and allied health professionals to discharge at weekends and out of hours within set parameters and criteria. Another area of focus, which will form a large part of the work during the reset week, is ensuring that patients are identified on the correct discharge pathways (care home, package of care, independent). Hospital@Home services will also support earlier discharges. Guidance is also provided around escalation in relation to delayed pathways of care and expectations throughout the patient's admission: from day one actions to the day before discharge. The team is working to ensure that all staff within ward environments have completed the training now available and are aware of the resources available. Overall, there has been a significant amount of work in this area.

Cllr. Evans expressed concern that there had been no progress against four actions from the previous review in 2017. He suggested that this lack of progress should have been identified internally, rather than by an Audit Wales review and was concerned that there might be other similar issues elsewhere. In response, Mrs Wilson advised that, whilst the previous review findings are on the Health Board Audit Tracker, the report had been marked as closed by the previous Chief Operating Officer, recognising that this was at a point in time. Audit Wales had clearly disagreed with this opinion, and Mrs Wilson committed to examine the process which had been previously undertaken. **JW**

Mr Davies welcomed the report and thanked Mr Carruthers and his team for the additional context and the clarity this provides. He enquired whether Audit Wales had identified, during their review, any examples of good practice in this area, from which HDdUHB might learn. Ms Beegan indicated that there will be aspects of this reflected within the regional report; however, agreed to share examples with Health Board colleagues. **AB** From an operational perspective, Mr Gareth Cottrell assured Members that the HDdUHB team is in regular contact with Welsh Government and Six Goals colleagues, with the access to networking information that this brings. Ms Chiffi added that Health Board representatives had recently attended a workshop where examples of good practice in relation to discharge processes had been shared, and these would be used to inform HDdUHB's approach. Building on this point, Mr Skitt emphasised that discharge planning is an area in which the Health Board cannot work in isolation; reflected by the need for a regional report. Partners in Local Authorities and the Third Sector must also be involved.

Mr Skitt's view was echoed by Mrs Marks, who indicated that this is a key message she hears regularly. Discharge can be dependent on availability of care packages, making it an issue which extends beyond the Health Board's remit. In view of this, Mrs Marks looked forward to receiving the regional report. Returning to the Table of Actions and **AC(25)108**, Cllr. Evans noted reference to extending Discharge Lounge opening hours

and enquired whether this incurs any additional cost. If so, whether this has been factored into the Health Board's financial position. Ms Chiffi advised that this is not an additional cost per se, as staff from elsewhere are being utilised. The situation in BGH will be slightly different, as a new workforce establishment will be required; however, this is separate to the three sites which already have Discharge Lounge provision.

Cllr. Evans also queried whether the reset week to address ambulance handover times had led to higher numbers of patients discharged. In response, Mr Carruthers emphasised that the measures put in place to achieve improvements in the 45 minute ambulance handover performance are not currently sustainable. They have involved a great deal of senior management resource and effort, for example. Of the sites, BGH has probably been most challenged, due to other influencing factors. It should also be noted that, whilst the 45 minute handover performance has improved, the 12 hour waits performance has deteriorated. This is, in part, the reason for the Discharge Reset Week planned for December 2025. With regard to BGH ED, Mr Skitt explained that the bed base at BGH is very small, making it more sensitive to impacts elsewhere in the system, but it also recovers quickly. Also, issues such as the CT scanner being out of action quickly leads to a backlog, due to the need to take patients to other sites for scans by ambulance, thereby exceeding the 45 minute target.

Mr Skitt agreed that there are improvements being seen in terms of ambulance handover times, and 'green shoots' of improvement in terms of wards and culture change. However, this will take time to fully embed, meaning that EDs will continue to be full for the time being. Noting earlier reference to the senior input which has been involved, Mrs Marks highlighted the challenges this presents. She enquired regarding work to change the culture among staff, to make improvements sustainable in the long-term. Mr Carruthers emphasised that it takes time to change culture; however, he believed that behaviours are changing. He also reported seeing a different kind of engagement with EDs from the inpatient areas. A national team has visited since the Getting It Right First Time (GIRFT) reviews last year, and the feedback from their visit to GGH was palpably different. They were able to see that ED staff there feel more supported, with a different culture of engagement from inpatient areas and other specialty teams in terms of taking patients from the ED. Mr Carruthers suggested that there are 'green shoots' of improvement on every site since the September reset week, which is starting to impact on behaviours and engagement.

He emphasised, however, that the journey of change has only just begun. Alongside this, and to make it sustainable, there must be consideration of how the organisation moves to a more seven day model of working; how to introduce a more integrated approach to community teams; and how to establish a streaming/hub model. All of which involve redesigning and reconfiguring the system and model. Mrs Marks expressed concern about the potential for

'initiative fatigue' and the risk of staff burnout from excessive demands. She enquired regarding support measures provided. Mr Carruthers shared these concerns. Returning to the topic of staff culture, Ms Chiffi agreed that there needs to be sustained change in this regard. The Community and Integrated Medicine Clinical Care Group (CCG) is taking steps to build a culture of learning and making a difference. Part of which is to close the feedback loop and provide feedback. Also, the Learning from Events meeting, which will incorporate a range of themes from incidents reported, audits undertaken, changes implemented and their impact on quality and performance metrics. She felt that this will be helpful to provide context for staff.

In addition, there are three accelerated workstreams in relation to access to care, patient flow, and the environment within EDs. Information being captured (on a monthly basis) as part of these workstreams includes both patient and staff feedback. This will help to identify how staff are feeling and support staff from a resilience and wellbeing perspective. Ms Chiffi agreed that staff are fatigued and have contributed a significant amount of work. It has been recognised that that is an area requiring focus. Cllr. Evans requested assurance that the proposed completion dates are achievable, and that Audit Wales are content with the Health Board's response. Ms Chiffi confirmed that there is a concerted effort on meeting completion dates, and Ms Beegan advised that Audit Wales regards the response as comprehensive. Following discussion, it was agreed that consideration of the report should form part of the PODCC item on the new operational structure. It should also be shared with the Chair of the Quality, Safety and Experience Committee (QSEC). **AC** **AC**

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

The Committee agreed to **ASSURE** the Board in relation to the Discharge Planning Progress Update.

Mr Andrew Carruthers, Mr Gareth Cottrell, Mr Peter Skitt, Ms Anna Chiffi and Mr Tom Alexander left the Committee meeting.

AC(25)168 Review of the Management of Outpatients

DEFERRED to 9 December 2025 meeting

AC(25)169 Clinical Audit Update

Mr Mark Henwood and Mr Ian Bebb joined the Committee meeting.

Introducing the Clinical Audit Update, Mr Mark Henwood reminded Members that Clinical Audit had moved to sit within the Medical Directorate in April 2025. He felt that this has been a helpful move in facilitating links with other areas. Agreeing, Mr Ian Bebb presented the report, which outlines the current position. Members will note that funding for the AMAT system has been secured, which is welcomed, and the team continues to roll out AMAT

implementation in terms of Clinical Audit. The Health Board is now participating in all national audits, and is reporting this at a senior level, via the CCG structure. Reporting around Clinical Audit includes any concerns and the sharing of good practice. The Clinical Audit Programme has been split into two six month programmes. Mr Bebb felt that it is developing into a more robust, quality programme than in previous years. Finally, he drew Members' attention to the sharing of learning via Whole Hospital Audit Meetings; and the report's recommendations, which are largely around taking assurance.

Mr Davies requested clarification around what participation in national audits actually comprises; whether this means conducting audits within the Health Board or simply supplying information. In response, Mr Bebb indicated that mandatory audits generally involve provision of data; he emphasised, however, that as the results are often Health Board or even site-specific, these do offer value. Mr Henwood assured Members that the previous issues with non-participation in mandatory national audits have been resolved. It is for the Health Board to determine how it uses the results from such audits. He is very much committed to ensuring that there is visibility in terms of audit outcomes and Key Performance Indicators (KPIs), and how these impact on improvement. Cllr. Evans enquired whether there are likely to be any exceptions to participation in national audits. Mr Henwood advised that there may be delays in participation, due to the impact on data collection of decisions around administrative staffing, made for financial reasons.

In response to a query around preparations for the October-March programme, Mr Bebb confirmed that this is in place; the timing issue was at the point of submitting the report to ARAC. Members heard that details of the programme are due to be considered by QSEC in December 2025. Cllr. Evans enquired how audit findings are reported, and was informed that this depends on the individual audit. National audits are reported via the CCG structure. Local audits have individual group ownership and are discussed at specialty forums. Others depend on the 'driver' for the audit. As mentioned during the introduction, there are also Whole Hospital and Whole Health Board Audit Meetings. Mr Henwood commended the AMAT system in this regard.

Noting that audits involve significant effort and produce large amounts of data, Mrs Marks requested assurance that the AMAT system will enable services to effectively interrogate and utilise this data. Mr Henwood recognised that this is where an increased focus is required. Audit data and results must feed into the Health Board's Annual Planning process and be sighted by the Board. Otherwise, it has questionable value. Building on this, Mr Davies queried whether the findings from national audits feed into workstreams such as the Clinical Services Plan. In response, Mr Henwood suggested that this probably has not been the case previously. However, data from clinical audits should be used to support the case for change. Mr Davies suggested that it should

be placed in the public domain and utilised to explain, for example, the risks involved in delivering services across multiple sites. Mr Henwood agreed that there are examples where the impact on patient outcomes is significant. Whilst service teams are aware of such cases, there is a strong argument for being more transparent with the data.

Decision: The Committee:

- **TOOK ASSURANCE** from the increased use of Audit Management and Tracking (AMAT) software within the Health Board, as well as the secured funding for the system
- **TOOK ASSURANCE** from the continuation of the majority of mandatory national audits and the processes followed for escalation
- **TOOK ASSURANCE** from the integration of clinical audit within all Clinical Care Groups
- **NOTED** the development of the 2025/26 programme
- **TOOK ASSURANCE** from the continued shared learning through Whole Hospital and Whole Health Board Audit Meetings

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

Mr Mark Henwood and Mr Ian Bebb left the Committee meeting.

AC(25)170 **Internal Audit Plan Progress Report**

Mr James Johns introduced the Internal Audit Plan Progress Report, drawing Members' attention to Section 2, which details outcomes from finalised audits. Progress with the programme of Internal Audits is positive. The fieldwork for one audit which was due to be reported to this meeting is nearing completion. There have been discussions with the Health Board around deferring certain audits and adding others. Members' attention was drawn to information contained within Appendix B around sampling, as requested at the previous meeting. Mr Johns explained that this is one element of the broader audit approach, and depends on the nature of the specific audit. The indicative value is based on practice and other factors and does vary, based on the nature of the risk based approach being taken.

Noting reference to changes to the Internal Audit Plan, Cllr. Evans enquired regarding the process for agreeing these. He queried the suggested deferral of audits in Primary Care and Complaints, observing that these are areas requiring focus. Mr Johns explained that there are other audits in Primary Care planned; the specific audit in question was in relation to a risk which had been de-escalated. Mrs Wilson added that this had been discussed with her and was at the Executive Director's request. The final decision would be for ARAC and the Chair of ARAC to make; there had been an issue of timing. Mrs Wilson committed to schedule a meeting between Cllr. Evans, Mr Johns and herself. **JW**

Cllr. Evans expressed concern that the two Internal Audits reported to the previous meeting had Limited Assurance ratings, and two further Limited Assurance reports are presented today. He enquired whether it will be possible to re-audit and/or address the findings sufficiently by the end of the year. Mrs Wilson reminded Members that HDdUHB chooses to target the Internal Audit programme in those areas which are highest risk. The results to date, with two Reasonable Assurance, two advisory reports and four Limited Assurance, do not represent a good position. There are plans to review the Sickness Management and Nursing Management audits, with discussions underway around how these are followed-up. Mr Johns suggested that it is more likely this will be via a recommendation tracking approach than a full re-audit.

Decision: The Committee **TOOK ASSURANCE** with regard to the delivery of the Internal Audit plan and from the outcomes of the finalised audit reports.

AC(25)171 Validation of Emergency Department Waiting Time Data (Limited Assurance)

Mr Andrew Carruthers, Mr Gareth Cottrell, Mr Peter Skitt and Ms Anna Chiffi joined the Committee meeting.

Mr Johns introduced the Validation of Emergency Department Waiting Time Data Internal Audit report. This audit had focused on validation of the Emergency Department data, particularly around the four hour target and the breach validation process in place. There is a system to capture and calculate information through the Welsh Patient Administration System (WPAS). In terms of data quality issues, there was a number of instances of casualty cards missing information. Whilst a Standard Operating Procedure (SOP) is in place, further work is required to address issues with this and ensure appropriate dissemination across the different sites. The audit identified some variation in arrangements across sites, particularly the level of clinical involvement in the validation process. Validation has only been undertaken at BGH since April 2025, following a change in management. Testing also revealed that, due to a system access issue at BGH, almost 40% of records are not subject to validation, with a risk of under/over-reporting of breaches. Taking these findings into account, the audit has concluded Limited Assurance overall.

Mrs Marks found the findings of this audit extremely disappointing, particularly noting that there were no low risk priorities. Some relate to administrative details, but others are more serious. She enquired what urgent steps are being taken to ensure data is validated, and the timescale for these. As a follow-up to this, the findings suggest that the validity of other data may be questionable, given the apparent relaxed attitude among staff to the importance of completing records. Finally, Mrs Marks enquired whether the fact that BGH was not undertaking validation was known, and whether this was viewed as acceptable.

Mr Skitt shared Mrs Marks' disappointment with the audit findings, along with her concerns. The audit recommendations are fully accepted, as is the need to take control of this area. BGH's non-participation in validation was not known until the operational structure changed, and immediate action was taken to address this. A number of the actions are either standard practice issues in terms of data entry and entry into records, or relate to the system not being interrogated properly. So whilst there are concerning findings, they should be relatively easy to correct. The SOP was developed quickly, in advance of the new structure being put in place. It will require reviewing in terms of process and structure; however, this should also be fairly straightforward to do. Issues in relation to clinical data entry and clinical validation will require discussions with staff around professional standards expectations within the organisation. Whilst Mr Skitt agreed that the audit's findings are disappointing, he felt the issues can be corrected very quickly.

Cllr. Evans requested clarification around the procedure for reviewing the SOP, noting that this will be subject to the standard internal governance processes. He also highlighted the fact that non-clinical staff have been found to be validating data is in itself a breach of the SOP. Mr Skitt stated that he has committed to review and revise the SOP with Ms Chiffi. It will then be subject to CCG governance processes and wider Health Board governance. **PS** Mrs Wilson suggested that he make contact with Ms Christine James in the Health Board Policies team. Mr Carruthers explained that he had requested an Internal Audit in this area due to a Welsh Government directive for health boards to focus on validation. He highlighted, however, that there is an ongoing national debate around whether clinicians should be undertaking this activity, due to the time commitment involved and whether it is the best use of their time. Securing clinical engagement in validation may, therefore, become challenging.

Mrs Marks requested clarification around the clinicians' concerns and Mr Carruthers indicated that this centres on a suggestion that there should be more digital solutions and the value of spending time analysing significant volumes of breach data. Whilst appreciating this reasoning, Mr Davies underlined the importance of such data. He also emphasised that data quality needs to improve, and that this is the responsibility of all Health Board staff. He agreed that, in the longer-term, digital solutions should be sought. Finally, Mr Davies suggested that a rating of Reasonable Assurance for Objective 1 could be viewed as overly generous, given the findings. Mr Thomas explained that there is some background in terms of the absence of a digital system in ED. It had originally been intended that Digital Health and Care Wales (DHCW) develop a system; however, this is not being taken forward. As a result, the Health Board would need to develop a local solution, which would require Board approval of a business case and would take time.

Whilst recognising that there is a debate around validation among clinicians, Mrs Marks highlighted that the NHS is responsible for providing a service to the public and is funded by taxpayers. Welsh Government requires Health Boards to collect and validate data; this is not debatable. Mr Carruthers agreed, emphasising that he is not attempting to suggest otherwise, rather to explain the potential challenges.

Cllr. Evans enquired regarding progress on the planned work in relation to waiting lists. Mrs Wilson advised that the terms of reference for the external review have been agreed. The Chief Executive has been seeking to identify an external individual to undertake the review, and has recently done so. A member of staff to lead internally has also been identified. It is hoped that the review will conclude by December 2025 and any learning will be shared with ARAC.

Mr Davies and Mr Winston Weir requested assurance around the monitoring of outcomes and actions, particularly in relation to whether the new SOP is being followed. In response, Mr Skitt advised that his expectation is that the actions and timescales for completion within the report will be adhered to. Cllr. Evans enquired whether the timescales are realistic and Mr Skitt confirmed that this was the case. Clarifying his query, Mr Davies indicated that this was more in relation to how implementation of the SOP will be monitored. He was advised that this will be audited by the CCG.

Mrs Wilson committed to discuss with Mr Johns how this audit's findings will be reviewed. It was highlighted that, should detailed audit work be required, sufficient time will need to be allowed for new arrangements to embed. **JW/JJ**

Decision: The Committee **NOTED** the Validation of Emergency Department Waiting Time Data (Limited Assurance) Internal Audit report.

The Committee agreed to **ADVISE** the Board in relation to the Validation of Emergency Department Waiting Time Data (Limited Assurance) Internal Audit report.

Mr Andrew Carruthers, Mr Gareth Cottrell, Mr Peter Skitt and Ms Anna Chiffi left the Committee meeting.

AC(25)172 Human Tissue Authority (Limited Assurance)

Mr James Severs and Mr Craig Baker joined the Committee meeting.

Mr Johns introduced the Human Tissue Authority Internal Audit report, which had examined aspects of the arrangements in relation to Human Tissue Authority (HTA) requirements. The review confirmed compliance with key HTA standards in relation to the secure storage of tissue and adherence to family wishes regarding disposal. Whilst tissue samples for all active cases

reviewed could be physically located and verified, there were instances of missing and incomplete forms and records. The audit also identified instances of delayed disposals resulting in tissue being held without consent, which had not been reported to the HTA as 'reportable incidents'. There is a programme of compliance audits; however, there is no evidence that action is taken to address areas of non-compliance. An overall rating of Limited Assurance has been concluded.

Thanking Mr Johns for the report, Mr James Severs advised that this is the first Internal Audit on HTA compliance commissioned in Wales. It had been intended that Swansea Bay UHB (SBUHB) would undertake an equivalent audit concurrently; however, SBUHB had not taken this forward. Mr Severs welcomed the assessment against the HTA standards, despite the fact that this has exposed some areas of development and vulnerability. A rigorous action plan, with challenging but achievable deadlines has been developed in response. Whilst disappointed with the outcome, Mr Severs felt that undertaking an audit was the right approach, as it provides a different viewpoint from an HTA inspection. He noted that none of the concerns raised in the Internal Audit were picked up during the statutory visit to the Health Board's licensed premises. This is an issue he will need to raise with the HTA directly. The agreed management action plan will be presented at the HTA Assurance Group on 16 October 2025, which Mr Severs will attend.

Cllr. Evans indicated that the report makes for concerning reading. However, as suggested by Mr Severs, it is only right to seek transparency and accountability in such areas. Observing that data quality had also been identified as an issue in this audit, Mr Davies queried how the importance of and individual responsibility for can be emphasised to the organisation as a whole. With regard to Key Finding 1, he noted that the completion date related to an action plan being in place. Mr Davies suggested that it would be preferable to be furnished with dates by which changes in the action plan are to be implemented. Mr Craig Baker assured Members that the action plan has already commenced, with various elements being undertaken. He added that the Health Board is compliant with HTA standards, and that certain aspects are outside the control of the organisation. He welcomed, however, the opportunity provided by the audit and action plan to reevaluate processes and working practices. Mrs Wilson explained that it will be challenging to track progress with actions, if they are not individually defined. The Health Board and ARAC require assurance on delivery of the actions themselves, rather than of an action plan. It was agreed that Mr Baker would examine the action plan and translate it into actions for the Audit Tracker. **CBaker**

Whilst Mrs Marks found the contents of this report extremely concerning, she recognised that the Health Board is compliant with the HTA standards. She also wished to acknowledged that responsibility for this area had only recently transferred to Mr Severs. Mrs Marks enquired whether the audit's findings had been

around – rather than compliance with basic requirements – achievement of a ‘gold standard’. Mr Baker indicated that it was the latter. As an example of the actions taken, it had been identified that there were delays in receipt of documentation from His Majesty's Coroner. Health Board staff had visited the Coroner’s Office to discuss their administrative processes, to feed into Health Board processes and ensure that deadlines are not breached. Overall, the team is changing processes and making the approach more proactive. Mr Severs advised that his intention when commissioning this audit was to identify the gaps; he had not anticipated the depth of findings shown. Whilst the report does make for uncomfortable reading, it also offers the opportunity to change practices to provide assurance that all possible steps are being taken. Mrs Marks welcomed these comments.

Referencing Key Finding 5 around tissue retention, Cllr. Evans enquired whether the Health Board should have self-reported such instances to the HTA. In response, Mr Baker advised that there are two cases which will be disclosed to the HTA. Cllr. Evans noted the finding around staff training, with the overall compliance position being 52% in August 2025. He queried whether it will be possible to address this by the end of the year. Mr Baker indicated that a comprehensive review of training is being undertaken. It is felt that current requirements are excessive and the team is looking to simplifying the competencies, which will make training compliance more achievable.

Noting the finding that a central record is held on a spreadsheet, Cllr. Evans queried whether this is the best method for maintaining a record of tissue samples. Mr Baker emphasised that the data is anonymised. The Health Board has recently procured a new tracking system Cerebro, which will further enhance robustness. In response to a query around transfer from one to the other, he indicated that the software and workstations are due to be installed in early 2026. Mr Weir requested an update on progress in terms of the Risk Register and was advised that more team members had been given access, which should ensure that risks are managed in a timely fashion. Members were assured that this action is on track. Mrs Wilson confirmed that there is good engagement between the Pathology team and the Assurance and Risk team.

Decision: The Committee **NOTED** the Human Tissue Authority (Limited Assurance) Internal Audit report.

Whilst recognising that there are plans in place to address concerns, and that the Health Board is compliant with the HTA standards, the Committee agreed to **ADVISE** the Board in relation to the Human Tissue Authority (Limited Assurance) Internal Audit report.

Mr Craig Baker left the Committee meeting.

AC(25)173 **Control of Contractors (Advisory Report)**

Mr Murray Gard introduced the Control of Contractors advisory report, which outlines the findings of a proactive review of the Health Board's Control of Contractors Policy, focusing primarily on how it addresses the Right To Work requirement. This was designed to 'dovetail' with the equivalent internal management review, and provide broader assurance over governance arrangements. The review recognises the positive actions which have already been undertaken, including the updates reported to previous ARAC meetings, together with enhancements to the contractual arrangements for capital schemes. Whilst no formal findings were raised, several observations were shared to support the ongoing policy development. All of these have been accepted by management and are being incorporated into the Policy.

Cllr. Evans noted that the issue of security and ID badges has been raised previously and requested an update. Mr Severs thanked Mr Gard for the report, advising Members that this had been through the relevant governance processes. Its findings have been enacted via both the Internal Audit report actions and via development of the policy. The Policy is currently out for consultation. The security actions are continuing to be progressed via the Security Management Group, with oversight through the Health and Safety Sub-Committee and Health and Safety Committee. There are no issues which have been flagged at any stage and actions are on track, as per the Internal Audit management plans.

Regarding Cllr. Evans' request, Mrs Wilson indicated that this was part of a much wider piece of work, involving individuals in addition to contractors. Mr Severs offered to provide an update to the next meeting via the Table of Actions. In response to a query around tracking, Mrs Wilson explained that this report is different from the norm, as the actions therein are not currently SMART (Specific, Measurable, Achievable, Realistic/Relevant, Timely). It was agreed that consideration would be given to whether the actions should be added to the central Audit Tracker or whether they can be monitored internally. **JS** **JW/JS**

Decision: The Committee **NOTED** the Control of Contractors (Advisory) Internal Audit report

The Committee agreed to **ASSURE** the Board in relation to the Control of Contractors (Advisory) Internal Audit report.

Mr James Severs left the Committee meeting.

AC(25)174 **Commissioning - Long Term Agreements (Reasonable Assurance)**

Ms Anne Simpson joined the Committee meeting.

Mr Gareth Heaven introduced the Commissioning - Long Term Agreements Internal Audit report. The objective of this review was

to assess the management and monitoring arrangements of commissioned long-term agreements (LTAs) for services provided by other NHS bodies to the Health Board. The review identified that the Health Board has approved LTAs for commissioned services with several NHS Wales bodies for 2025-26, which outline roles and responsibilities, quality and performance monitoring arrangements, and financial and service planning details. Financial and performance monitoring arrangements are established, with providers submitting regular monthly statements. An established governance structure is in place, and a new operational Commissioning and Contracting Oversight Group has been established. Health Board representation was also evident at other All Wales groups and meetings. One key matter arising was identified: HDdUHB not receiving regular quality and safety reports from any LTA provider organisations, with the exception of one provider, whose reports also lack some key detailed narrative on the subsequent actions taken and no reporting of patient experience. The audit has concluded an overall rating of Reasonable Assurance.

Mr Davies recalled that the issue of quality and safety reports had been raised previously, and queried whether this information should be shared with QSEC, given that it relates to the treatment of HDdUHB patients. He otherwise commended the team for the report's findings. Ms Anne Simpson advised that this information is received for HDdUHB's main provider, SBUHB, and is a 'work in progress' with other main providers. She also reflected that HDdUHB, as a provider of commissioned services, does not share an equivalent report with its main commissioners either. It has, as a health board, always received details of serious incidents and complaints relating to its residents via the national reporting route; and all health boards are bound by the Duty of Candour. It will be part of the commissioning and contracting intentions for 2026/27 to receive these reports.

Decision: The Committee **NOTED** the Commissioning - Long Term Agreements (Reasonable Assurance) Internal Audit report

The Committee agreed to **ASSURE** the Board in relation to the Commissioning - Long Term Agreements (Reasonable Assurance) Internal Audit report.

Ms Anne Simpson left the Committee meeting.

AC(25)175 Capital Governance Arrangements (Advisory Report)

Ms Eldeg Rosser joined the Committee meeting.

Mr Gard introduced the Capital Governance Arrangements (Advisory Report), which reviewed the capital management reporting structure to confirm that it remains appropriate and effective. Overall, the governance arrangements are robust; key committees were operating in line with their terms of reference and reporting flows were well established. No significant gaps in reporting were identified and no significant concerns were raised.

A small number of observations are noted in Appendix A, the actions in relation to which have all been completed, which is welcomed.

Mrs Wilson highlighted that there is a difference between management and assurance. The 'A Healthier Mid and West Wales' Group is a management group for the Executive Director of Strategy and Planning to discharge his accountabilities with regard to responsibility for that area, whereas other forums are for assurance. This may result in slight duplication; however, this is for purpose.

Decision: The Committee **NOTED** the Capital Governance Arrangements (Advisory) Internal Audit report

The Committee agreed to **ASSURE** the Board in relation to the Capital Governance Arrangements (Advisory) Internal Audit report.

Ms Eldeg Rosser left the Committee meeting.

AC(25)176 Vaccination and Immunisation

DEFERRED to 9 December 2025 meeting

AC(25)177 Financial Assurance Report

Mr Thomas presented the Financial Assurance Report, noting that Appendix 5, originally included, should have been presented to the In-Committee session. There were no 'Alert' issues. 'Advise' issues related to breaches of Standing Financial Instructions (SFIs), staff overpayments and losses and write-offs. Staff overpayments were isolated in the main to one area, due to turnover of staff.

Observing that breaches of SFIs are occurring regularly, Cllr. Evans enquired regarding the effectiveness of re-education in this regard. In response, Mr Thomas suggested that, whilst education does play an important role, the point at which more challenging conversations are required is being reached. The level of SFI breaches is too high. In terms of losses and write-offs, much of this figure relates to stock write-offs. Electronic Prescribing and Medicines Administration (ePMA) systems may assist in this regard; however, there will always be challenges associated with multiple small sites.

Referencing the VAT recovery in relation to the BT PSBA network, Mr Davies queried whether there might be other similar cases to which the same principle can be applied. Members heard that the Health Board has a dedicated tax expert with experience as a tax accountant. He liaises with Ernst and Young, the Health Board's tax advisors, and any learning from examples such as this is applied to processes going forward.

Decision: The Committee:

- **DISCUSSED** the breaches of Standing Financial Instructions (SFIs) as detailed
- **DISCUSSED** the staff overpayments as detailed and **TOOK ASSURANCE** that actions to control them are sufficiently embedded.
- **DISCUSSED** losses as detailed
- **TOOK ASSURANCE** from the actions taken to reduce the instances of non-compliance with the No PO, No Pay policy; to ensure Public Sector Payment Policy (PSPP) compliance; to manage Single Tender Actions (STAs) and ensure National Minimum Wage (NMW) compliance.
- **SCRUTINISED** the award of contracts listed

AC(25)178 Counter Fraud Update

Mr Ben Rees introduced the Counter Fraud Update report, highlighting the 'Prevent and Deter' section. This describes various proactive exercises, which are outlined in more detail as part of the In-Committee report. There is also reference to NFI activity, as mentioned earlier by Audit Wales. Of the matches identified, only three are outstanding; one of which involves an ongoing investigation and two others remain outstanding due to third party actions.

Noting that, at the half-way point of the year, less than half of the Counter Fraud resources have been utilised, Mr Davies enquired whether there was a reason for this. Mr Rees suggested that this is partly due to annual leave during this portion of the year. Experience suggests that the second part of the year will see increased activity, which he was confident will utilise remaining resources. Replying to a query around declaration of secondary interests, Mr Rees indicated that there has been a 50% response rate. Most of these have involved potential conflicts of interest, or queries around this topic. This exercise has identified the need for greater education around conflicts of interest and/or a requirement that Health Board employees declare all secondary employment. The latter would require further discussion.

Agreeing, Mrs Marks indicated that she is hearing more and more often of people taking second jobs. The requirement to declare any secondary employment would make the situation clearer all round. Mrs Wilson advised that this issue has also been raised at QSEC, and is an area requiring consideration. In response to a query around whether any new or different trends are being seen, Mr Rees advised that a data trends report would be provided for the December 2025 meeting. In the interim, increasing levels of referrals involving secondary employment and working whilst on sick leave were being seen. The Counter Fraud team will engage with the Workforce team prior to the Fraud Awareness Week in late November.

Cllr. Evans looked forward to the data trends report, noting that those mentioned reflect national trends reported at the AWACC meeting. Building on this, Mr Rees emphasised that HDdUHB

Counter Fraud staff regularly attend meetings will colleagues across Wales, and that Counter Fraud services seek to adopt a 'once for Wales' approach wherever possible.

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

AC(25)179 Internal and External Recommendations and WHC Tracking Assurance Report

Presenting the report, Mrs Wilson explained that the format of this has been changed, to make it consistent across all committees. There has been good progress on closing recommendations and on those services in Level 3 escalation. A meeting has taken place with staff from the Planned and Specialist Care CCG to discuss Welsh Health Circulars (WHCs) behind schedule. Members heard that Estates and Facilities are now in Level 1 for the Governance domain, which represents a good achievement. The area of most concern currently is probably the CIM CCG, with its senior managers focusing on the Reset Week and other demands. Ms Claire Bird advised that Mr Skitt, as CCG Service Director, has tasked a senior member of the CCG team with leading on AMAT actions.

Regarding the most recent round of escalation meetings, and as a general reflection, Mr Thomas expressed concern around responsiveness in terms of input measures. He explained that the Workforce and Quality and Safety measures being tracked are fundamentally input measures. There is an increasing sense of frustration that the level of responsiveness is not as it should be. Mrs Wilson felt that the Assurance and Risk team is generally getting much better engagement from CCGs. However, corporate functions can only do so much to facilitate engagement, recognising that accountability sits with the CCGs.

Noting reference in the report to development of an audit tracking performance dashboard via 'Power BI', Mr Davies suggested that this would be very useful to the CCGs in tracking their compliance. He observed that 45% of recommendations are overdue and, of this, 68% are overdue by more than six months. This does not present a particularly good picture. Mr Davies also noted that, since July 2025, there has been an increase in recommendations with revised timescales for completion, and enquired regarding the reason for this. Mrs Wilson advised that a number of recommendations sit within CIM, where (as indicated above) capacity and competing demands has been an issue. She assured Members that these recommendations are being worked through and considered on an individual basis.

Mr Thomas suggested that this links into Escalation, and the issue of areas remaining at Level 3 for extended periods. Whilst there has been a contributory factor of the new operational structure being implemented and maturing; consideration does now need to be given to the meaning of Level 4 escalation, and whether there are other interventions which the Chief Executive could and

should be taking. Whilst acknowledging this, Mr Davies recognised the need to be aware of the many and varied demands placed on operational teams. It was agreed that Mrs Wilson and her team should examine those recommendations overdue by six months or more, whilst recognising that it is the CCGs' responsibility to identify whether they can be closed. **JW**

Welcoming this suggestion, Mrs Marks noted that a number of recommendations are likely to relate to systemic issues which cannot necessarily be addressed easily, due to capacity or funding. She suggested that, for these, consideration be given to whether it might be possible to take a different approach or propose an alternative action to address the recommendation. This group of recommendations fundamentally differs from those which are simply delayed due to inaction. The latter being a management issue, the former being a more serious organisational issue.

Mr Winston Weir left the Committee meeting.

Highlighting the graph on page 8 of the report, 'Audit Tracker Analysis – Overdue recommendations', Mrs Marks noted the recommendations overdue by more than 24 months in Primary Care, Community and Long Term Care. She was conscious that, as an organisation, the Health Board wishes to move towards a Social Model for Health and Wellbeing. In view of this, she enquired whether a more holistic or strategic approach is required, to address areas where recommendations have been outstanding for some time. Mrs Wilson described an exercise being undertaken currently with regard to overdue WHCs, where it has been recognised that implementation is not possible due to funding constraints. Quality Impact Assessments are being undertaken for the relevant areas. Those that require it, will then be added to the Risk Register. A similar process will be applied for other overdue recommendations, once capacity permits.

Mr Thomas suggested that there has also been an element of (out of necessity) prioritising the most pressing issues. In addition, the Health Board has, in the past, tended to accept Audit Wales and Internal Audit recommendations without question, even when these cannot be implemented due to issues beyond the organisation's control. Mrs Wilson suggested that this approach has not been limited to Audit Wales and Internal Audit, but also applies to the findings of external bodies and regulators.

Decision: The Committee **TOOK ASSURANCE** that the Health Board is: continuing to address and implement findings from audits, inspections and regulators; addressing and implementing the requirements as raised within Welsh Health Circulars; and strengthening the internal escalation arrangements for the domain of governance.

Whilst the Committee agreed to **ASSURE** the Board in relation to the Internal and External Recommendations and WHC Tracking

Assurance Report, concerns were expressed around the position in relation to the Community and Integrated Medicine Clinical Care Group (CCG).

AC(25)180 ARAC Workplan 2025/26

The Committee **NOTED** the Audit Work Programme 2025/26, which will be updated in line with discussions and to align with Audit Wales and Internal Audit Plans.

AC(25)181 Any Other Business

There was no other business reported.

AC(25)182 Matters and Risks for Escalation to the Board

As noted.

AC(25)183 Date and Time of Next Meeting

9.30am, 9 December 2025

2.2

09:30, 5 Mins

2.2 - Table of Actions

Rhodri Evans (Hywel Dda UHB - Independent Member)

For assurance

Attachments

2.2 Table of Actions ARAC 14 Oct 2025.pdf

2.2 Appendix 1.pdf

2.2 Appendix 2.pdf

Audit & Risk Assurance Committee
TABLE OF ACTIONS
Arising from Meeting held on 14 October 2025

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
AC(25)112	**24/06/2025**	**Contract Management (Advisory Report)**	To provide an update on progress to the next meeting	**HT**	~~**August**~~ **December 2025**	12 August 2025 **In Progress** Raised nationally, but not as yet discussed by the Directors of Finance peer group. A request has been submitted to include this on the workplan. Suggest that this action is deferred for a response by December 2025, to allow a fuller response. 9 December 2025 **Complete** Contract management arrangements were discussed at the Directors of Finance peer group meeting on 24 October. NWSSP have developed a contract management framework nationally, and will lead upon a national response. The slide attached at Appendix 1 provides the workplan summary.
AC(25)164	**14/10/2025**	**Escalation Status Update Report**	To provide an update following clarification of the governance process undertaken around, and agreement of, the Escalation Framework	**PK/LD/ SA/HT**	**December 2025**	**Complete** Email sent to Welsh Government on 3 November 2025, confirming acceptance of the revised Escalation Framework and outlining ARAC's concerns regarding the

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
						decision-making process and governance of changes to the financial domain escalation criteria. The Executive Director of Strategy and Planning is discussing this further with Welsh Government.
AC(25)167	**14/10/2025**	**Review of Urgent and Emergency Care (Discharge Planning and Impact of Patient Flow)**	To examine the process undertaken in closing the report in relation to the 2017 review	**JW**	**December 2025**	**Complete** Approval was obtained in September 2018 from the relevant Service Delivery Manager in Unscheduled Care confirming that all actions to address recommendations raised within the report had been completed, with formal approval received in November 2018 from the Director of Operations to approve overall report closure. It is noted that due process was followed in line with protocols in place at the time, which pre-date current arrangements with the utilisation of the AMAT system and the requirement for service leads to provide evidence to support the formal approval of closure of recommendations
			To share examples of good practice from elsewhere	**AB**	**December 2025**	Examples of good practice will be shared through an All Wales output which brings together the key findings from all of the UEC work.
			To ensure that consideration of the report forms part of the PODCC	**AC**	~~**December 2025**~~ **February**	**In Progress** A verbal update on the Operational Structure was provided at the

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
			item on the new operational structure		**2026**	PODCC meeting; further work is required due to the announcement of the departure of the Director of Primary Care, Community and Long Term Care and the need to review the CCGs to realign aspects of that portfolio. A written update will be provided to the next PODCC meeting.
			To share the report with the Chair of QSEC	**AC**	**December 2025**	**Complete**
AC(25)170	**14/10/2025**	**Internal Audit Plan Progress Report**	To schedule a meeting between the Chair of ARAC, Head of Internal Audit and Director of Corporate Governance to discuss changes to the IA Plan programme	**JW**	**December 2025**	**Complete** Meeting held on 10 November 2025.
AC(25)171	**14/10/2025**	**Validation of Emergency Department Waiting Time Data (Limited Assurance)**	To review and revise the SOP and take it forward via CCG and wider Health Board governance processes	**PS**	**~~December 2025~~ February 2026**	**In Progress** The Review of the existing SOP has commenced, with a view to presenting to CIM CCG at the end of November 2025.
			To discuss how the audit findings will be reviewed	**JW/JJ**	**December 2025**	**Complete** Following discussion with the Director of Corporate Governance and the ARAC Chair, a re-audit has been agreed, to be added to the current Internal Audit plan and completed prior to the conclusion of the 2025/26 annual opinion.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
AC(25)172	**14/10/2025**	**Human Tissue Authority (Limited Assurance)**	To examine, with the Audit and Risk Business Partner for Pathology, the action plan and translate it into actions for the Audit Tracker	**CBaker**	**December 2025**	**Complete** Met with Assurance and Risk business partner and clarified timelines for actions. Updates and evidence to be provided via AMAT by December implementation date.
AC(25)173	**14/10/2025**	**Control of Contractors (Advisory Report)**	To provide an update on work in relation to security and ID badges	**JS**	**December 2025**	Please see Appendix 2.
			To consider whether the actions identified should be added to the central Audit Tracker or whether they can be monitored internally	**JW/JS**	**December 2025**	**Complete** The report is being monitored on AMAT, with 6 of the 7 recommendations raised noted as complete by the service. The outstanding recommendation has a completion date of January 2026. Progress updates and evidence submitted to demonstrate the implementation of the recommendations will be reviewed by Internal Audit in order to formally approve for closure. Recommendations raised within advisory reports are routinely monitored on AMAT as part of current monitoring arrangements.
AC(25)179	**14/10/2025**	**Internal and External Recommendations and WHC Tracking Assurance Report**	To examine recommendations overdue by 6 months or more, to identify whether they can be closed, or whether additional support is required	**JW**	**~~December 2025~~ February 2026**	**In Progress** A meeting will be scheduled in December 2025 between the Director of Corporate Governance/ Board Secretary, Assistant Director of Assurance and Risk, and Head of Assurance and Risk to review those

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
						recommendations overdue by greater than 6 months (based on the escalation data at October month end) to determine the appropriate course of action to support the progression of these overdue recommendations with relevant Clinical Care Groups / Executive Functions.

CONTRACT MANAGEMENT

NHS Wales Shared Services Partnership

Internal Contract Management Procedure

Central Contracts Register Q3

Awareness Sessions

Pre-procurement agreement on contract management requirements (If any)

Nominated Contract Manager/Authorised Officer identified and engaged in the procurement process

Legislative requirements - Procurement Act 2023 – KPIs (min 3 for >£5m), publication of notices, e.g. annual performance against KPIs (standard rating), potential for future debarment, modification notices

A comprehensive review of the Control of Contractors Policy has taken place which has undergone global consultation and received CCG approval. Final ratification will occur at an upcoming health and safety compliance group meeting. Workforce colleagues will be contacted to further refine the policy pending final approval.

Several key changes have been introduced. Contractors must now be clearly identified, either by a Health Board-issued contractors badge, visible company identification, or branded workwear. A new Right-to-Work and Competency Declaration process is required for every contract. Induction tracking has been strengthened, and managers are receiving training on contractor control responsibilities. At acute sites, contractor sign-in procedures have been tightened to ensure all arrangements are verified with Estates, including referencing asbestos registers, maintaining daily sign-in and sign-out records, and complying with safety protocols. These measures are under full review, and the results will be presented to the Health & Safety Group in January.

The team have implemented a “check and challenge process” to align with policy development and internal audit recommendations. Senior estates managers review compliance, supporting process and intelligence gathering for gap analysis, which informs action plans.

For example, this check and challenge concerns some of the following elements

1. Check with company – right to work in the UK
2. Signing process
3. Do they have risk assessment and method statement?
4. Do they have the appropriate permits?
5. Have they seen the asbestos register?
6. Have they engaged appropriately with estates or other designated persons (IT or other contractors)?

The revised policy has addressed the six recommendations from the NWSSP internal audit process. The following sections of the policy has been revised:

- **Section 2- General rules and information** – a new subsection has been added detailing right-to-work-in-UK responsibilities.
- **Section 2.22 Permits to work** – Access onto RAAC affected flat roofs added to list.
- **Section 2.26 Risk Assessments and Method Statements (RAMS)** – Asbestos risks and RAAC related risks have been added to the checklist for contractors.
- **Section 2.27 Starting the Work** - the Induction sub-section has been updated to reflect current practice.
- **Section 3 Hazards, risks, and control measures** – a new sub-section has been added: 3.35 Reinforced Autoclaved Aerated Concrete (RAAC).

- **Section 3.45 Roof Work** – a sign-posting paragraph regarding RAAC has been added to the flat roof sub-section.
- **Appendix 1 Key contacts** – table has been updated.
- Appendix **3 Safety rules for contractors (summary)** – the numbered list has been revised for clarity, and a new item added regarding RAAC.
- **Appendices 5 and 6 (RAMS template and guidance) removed, and all references to these appendices deleted** – this is not regarded as being within the remit of HB responsibilities to provide this information.
- **Appendix 8 (point of work risk assessment template) removed** - this is not regarded as being within the remit of HB responsibilities to provide this information.

2.3

09:35, 0 Mins

2.3 - Matters Arising not on Agenda

Rhodri Evans (Hywel Dda UHB - Independent Member)

For discussion

2.4

09:35, 20 Mins

2.4 - Escalation Status Update Report

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

For assurance

Attachments

2.4 ARAC De-escalation Criteria Assessment December 2025.pdf

ARAC Escalation Status – Governance & Leadership Criteria and DPOC Analytical Addendum

1. Summary of Governance and Leadership Criteria

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The table below provides a summary of the seven governance and leadership criteria assessed in this paper. Of these, three are rated Assure and four are rated Advise.

Criterion	Lead Exec	Summary	Rating
MD1 – Operational structure and SOP	Ms Joanne Wilson	Phase one implemented; phase two slipped; IA review not yet reported.	Advise
MD2 – Board oversight and Duty of Quality	Ms Joanne Wilson	Strong external confirmation from Structured Assessment 2025; governance arrangements effective.	Assure
MD3 – Programme and performance management	Mr Lee Davies	Improving Together framework strong; delivery against annual plan on track in the main, however, the current forecast is still in excess of the annual plan target control total.	Advise
MD4 – Board sighted on key risks (BAF/CRR)	Ms Joanne Wilson	Mature approach confirmed; revised Risk Management Framework approved September 2025.	Assure
MD5 – Governance structures and Triple-A	Mr Lee Davies	Committee structures sound; Triple-A model variation noted; R1 action runs to January 2026.	Advise
MD6 – Governance and leadership maturity	Mr Lee Davies	Self-assessment completed April 2025; externally benchmarked; maturity matrix refreshed to ten dimensions.	Assure
MD7 – HIW and other regulators	Ms Sharon Daniel	Tracking robust; residual backlog of higher-risk actions; learning not consistently demonstrated around DPOC.	Advise

Criterion 41 (MD1) – Operational structure and SOP

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ARAC assurance rating: Advise

Current Position Summary

Reason - High-level structure and governance are in place, but phase two has slipped and the Internal Audit review has not yet reported, so the assurance period has effectively lapsed.

This criterion is concerned with whether the revised operational structure and associated standard operating processes are fully implemented and working as intended, with Internal Audit confirming effectiveness. Since October, the Structured Assessment has confirmed that phase one of the new operational structure, the four Clinical Care Groups, has been implemented, leadership teams are in place and the governance framework has been updated around them. However, phase two, which sets out the detailed sub-structures and operating arrangements beneath each Care Group, has not yet been delivered, and Audit Wales notes ongoing concern about the pace of change and uncertainty for staff.

The planned Internal Audit review of post-restructure operational governance is now expected to report to ARAC in February 2026 rather than in time for this December 2025 committee. Taken together, this means that while the structural design and high-level governance are reasonably sound, the organisation has not yet completed the implementation or secured the independent assurance originally intended within this period. On that basis, the current position is best reflected as Advise, pending completion of phase two and receipt of the Internal Audit opinion.

Criterion 42 (MD2) – Board oversight and Duty of Quality

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ARAC assurance rating - Assure

Reason - The Structured Assessment 2025 provides strong, current, external confirmation that oversight, scrutiny and Duty of Quality arrangements are working as intended.

This criterion tests whether the Board and its Committees are providing effective oversight and scrutiny of services, with consistent consideration of the Duty of Quality in decision-making. Since the October meeting, the Structured Assessment has confirmed that the Board continues to have good governance arrangements, with public transparency through live-streamed meetings, timely public papers and limited in-committee business. ARAC is identified as playing a key role in supporting compliance with Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

The report also confirms that patient and staff experience remains visible in Board and Committee business and that the Board uses a refreshed maturity matrix and an active development programme to support its effectiveness. This is consistent with the Duty of Quality being hard-wired into Board templates and annual reporting on the Quality and Engagement Act. There is no new evidence that would weaken the position reported in October; the Structured Assessment strengthens the assurance available to the Committee, and this criterion can reasonably be regarded as fully met.

Criterion 43 (MD3) – Programme and performance management / Delivery against plan

ARAC assurance rating – Advise

Reason - The framework and escalation arrangements are strong, but delivery against a financially balanced plan remains unresolved and extends beyond the December period.

This criterion examines whether there is an effective programme and performance management framework, with clear escalation, that the Board can use to oversee and drive delivery against agreed plans. Since October, the Structured Assessment has confirmed that the Improving Together framework was updated and approved in March 2025 to reflect the new operational structure and to introduce a clearer, four-level escalation model. Internal Audit has provided Substantial Assurance on the performance management arrangements themselves, while a separate review of data quality gave Limited Assurance and has prompted a specific improvement programme.

At the same time, Audit Wales notes that work on the long-term strategy refresh and Clinical Services Plan is ongoing and that the Annual Plan / IMTP and financial position do not yet meet Welsh Government requirements. However, significant progress has been made, but there is a residual gap in terms of meeting the revised Target Control Total.

Criterion 44 (MD4) – Board sighted on key risks (BAF / CRR)

ARAC assurance rating – Assure

Reason - The risk framework, BAF and CRR processes are mature and have been strengthened further in response to Audit Wales recommendations.

This criterion focuses on whether the Board is routinely and meaningfully sighted on key risks through the Board Assurance Framework and Corporate Risk Register, and whether this supports constructive scrutiny. Since October, the Structured Assessment has confirmed that the Board's approach to strategic risk is mature, with the BAF and CRR regularly considered and used to inform challenge and decision-making. Committees have clearly defined risk and planning objective allocations, and ARAC receives a consolidated Risk Assurance Report.

A revised Risk Management Framework and Strategy were approved in September 2025, and in response to Audit Wales Recommendation R2 the BAF dashboard has been updated to make Committee oversight arrangements explicitly visible. These developments are consistent with, and build on, the position reported previously. No new gaps have been identified. On this basis, the criterion can reasonably be regarded as fully delivered and remains at Assure.

Criterion 45 (MD5) – Governance structures and Triple-A escalation

ARAC assurance rating – Advise (governance strong, model still embedding)

Reason - - Committee structures and escalation routes are sound, but the Triple-A model is not yet being applied consistently and the Audit Wales action runs into January 2026.

This criterion considers whether governance and assurance structures are clear, and whether the Alert / Advise / Assure (Triple-A) escalation model is being used appropriately and consistently across Committees. The Structured Assessment confirms that the revised Committee structure, aligned to escalation domains, has been implemented and is functioning, with up-to-date Terms of Reference and forward plans published. It also recognises that the Triple-A model is valued and has sharpened focus on key issues.

However, Audit Wales notes variation in how the model is applied, including some Committees operating at too operational a level and differences in how Chairs reach their ratings. Recommendation R1 - therefore calls for a specific development intervention, including a briefing for Independent Members and clearer prompts for Chairs, with actions scheduled to complete by the end of January 2026. In light of this, the underlying governance arrangements can still be regarded as robust, but the escalation model itself cannot yet be described as fully embedded within the time period originally envisaged. For December, the position is more appropriately described as Advise, recognising strong structures with a live development requirement around Triple-A.

Criterion 49 (MD6) – Governance and leadership maturity

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ARAC assurance rating – Assure

Reason - This criterion considers whether the Board has undertaken a robust self-assessment against an agreed governance and leadership maturity matrix, with the process externally tested and the maturity level understood. The Board completed a detailed self-assessment in April 2025, which was externally benchmarked and endorsed by ARAC, and the approach has been confirmed as well-established in the Structured Assessment. The maturity matrix has been refreshed to cover ten distinct dimensions and is used alongside internal and external evidence to inform the Board's understanding of its effectiveness. Most related recommendations from previous assessments have been implemented, with a small number of development actions being taken forward through the broader strategy refresh rather than indicating a weakness in the self-assessment process itself. On this basis, the core requirement of Criterion 49 is met and an Assure rating is appropriate

Criterion 51 (MD7) – HIW and other regulators (including Audit Wales)

ARAC assurance rating – Advise

Reason - Tracking and escalation arrangements are strong, but there is a residual backlog of higher-risk actions and learning is not yet demonstrated consistently, particularly around patient flow and DPOC.

This criterion tests whether the organisation is acting appropriately on concerns raised by HIW, Audit Wales and other regulators, with robust escalation, tracking, closure and organisational learning. Since October, the evidence base has strengthened. The AMaT inspections dashboard now consolidates HIW activity across 14 inspections, 277 must-do recommendations and 497 actions, providing a clear view of completed, in-progress and overdue work. Structured Assessment confirms that recommendation tracking more broadly is robust, with integrated reports to ARAC and other Committees covering risks, recommendations and Welsh Health Circulars, and that overall progress on historic Audit Wales work is positive, albeit with a number of open and overdue actions remaining.

2. Delayed Pathways of Care (DPOC) – Analytical Addendum

This section provides a statistical bridge between the Audit Wales "Urgent and Emergency Care: Flow out of Hospital – West Wales Region" report to March 2025 and the latest Targeted Intervention (TI) tracking for delayed pathways of care (DPOC) from April to October 2025. It is intended to support ARAC's assurance role and to link clearly to the separate Audit Wales agenda item without duplicating it. Moreover, this is being raised "by exception" in line with ARACs request to bring any material issues to the committee (the timing is fortuitous given agenda item 3.4)

2.1 DPOC – where Audit Wales left us (to March 2025)

- Audit Wales reported an average of around 221 clinically optimised patients per month experiencing delayed discharge across West Wales in 2024–25, with 55,482 delayed bed days at an estimated cost of £27.7m (around 22% of total bed capacity).
- The analysis for Hywel Dda shows an average of 203 delayed pathways per month over October–December 2023, which is used as the formal TI baseline for the 5% reduction test.
- Using the same internal data, the mean number of delayed pathways from April 2023 to March 2025 is approximately 221 per month, matching the Audit Wales figure and confirming that internal and external views describe the same underlying pressure.
- From April 2025 onwards, the TI analysis sets a DPOC target of approximately 174 pathways per month (the level implied by three consecutive 5% reductions from the October to December 2023 baseline). At the point Audit Wales reported, the DPOC average of around 221 was therefore roughly 9% above the TI baseline and 27% above the TI target.

2. Delayed Pathways of Care (DPOC) – Analytical Addendum

2.2 DPOC since the report: April–October 2025 profile

- For this analysis, March 2025 is treated as the end of the Audit Wales period, and DPOC performance from April–October 2025 is taken from the TI "PoCD HDda" series tracker.
- Monthly DPOC totals for Hywel Dda in this period are: April 2025 - 223; May - 234; June - 230; July - 211; August - 212; September - 230; October - 258. The best month in the period is July (211) and the worst is October (258) which is the latest position.
- The mean for April to October 2025 is approximately 228 delayed pathways per month, compared with 203 at TI baseline and around 221 during the Audit Wales period.
- In percentage terms this equates to approximately +13% versus the TI baseline (203 to 228); approximately +4% versus the Audit Wales period (221 to 228); and approximately +31% versus the TI target of 174. On average, DPOC is therefore further away from the TI target after the Audit Wales period than it was during it.

2.3 Test against the formal TI de-escalation criterion

- The UEC de-escalation criterion for DPOC is a continuous reduction in delayed pathways of at least 5% in three consecutive months, then maintained, against the October–December 2023 baseline.
- Reviewing month-on-month percentage change in DPOC from October 2023 onwards shows several single-month reductions greater than 5%, but no period with three consecutive months each achieving a 5% or greater reduction.
- In the April–October 2025 period there is one significant improvement (June to July, approximately –8.3%), but this is immediately followed by increases (July to August, approximately +0.5%; August to September, approximately +8.5%; September to October, approximately +12.2%).
- Overall, the pattern is best described as "volatile around a high mean" rather than a consistent downward trend. The 5% over a 3-month de-escalation test has not been met at any point since the TI baseline, and the months after the Audit Wales period do not contain a qualifying improvement run.

2. Delayed Pathways of Care (DPOC) – Analytical Addendum

2.2 Implications for ARAC and the escalation narrative (DPOC)

- The external Audit Wales finding of very high delayed discharge levels and bed-day loss is confirmed by the TI DPOC series; internal data show that, on average, DPOC has worsened slightly since the Audit Wales period rather than improved.
- Against the TI DPOC performance criterion, the Health Board is further away from the target (174 pathways per month) now than at baseline or during the Audit Wales window. There is no evidence of the required 5%, 3-month reduction run, and October 2025 represents a local high point (258) rather than consolidation of earlier gains.
- DPOC therefore remains a binding constraint on any case for UEC de-escalation. Even if ambulance handovers or 12-hour waits show improvement, the DPOC metric on its own clearly does not support movement away from Level 4 at this stage.
- From an Audit Wales perspective, DPOC sits at the heart of partners' shared responsibility for improving urgent and emergency care flow across West Wales. Positioning this analysis alongside the national escalation criteria allows ARAC to see clearly how local performance against DPOC contributes to the wider assurance picture for Welsh Government and helps to avoid unnecessary duplication when the Committee considers the separate Audit Wales agenda item.
- Any positive narrative for ARAC should therefore focus on enabling actions and programme delivery (POCD, Six Goals, RPB work), while being explicit that the formal DPOC de-escalation test has not yet been satisfied.

2. Delayed Pathways of Care (DPOC) – Analytical Addendum

Audit Wales Discharge Planning Report – Key Cross-Reference Points

The Audit Wales Discharge Planning Progress Update (August 2025) provides additional context that should inform the Committee's consideration of DPOC performance:

- **Root cause attribution:** Audit Wales reports that approximately 26% of discharge delays relate to Health Board discharge planning issues, including the completion of clinical assessments. This breakdown is not currently reflected in the TI tracking but would help ARAC understand which elements of delayed discharge are within the Health Board's direct control.
- **Discharge lounge underutilisation:** Audit Wales found an inconsistent approach to discharge lounge use across sites and limited monitoring of their impact on patient flow. Recommendation R1 calls for the Health Board to actively promote discharge lounges and monitor their use. Progress against this recommendation should be tracked alongside DPOC metrics.
- **Training gaps:** Audit Wales identifies an inconsistent approach to discharge planning training and notes that staff recognised training requirements. The new discharge policy (April 2025) timing aligns with the start of the post-Audit Wales tracking period, but the management response notes that training compliance is currently low. Regional Recommendation R6 calls for an ongoing programme of refresher training.
- **Frontier data quality:** The 2024 Internal Audit review of discharge planning gave Limited Assurance, finding that information in the Frontier discharge platform was often incomplete and inaccurate. While remedial work has been undertaken, this may affect the reliability of DPOC tracking data and should be noted as a caveat to the quantitative analysis above.
- **Bed capacity impact:** Audit Wales quantifies the impact as 55,482 delayed bed days at an estimated cost of £27.7m, representing approximately 22% of total bed capacity. This provides important context for understanding the scale of the DPOC challenge and its financial implications for the Health Board.

3. Conclusion and Recommendations for ARAC

This paper demonstrates continued progress against the governance and leadership escalation criteria, with three of the seven criteria now rated Assure and four rated Advise. The overall trajectory is positive, with the Structured Assessment 2025 providing strong external validation of the Health Board's governance arrangements.

The Committee is asked to:

- **NOTE** the positive assurance ratings for MD2 (Board oversight and Duty of Quality), MD4 (Board sighted on key risks), and MD6 (Governance and leadership maturity), which confirm that the Health Board's core governance arrangements are functioning effectively.
- **NOTE** the Advise ratings for MD1, MD3, MD5 and MD7, recognising that these reflect work in progress rather than fundamental concerns, with clear actions and timescales identified.
- **CONSIDER** whether the DPOC analytical addendum provides sufficient assurance that the organisation understands the current position and the actions required to meet the TI de-escalation criterion.
- **SCRUTINISE** the linkage between DPOC performance and the enabling actions identified in the Audit Wales Discharge Planning report, particularly progress against R1 (discharge lounges) and R6 (training and policy embedding).
- **ADVISE** whether any matters should be escalated to Board or drawn to the attention of other Committees such as F&P (given the remit of said committee).

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GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

2.5

09:55, 5 Mins

2.5 - All Wales NHS Audit Committee Chairs' Meeting Update

Rhodri Evans (Hywel Dda UHB - Independent Member)

For information

Attachments

2.5 AWACC Meeting notes 30 September 2025.pdf

ALL WALES AUDIT COMMITTEE CHAIRS (AWACC) MEETING NOTES FROM THE MEETING HELD REMOTELY VIA MICROSOFT TEAMS ON 30 SEPTEMBER 2025 @1PM

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

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

MEMBERS PRESENT:

Peter Curran	Chair, Welsh Ambulance Services NHS University Trust
Anne Beegan	Audit Wales
Simon Cookson	NWSSP Internal Audit
Stephen Elliot	Powys Teaching Health Board, Independent Member
Rhodri Evans	Hywel Dda University Health Board, Independent Member
Urtha Felda	Betsi Cadwaladr University Health Board, Independent Member
Sarah Harland	Secretariat, Welsh Ambulance Services NHS University Trust
Iwan Jones	Aneurin Bevan University Health Board, Independent Member
Trish Mills	Director of Corporate Governance/Board Secretary, Welsh Ambulance Services NHS University Trust
Carl Window	Counter Fraud Manager, Welsh Ambulance Services NHS University Trust
Nuria Zolle	Swansea Bay University Health Board, Independent Member
Nicholas Raynor	Audit Wales

APOLOGIES:

Pippa Britton	Chair of the Board, Public Health Wales
Graham Dainty	Head of NHS Counter Fraud Services (Wales)
Andrew Doughton	Audit Wales
Dave Edwards	Cardiff & Vale University Health Board, Independent Member
Gareth Jones	Velindre NHS Trust, Independent Member
Helen Jones	Audit Wales
Ceri Mcgaugie	Betsi Cadwaladr University Health Board, Corporate Office
Patsy Roseblade	Cwm Taf Morgannwg, Independent Member
Jayne Sadgrove	Health Education and Improvement Wales, Independent Member
Dave Thomas	Audit Wales
Anthony Veale	Audit Wales

1. **Committee Structure and Future Planning:** Peter led a discussion with the group on the future structure of the committee, covering meeting frequency, action logs, and the adoption of concise action logs instead of full minutes, as well as proposals for deep dives and annual in-person events.
    a. **Action Log Adoption:** Peter proposed the adoption of a concise action log instead of full minutes for committee meetings, citing the peer group nature of the committee and the time-saving benefits for the secretariat. The group agreed to this approach, aligning with advice from the Directors of Corporate Governance Peer Group.
    b. **Meeting Frequency Decision:** The group debated the frequency of meetings, considering attendance issues and competing priorities. After discussion, the consensus was to hold four meetings per year, with flexibility for one longer in-person event and consideration of timing to improve attendance.
    c. **Deep Dive Topics and Safe Space Format:** Peter summarised feedback from a questionnaire, identifying key areas for deep dives. Seven priority themes were identified for deep dives: Board Assurance Framework, Risk Management & Appetite, Counter Fraud issues, Audit Committee role in partnership working, challenges faced by chairs (including conflicts), Clinical Audits, Financial sustainability/Digital.
    d. The group agreed to divide future meetings into Part A (all members) and Part B (chairs only) to create a space for open discussion.
    e. **Membership and Chair Turnover:** Anne highlighted the importance of tracking chair turnover and interim arrangements, suggesting the creation and circulation of a list of current chairs and their terms. Trish and Sarah took an action to liaise with Directors of Corporate Governance to maintain this information.
    f. **Annual In-Person Event Proposal:** Peter proposed an annual in-person event for networking and sharing best practice, open to all Audit Committee members and possibly vice chairs and prospective public appointees. Anne noted the need to manage time commitments for members who chair multiple committees.

2. **Audit Wales and Internal Audit Updates:** Anne and Nicholas provided updates on Audit Wales activities, including national studies, the National Fraud Initiative (NFI), and links to governance work, while Simon presented internal audit findings, highlighting assurance levels, key risk areas, and the use of AI in audit processes.
    a. **National Studies and Shared Learning:** Anne outlined ongoing national studies such as urgent and emergency care, rebalancing care, and additional learning needs, emphasising the importance of shared learning from structure assessments and the development of sessions on board walkarounds, measuring impact, and report writing for directors of corporate governance.

b. **National Fraud Initiative Assessment:** Nicholas explained the NFI as a UK-wide counter fraud exercise, detailing the current assessment of governance arrangements, data matching, and reporting outcomes. He described the low fraud outcomes in Welsh health bodies, attributing this to strong shared services and consistent processes, and discussed plans to share best practice across sectors.
c. **Internal Audit Findings and AI Adoption:** Simon reported on internal audit outcomes, noting that most audits achieved reasonable or substantial assurance, with limited assurance concentrated in areas like clinical governance and workforce. He described the increasing use of AI for report writing and analysis, and the need for robust governance protocols around its use.
d. **Contract Management and Training:** Simon and Stephen discussed findings from contract management reviews, identifying training as a key area for improvement. Simon confirmed ongoing collaboration with finance and procurement teams to address these issues, and regular liaison with HIW to align audit and inspection programmes.
e. **Cybersecurity Audit Insights:** Peter raised concerns about cybersecurity, prompting Simon to share that several audits had been completed, some with limited assurance, and that findings would be summarised and shared with the group once all reviews were finalised.

3. **Counter Fraud Updates and Initiatives:** Carl, as a member of the Counter Fraud Liaison Group, provided a comprehensive update on counter fraud activities, including mandatory training, job description standardisation, reporting improvements, and collaboration with national authorities, with further discussion on resource levels and prosecution outcomes.
    a. **Mandatory Training and Legislation:** Carl reported on the push for mandatory counter fraud e-learning in response to the Economic Crime and Corporate Transparency Act, noting that only five health boards currently require it and highlighting its role in due diligence and compliance.
    b. **Job Description and Reporting Standardisation:** The liaison group streamlined counter fraud job descriptions and reporting requirements, creating templates and a standardised quarterly submission platform to ensure consistent and accurate data for Welsh Government and stakeholders.
    c. **Fraud Recovery and Prevention Figures:** Carl described recent training on calculating recovery and prevention figures, leading to the adoption of an approved methodology for consistent reporting across Wales, addressing previous disparities in reported outcomes.
    d. **Resource Levels and Investment Discussion:** Iwan and Carl discussed the limited resources available for counter fraud work, with only 27 staff across Wales, and agreed that increased investment would likely yield

greater returns in fraud prevention and detection, though the optimal level of investment remains undetermined.

e. **Prosecution and Sanction Outcomes:** Carl explained the range of sanctions applied in fraud cases, including civil recovery, cautions, and disciplinary actions, noting that criminal prosecutions are infrequent but supported by a robust challenge process with the CPS when necessary.
f. **AI and Data Analytics in Fraud Detection:** Nuria queried the use of AI and data analytics in counter fraud, with Carl confirming that while interest is high, tangible outcomes are yet to emerge, and compliance with new legislation is largely aligned with existing anti-fraud and bribery provisions.

4. **Corporate Governance and Board Development:** Trish updated the group on corporate governance initiatives, including:
    a. **Community of Practice Launch:** Trish described the launch of a corporate governance community of practice, aimed at promoting governance careers, supporting staff development, and sharing best practice across health boards through masterclasses, mentoring, and collaborative platforms.
    b. **Board Development and Leadership Offerings:** Academi Wales is refreshing its board and leadership development programmes, consulting on themes relevant to NHS boards, and continuing to offer sessions such as 'Healthy Boards' and 'High Performing Organisations', with updates to be shared as available.
    c. **Public Accountability Meetings:** Trish outlined the format and scheduling of upcoming public accountability meetings, which will be held at Welsh Government premises, involve advance evidence packs, and be accessible to the public via live stream or recording, with lessons learned to refine the process. Urtha suggested including experiences from public accountability meetings on the January agenda to facilitate group learning and provide feedback to Welsh Government, a proposal supported by Peter and noted for future planning.
    d. **Corporate Governance Conference:** The first corporate governance conference is scheduled for 24 October at DHCW premises, featuring keynote speakers, roundtable discussions, and presentations from internal and external audit, with recordings and materials to be shared with the wider group.

5. **Consent Items and Meeting Closure:** Peter briefly addressed consent items, including the Welsh risk pool and the Counter Fraud Steering Group highlight report, before closing the meeting and confirming next steps and future meeting dates.

a. **Welsh Risk Pool Update:** Peter noted the increase in the Welsh risk pool and referenced the information provided in the meeting pack, indicating that finance committees are monitoring the situation.
b. **Counter Fraud Steering Group Report:** Peter mentioned his attendance at the Counter Fraud Steering Group and the inclusion of its highlight report in the meeting materials, available for review by members.

Follow-up tasks:

- **Distribution of Deep Dive Topics:** Send the list of proposed deep dive topics to all members for review and additional suggestions. (Sarah)
- **Audit Committee Chair List Update:** Compile and circulate an up-to-date list of current Audit Committee chairs, including their tenure and any known upcoming changes, with input from directors of corporate governance. (Trish, Sarah)
- **Agenda Planning Collaboration:** Coordinate with directors of corporate governance to align agendas and key themes between this group and the directors' group, ensuring relevant topics are addressed jointly. (Trish)
- **Public Accountability Meeting Feedback:** Include an agenda item for the January meeting to discuss experiences and learning from the new public accountability meetings, with the aim of providing group feedback to Welsh Government. (Peter)

The next meeting is scheduled for the 26 January 2026 @10am.

2.6

10:00, 5 Mins

2.6 - Committee Self-Assessment

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

For assurance

Attachments

2.6 ARAC Self Assessment December 2025.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	09 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit and Risk Assurance Committee (ARAC) Self-Assessment Report 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Director of Corporate Governance
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

The purpose of the report is to present the outcome of the Audit and Risk Assurance Committee Self-Assessment 2025/26 process to the Committee.

Cefndir / Background

In line with Section 10.2.1 of Standing Orders, the Board is required to 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. Section 10.2.2 also states that each Committee must also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-Committees it has established.

In addition to the annual Committee self-assessment process, after each meeting Independent Member Reflective Sessions take place to gather feedback and insights from Members on the meeting, in terms of what has gone well, what could have gone better, how quality has informed discussions, and issues that need to be raised at the Committee Chair's meeting. This feedback helps with the evaluation process and continuous improvement.

During previous years, Committee self-assessments have been based on a comprehensive review of feedback provided by the Committee membership from completion of a long questionnaire assessment. While these approaches provided valuable insights, they also led to survey fatigue and limited engagement. Feedback from a recent Corporate Governance Conference has highlighted the need for a proportionate process for assessment that avoids unnecessary complexity. This year's approach will streamline the assessment, focusing on critical governance behaviours and outcomes rather than exhaustive questionnaires.

This year's Committee self-assessment form focuses on five core areas of governance and assurance:

Governance, Assurance, and Oversight
Ensuring robust assurance to the Board on governance, risk management, and internal controls across all organisational activities.

Risk Management and Internal Control
Confirming that significant risks are identified, managed, and reported effectively through risk registers and governance structures.

Internal and External Audit
Overseeing audit programmes and ensuring timely implementation of recommendations to mitigate key risks.

Financial and Annual Reporting
Providing assurance on the integrity, clarity, and transparency of financial statements and governance disclosures.

Committee Effectiveness and Continuous Improvement
Assessing whether membership, work plans, and information enable the Committee to operate effectively and add value to the Board's assurance framework.

With some additional considerations such as engagement of Independent Members (IMs) and Executive Directors (EDs), quality of papers, and adequacy of information on risks, impacts, and outcomes to support assurance and decision-making.

Asesiad / Assessment

To improve response rates, taking into account that there is a process of continuous improvement through the IM Post Committee Reflective Sessions, a short questionnaire was circulated to members to gather feedback on 5 key areas for the Committee.

Respondents were asked to rate their level of agreement to 5 statements relating to key areas of focus for the Committee on a scale of 1–5. (1 - strongly disagree up to 5 – strongly agree) and to provide more information to support their rating.

Below are the statements relating to 5 key areas of focus for the Committee and the average ratings based on the responses received. 8 (out of 9) responses were received (89% response rate).

Area and Statement	Average Rating
Governance, Assurance and Oversight *(The Committee provides robust assurance to the Board on the adequacy and effectiveness of governance, risk management and internal control systems across the whole of the organisation's activities, both clinical and non-clinical)*	4.6
Risk Management and Internal Control *(The Committee ensures that significant risks are identified, managed and reported appropriately through the risk registers and the Board Governance Structure)*	4.7
Internal and External Audit *(The Committee effectively oversees internal and external audit programme, ensuring recommendations are tracked and implemented in a timely manner)*	4.7

Financial and Annual Reporting *(The Committee provides assurance to the Board on the integrity of financial statements, the Annual Governance Statement and associated disclosures)*	4.7
Committee Effectiveness and Continuous Improvement *(The Committee's membership, workplan and information enable it to operate effectively and add value to the Board's overall assurance framework).*	4.5

The following themes were provided:

What has gone well:

- Effective Chairing and Membership: The Committee is well-chaired, with strong Independent Member engagement.
- Quality of Papers: Reports and papers are generally well-prepared and clear.
- Robust Scrutiny: Members provide insightful and respectful challenge, particularly on risk and assurance matters.
- Action Tracking: Effective monitoring of actions and progress provides confidence in assurance.
- Improved Reporting: New style reports and improved finance reporting enhance clarity and scrutiny.

What we want to change going forward:

- Consistency in Member Engagement: Some comments noted that questions are often asked by a small number of Independent Members; broader participation is needed.
- Operational vs Strategic Focus: Occasional drift into operational detail rather than maintaining strategic oversight.
- Audit Paper Scheduling: Deferred or batched audit papers can lead to heavy agendas and reduced discussion time.
- Timeliness of Audit Recommendations: Some delays in implementing audit recommendations were highlighted.
- Risk Explanation Clarity: Rationale for risk scores and mitigation sometimes lacks clarity.

Suggestions from Respondents

- Focus discussions on higher-risk areas.
- Ensure consistent engagement from all members.
- Maintain realism in action tracker timelines.
- Continue improving report formats for clarity and assurance.
- Strengthen pace of delivery for agreed actions.

Overall Conclusion

The Committee is performing strongly, with high ratings across all domains. It demonstrates maturity and continuous improvement, supported by effective leadership and robust processes. Key opportunities lie in enhancing member engagement, maintaining strategic focus, and improving timeliness of audit actions.

Area for improvement	By Whom	By When
Utilise an IM Development Session to focus on the role of the Independent Member to ensure there is impactful engagement and scrutiny from all Independent Members, and that discussions are at the appropriate level for the relevant discussion.	Director of Corporate Governance	March 2026
To continue to work with Internal and External Audit on the delivery of plans and to escalate any issues of concern to the relevant Lead Executive to reduce deferred reporting of scheduled audit work	Director of Corporate Governance	Regular meetings are in place with issues escalated when raised.
To continue to provide the Committee with oversight and assurance in respect of the systems and processes in place to support the implementation on external recommendations, Welsh Health Circulars and Ministerial Directions and the management of risks within the organisation.	Director of Corporate Governance	Through the External Recommendations Assurance Report and the Risk Assurance Report

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to **CONSIDER** the outputs from the Committee Self-Assessment process and **AGREE** to the actions to be taken to improve its effectiveness.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	10.6 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committees performance and operation, including that of any sub-committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.1
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 Terms of Reference ARAC Self-Assessment digital form results
Rhestr Termau: Glossary of Terms:	Included within the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Director of Corporate Governance

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:	No direct impacts
Gyfrinachedd: Privacy:	No direct impacts
Cydraddoldeb: Equality:	No direct impacts

3

10:05, 0 Mins

3 - Audit Wales

3.1

10:05, 10 Mins

3.1 - Audit Wales Update Report

Anne Beegan, Urvisha Perez, David Williams

For assurance

Attachments

3.1 Audit Wales ARAC Update (09.12.25).pdf

Archwilio Cymru
Audit Wales

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

Date issued: December 2025

This document has been prepared for the internal use of Hywel Dda University Health Board as part of work performed / to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

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Audit and Risk Assurance Committee Update

About this document

1 This document provides the Audit and Risk Assurance Committee with an update on our current and planned accounts and performance audit work at Hywel Dda University Health Board. We presented our most recent Audit Plan to the committee in April 2025.

2 We also provide additional information on:

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

3 Details of future and past Good Practice Exchange (GPX) events are available on our website.

Accounts audit update

4 **Exhibit 1** summarises the status of our current and planned accounts audit work.

Exhibit 1 – accounts audit work

Area of work	Executive Lead	Focus of the work	Status	Planned date for consideration
Audit of the 2024-25 Health Charities Annual Report and Accounts	Director of Finance	To provide an audit opinion on the 2024-25 Health Charities Annual Report and Accounts.	In progress. The audit field work will be completed in December. Audit certification will take place in January 2026.	January 2026
Audit of the 2025-26 Health Board's Annual Report and Accounts	Director of Finance	To provide an audit opinion on the Health Board's 2025-26 Annual Report and Accounts.	Not started	June 2026

Performance audit update

5 **Exhibit 2** summarises the status of our current and planned performance audit work.

Exhibit 2 – performance audit work

Area of work	Executive Lead	Focus of the work	Status	Planned date for consideration
Structured Assessment 2025 – core	Board Secretary	Our structured assessment work is designed to examine the existence of proper arrangements for the efficient, effective, and economical use of resources. Our 2025 Structured Assessment will review: • Board and committee cohesion and effectiveness; • Corporate systems of assurance; • Corporate planning arrangements; and • Corporate financial planning and management arrangements.	Complete - in today's papers.	December 2025
Review of urgent and emergency care	Director of Operations	This work has examined different aspects of the urgent and emergency care system and includes analysis of national data sets to present a high-level picture of how the urgent and emergency care system is currently working.	Blog and data tool published in April 2022	

Area of work	Executive Lead	Focus of the work	Status	Planned date for consideration
		The work has examined the actions being taken by NHS bodies, local government, and Regional Partnership Boards to secure timely and safe discharge of patients from hospital to help improve patient flow (Part 1). We have also reviewed progress being made in managing urgent and emergency care demand by helping patients access services which are most appropriate for their care needs (Part 2).	Local report – complete Regional report – complete, in todays papers Part 2 – complete	Presented to the committee in October 2025 December 2025 Presented to the committee in June 2025
Structured Assessment 2024 Deep Dive - review of investment in digital systems	Director of Finance	This review will examine digital arrangements, with a particular focus on how NHS bodies are investing in digital technologies, solutions, and capabilities to support the workforce, transform patient care, meet demand, and improve productivity and efficiency.	Fieldwork underway	February 2026
Review of the management of outpatients (Local work 2024)	Director of Operations	This work has examined the management of outpatients, including assessing the Health Board's progress on the recommendations made in our 2015 and 2018 Review of Follow-up Outpatient Appointments.	Report being drafted	February 2026

Area of work	Executive Lead	Focus of the work	Status	Planned date for consideration
Structured Assessment 2025 Deep Dive - review of the arrangements to manage estates	Director of Allied Health Professions and Health Science	This review will examine the effectiveness of corporate arrangements to manage the Health Board's estate with a particular focus on how NHS bodies are prioritising resources to meet strategic priorities whilst also ensuring the current estate remains fit for purpose. When undertaking this work, we will take into account the local work which examined the Health Board's arrangements for managing capital prioritisation.	Project brief due to be issued in December 2025	April 2026
Review of cancer services	Director of Operations	This work will follow on from the review of national leadership arrangements for cancer services. Whilst the exact focus of this work is to be determined, it is likely to consider: • The progress NHS bodies are making towards achieving Welsh Government targets and quality standards for cancer services; • The efficacy of local plans and associated actions to recover cancer waiting lists; and • Use of the additional Welsh Government financial allocations to improve cancer services.	Planning	June 2026

Area of work	Executive Lead	Focus of the work	Status	Planned date for consideration
Review of radiology services (Local work 2025)	Director of Operations	This work 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 our 2017 radiology service review.	Fieldwork underway	February 2026

Other relevant publications

6 **Exhibit 3** provides information on other relevant examinations and studies published by the Auditor General in the last six months. The links to the reports on our website are provided. The reports highlighted in **bold** have been published since the last committee update.

Exhibit 3 – relevant examinations and studies published by the Auditor General

Title	Publication Date
NHS Wales Finances Data Tool	**September 2025**
Temporary Accommodation, long-term crisis?	July 2025
Cost Savings Arrangements – A checklist for NHS Board Members	June 2025

Additional information

7 Exhibit 4 provides information on corporate documents published by Audit Wales since the last committee update.

Exhibit 4: corporate documents published by Audit Wales

Title	Publication Date
Interim Report 2025-26	November 2025
Estimate of Income and Expenses for the year ended 31 March 2027 (supporting information)	November 2025
Equality Report 2024-25	October 2025

8 There are no relevant Audit Wales consultations currently underway.

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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

3.2

10:15, 20 Mins

3.2 - Structured Assessment 2025

Anne Beegan, Urvisha Perez, Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

For assurance

Attachments

3.2 HDUHB 2025 Structured Assessment Report - final.pdf

3.2 Management Response Form - HDUHB 2025 Structured Assessment (Final).pdf

Archwilio Cymru
Audit Wales

Structured Assessment 2025

Hywel Dda University Health Board

October 2025

About us

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

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- call us on 029 2032 0500
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Corresponding in Welsh will not lead to a delay.

Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

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

Contents

Audit snapshot

What we looked at

1 We looked at how well Hywel Dda University Health Board (the Health Board) is governed and whether it makes the best use of its resources. We looked at four areas in particular:

- how well its board works;
- how it keeps track of risks, performance, service quality, and recommendations;
- how it produces key plans and strategies; and
- how it manages its finances.

2 We also looked at the Health Board's progress in implementing recommendations from:

- previous structured assessment reports; and
- our 2024 report on cost savings.

3 We did not look at the Health Board's operational arrangements.

Why this is important

4 NHS bodies continue to face a wide range of challenges associated with the need to modernise and transform services to deal with constrained finances, growing demand, treatment backlogs, workforce shortages, and an ageing estate. It is therefore more important than ever for the boards of NHS bodies to have strong corporate and financial governance arrangements in place. This helps provide assurance to themselves, the public, and key stakeholders that they are taking the right steps to deliver safe, high-quality services and to use public money wisely.

What we have found

5 The Health Board remains strongly committed to public transparency and continues to have good governance arrangements. Good quality information supports scrutiny, but there is an opportunity to clarify the Triple A process to ensure it effectively supports scrutiny. Since last year, the Board has stabilised, with no interim arrangements in the Executive Team.

6 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.

7 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.

8 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 Welsh Government. However, the Health Board has improved on its opening plan deficit of £31.5m, 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.

What we recommend

9 We have made two recommendations to the Health Board, which focus on:

- clarifying the use of the Triple A (Alert, Advise, Assure) process; and
- updating the Board Assurance Framework Dashboard to include committee oversight arrangements.

Key facts and figures

Under the Welsh Government's escalation and intervention arrangements the Health Board is at Level 4 for finance, strategy and planning, urgent and emergency care, fragile services (including ophthalmology) and Healthcare Associated Infections. It is also at Level 3 for leadership and governance, and planned care and cancer.

The Health Board does not have an approved Annual Plan or Integrated Medium-Term Plan for 2025-26.

The Health Board did not meet its financial duty to breakeven on its revenue spend in-year and over a three-year period, reporting a three-year cumulative deficit of £148.9 million.

In 2024-25, the Health Board delivered £31.5 million in savings, against a target of £32.4 million. Its 2025-26 savings target is £46.4 million. At month seven, the Health Board has identified £48.4 million in savings, delivered £31.5 million, but there is a £4.7 million gap in recurrent savings.

The Health Board is forecasting a year-end deficit of £28.3 million, against a Welsh Government expectation of £24.1 million.

The Health Board has fully implemented five outstanding recommendations since our last structured assessment report. One recommendation remains in progress.

Our findings

Board effectiveness and openness

The Board and its committees continue to work well, remain transparent and committed to hearing from patients and staff

Public openness of board business

10 The Board continues to have a strong commitment to public transparency by ensuring:

- Board meetings are well publicised on the Health Board's website and through social media;
- members of the public can attend Board meetings in person, watch via a livestream or a recording uploaded to the Health Board's website after the meeting;
- Board and committee papers are available on the Health Board's website five days before meetings, keeping late papers to a minimum;
- private Board and committee meetings are held only to discuss sensitive topics, with private Board agendas publicly available; and
- public Board papers continue to include high level summaries of private Board and committee discussions.

11 Committee meetings are not livestreamed or recorded. To support public transparency, the Health Board aims to publish draft minutes to its website within one-month of each meeting. However, as reported last year, due to capacity constraints, this process is not always timely.

Supporting effective board conduct

12 The Health Board continues to have robust arrangements to support the Board and its committees to run effectively. The Audit and Risk Assurance Committee (ARAC) plays a key role in ensuring governance controls are in place and followed. This includes overseeing compliance with Standing Orders, Scheme of Reservation and Delegation, and Standing Financial Instructions, and reviewing them annually to ensure they reflect current arrangements.

13 As part of this year's review of Standing Orders, the Health Board updated its Corporate Scheme of Delegation to reflect its new operational structure[1]. The Board approved changes to its Standing Orders and Standing Financial Instructions in May and July 2025, respectively. Both documents are available on the Health Board's website.

14 The Health Board maintains strong arrangements to ensure probity and propriety, including up-to-date registers of interests, gifts, and hospitality, which are available on its website. ARAC oversees these arrangements through an annual assurance report. Declarations of interest remain a standing item on all Board and committee agendas.

15 The Health Board maintains clear processes for ensuring policies are reviewed and updated. To guide the process, it has an up-to-date written control documentation policy, last reviewed in February 2025.

16 Clinical Care Groups are held to account on policy management through Executive Improving Together Sessions and the internal escalation framework. Committees continue to receive regular updates on out-of-date policies and requests for approval or extension. Policies are easily accessible on the Health Board's website.

[1] In April 2025, the Health Board introduced its new operational structure, which is focused around four Clinical Care Groups: Community and Integrated Medicine, Operational Allied Health and Health Sciences, Mental Health and Learning Disabilities and Planned Care and Specialist Care.

Assurance on Joint Commissioning Committee effectiveness

17 The Joint Commissioning Committee (JCC) was set up in April 2024 as a joint committee of the seven health boards in Wales. The JCC plans and commissions a range of specialised services and other healthcare services, including emergency medical services, on behalf of the seven health boards.

18 As part of this year's structured assessment, we reviewed whether the Board is receiving the right level of assurance on JCC business, as well as the Health Board's involvement in JCC meetings and activities. We found that the Board, Quality Safety and Experience Committee (QSEC), and Finance and Performance Committee (FPC) receive routine assurance on the work of the JCC and its sub-groups.

19 In June 2025, the JCC Chair, Chief Commissioner, and leadership team provided their annual update to the Board during a Board seminar session. The Chair's Report to the July 2025 Board meeting included a summary of the discussion.

Board and committee meeting effectiveness

20 In January 2025, the Board approved its new committee structure, which went live in April 2025. This included standing down the Strategic Development and Operational Delivery, and Sustainable Resources Committees, and setting up the following new committees:

- Digital, Data and Innovation Committee (DDIC);
- Finance and Performance Committee (FPC); and
- Strategy and Planning Committee (SPC).

21 The Health Board revised its committee structure to better align with the targeted intervention domains and strengthen the focus on digital, finance, performance, and strategic planning. The changes also reflect feedback from 2023-24 committee effectiveness reviews, which highlighted the need for committees to have a clearer purpose to ensure they are well understood.

22 As in previous years, we found that committees have up-to-date, publicly available terms of reference and work programmes. These clearly outline oversight responsibilities for planning objectives and where applicable, responsibilities for overseeing targeted intervention de-escalation criteria. The Board also has an up-to-date work programme.

23 Board and committee meetings continue to be well chaired and supported by the Corporate Governance Team. We continue to see strong scrutiny and open discussion of service challenges. Independent members remain open when they are not assured, reinforced by the Triple-A process.

24 However, we found discussion at some of the newly formed committees can be too operational. This should improve as the committees become more established. We routinely see matters referred between committees, with the committee chairs meeting also supporting this process.

25 High-risk matters continue to be escalated to the Board through the Triple-A process (Alert, Advise, Assure). The Triple-A process has been in use for over a year and continues to receive positive feedback, especially the improved focus on key challenges. The process is generally well used, but still embedding. Some committee chairs need to be reminded to use the process, or they consult executive leads for their opinion on levels of assurance. Committee chairs and independent members should decide their levels of assurance without input from executive leads.

26 There is also a risk of committees using the ‘Alert’ rating to escalate issues to the Board for action rather than reviewing whether the area of concern should remain and be overseen by the committee. There is clear guidance on the process, but the Health Board should hold a briefing session with independent members to reinforce the process.

Quality and timeliness of Board information

27 The Board and its committees continue to receive good quality, timely papers, supported by interactive dashboards and data tools. Generally, we received positive feedback on the quality of papers. Although there were some suggested areas for improvement, these relate to repetition between papers, the volume of papers, better triangulation of information, improved focus on the impact of actions and better use of data.

28 Positively, we continue to see operational officers routinely attending committees to present papers. However, officers have varying levels of experience at presenting at committee level. To support this, the Corporate Governance Team is delivering governance training for Clinical Care Groups. This includes report writing and presentation. Guidance is also included in the call for Board and committee papers.

Hearing from staff and service users

29 The Board remains committed to hearing from patients and staff. Patient experience insights are shared through the Improving Patient Experience Report and regular patient and staff stories at the Quality, Safety and Experience (QSEC), People, Organisational Development and Culture (PODCC) and Health and Safety (HSC) committees.

30 The Health Board has set up a task and finish group to reviewing patient experience reporting. The Board is also completing a self-assessment against the NHS Wales People's and Experience Framework, with findings to be reported to QSEC in December 2025.

31 The Health Board uses a variety of methods to hear from a diverse range of patients and service users. For example, during consultations on service change, such as the Clinical Services Plan, it ensures inclusive engagement by using a wide range of methods to reach diverse groups of citizens. Board members also maintain contact with frontline staff through regular patient safety walkabouts, which offer valuable opportunities to hear from both staff and patients.

32 The ‘Speak-up’ process, launched in October 2024, allows staff to raise concerns confidentially. PODCC and QSEC receive twice yearly updates on reporting trends and progress on its implementation, with the last update in August 2025. Additionally, several staff networks and advisory groups report to PODCC including the LGBTQ+ network, armed forces network and the newly established Equality Diversity and Inclusion Task Force.

Board cohesion and continuous improvement

33 Last year, we reported significant Board level changes. Since then, the Board has stabilised, with no interim arrangements at executive level. The interim Executive Director of Nursing and interim Executive Medical Director were appointed substantively in April and May 2025, respectively. Additionally, the new Independent Member (Community) joined the Board in May 2025.

34 However, there has been considerable change at operational level. In April 2025, the Health Board implemented phase one of its new operational structure. Leadership teams are now in place across all four Clinical Care Groups. However, phase two, which focuses on the structures below each care group, is yet to be implemented. The pace of progress continues to be a concern for the Board, as ongoing uncertainty is unsettling for staff. The Health Board aims to complete phase two by December 2025.

35 The Board continues to demonstrate a strong commitment to learning and development. It has a well-developed programme of Board development, supported by organisational development and learning activities. The Board’s approach to evaluating its effectiveness is well established, continuing to draw on internal and external sources of assurance.

36 For its 2024-25 review, the Board refreshed its maturity matrix. Instead of assigning an overall maturity score, it assessed and scored itself against 10 criteria. This approach provides a clearer understanding of the Board’s strengths and areas for improvement.

Providing board assurance

There are strong arrangements to oversee risk, performance, service quality and safety, and audit recommendations

Managing strategic and corporate risks

37 The Board continues to have a mature approach to overseeing strategic risks. The Board reviews its Board Assurance Framework (BAF) at alternate meetings. For 2025-26, the Board approved new strategic objectives (see **paragraph 56**). The principal risks, outcome measures and planning objectives align with the new objectives.

38 The BAF cover report and dashboard provide a clear summary of progress against the strategic objectives and delivery risks. Each committee is assigned relevant planning objectives for in-depth scrutiny. However, these arrangements are unclear in the BAF dashboard.

39 The Board and its committees maintain strong oversight of the Corporate Risk Register, which the Board receives every other meeting. Committees routinely scrutinise risks assigned to them and provide assurance to the Board through their assurance reports.

40 Recently, the Health Board has developed an Assurance and Risk Report. This report provides each committee updates on principle, corporate and operational risks assigned to them. It also includes relevant audit and inspection recommendations, Welsh Health Circulars, and Ministerial Directions.

41 The Board approved the Health Board's revised Risk Management Framework and Risk Management Strategy in September 2025. The framework outlines the processes and procedures, while the strategy sets out key improvement objectives for the next 12 months. These objectives are to:

- support operational risk management arrangements to ensure a consistent approach to the ownership and oversight of risks;
- ensure the Board is sighted on key risks and areas of concern on a regular basis; and
- improve the risk maturity of the Health Board.

42 ARAC continues to receive updates every other meeting via the Risk Assurance Report on the effectiveness of the Risk Management Framework, and progress on the Risk Management Strategy. The report maintains good analysis of risk management across the organisation, including risk themes, issues, and escalation status by Clinical Care Groups and Corporate Directorates.

Managing performance

43 The Improving Together Framework sets out the Health Board's approach to performance management and improvement. Approved by the Board in March 2025, the revised framework reflects the new operational structure and incorporates strengthened escalation arrangements. It introduces a fourth escalation level for escalated areas that are not showing sufficient progress. Although further work is needed to define how the fourth level will operate in practice.

44 In April 2025, ARAC received a substantial assurance Internal Audit report on the Health Board's performance management arrangements. The review found that the Performance Management team actively supports departments, and there is regular reporting of performance data. The review made two medium-priority recommendations related to persistent underperformance in escalated services and data quality assurance.

45 Separately, in February 2025, Internal Audit issued a limited assurance report on data quality, identifying three high and one medium-priority recommendations. These related to resourcing of the Information Quality Assurance Team, data correction processes, the absence of data quality metrics, and the lack of an information and intelligence strategy. The Health Board has developed a data quality improvement programme.

46 The Board and its committees continue to show strong oversight of organisational performance. The Board and Finance and Performance Committee review the Integrated Performance Assurance Report (IPAR), supported by its dashboard at each meeting. The IPAR cover report clearly highlights areas of poor performance.

47 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.

Monitoring quality and safety

48 The Quality, Safety, and Experience Committee (QSEC) continues to maintain oversight of the quality and safety of services. This is supported by a Quality Management System, covering quality planning, control, and improvement. The Health Board is refreshing its 2023-26 Quality Improvement Strategic Framework, aiming to seek Board approval by March 2026. In April 2025 QSEC received an update on its progress.

49 QSEC receives assurance through a range of reports, including the Quality and Safety Assurance Report, deep-dives, and updates on its sub-groups, clinical audit, and inspections.

50 The Health Board is strengthening oversight of service quality and safety. In August 2025, QSEC approved changes to quality and safety governance arrangements. The changes aim to improve strategic focus at committee level and strengthen operational oversight.

51 Changes included replacing the Quality, Safety and Experience Sub-Committee with a new Quality and Safety Intelligence Group (QSIG). QSIG reports to the executive-level Integrated Quality, Finance, Performance and Delivery Group. QSEC now also receives six-monthly assurance reports from each Clinical Care Group and Public Health. The Health Board intends on reviewing the effectiveness of these arrangements, reporting to QSEC in December 2025. Internal Audit will also provide independent review.

52 The Health Board continues to implement the duties of the Health and Social Care (Quality and Engagement) Act 2020. It published its 2024–25 annual reports outlining how it met the duties of quality and candour. The Board received both reports at its Annual General Meeting in September 2025.

Tracking and monitoring recommendations

53 The Health Board continues to have robust arrangements for tracking audit and review recommendations. ARAC receives assurance on internal and external recommendation tracking at every other meeting. Since October 2025, the report also includes compliance with Welsh Health Circulars. The report provides comprehensive analysis including recommendation status, thematic trends, and analysis of internal escalation on implementing recommendations.

54 Committees have also started receiving an Assurance and Risk Report, which includes updates on relevant audit and inspection recommendations, as well as Welsh Health Circulars. Executives hold Clinical Care Groups and Corporate Directorates to account on recommendation tracking through Executive Improving Together sessions. In November 2025, there were 29 open Audit Wales recommendations across all reviews, of these 16 were overdue.

55 Our review of the Health Board's progress to address previous recommendations has found a positive position, with:

- five out of six recommendations from past structured assessment reports now complete. The remaining recommendation is in progress; and

- all 12 recommendations from our cost savings report now complete. We discuss this more in **paragraph 80**.

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

Producing key strategies and plans

56 The Health Board is refreshing its long-term strategy, 'A Healthier Mid and West Wales'. It aims to present the draft for Board approval in January 2026. The process is supported by regular Board engagement and updates, and internal and external stakeholder engagement. The Health Board does not expect to make major changes to its strategy. It is focusing its engagement activity on parts of the strategy that will need updating.

57 Once approved, the Health Board will need to review its governance arrangements and supporting plans to ensure they support the strategy's delivery. In January 2025, the Board agreed a revised, purpose statement and strategic objectives for 2025-26[2]. These will be tested through the strategic refresh and might need refinement as a result.

58 The Health Board is progressing its Clinical Services Plan[3], a planning objective for 2025–26. A public consultation programme ran over the summer, ending on 31 August 2025, with broad engagement across communities, staff, and seldom-heard groups. The Health Board received a positive response rate, with many alternative service options proposed.

[2] The Health Board's refreshed purpose statement is: Healthier Lives, Well Led, and its strategic objectives are: Thriving Workforce, Healthier Communities, Great Care and Positive Futures.
[3] The Clinical Services Plan focuses on the Health Board's nine most fragile services.

59 To allow time for full consideration, the Board will hold an extraordinary meeting in February 2026. The Quality, Safety and Experience Committee has held extraordinary meetings to review the options from a quality perspective. However, the Clinical Services Plan does not cover all services and has a medium-term focus.

60 The Health Board is currently working to an Annual Plan, as it was unable to submit an approvable financially balanced three-year Integrated Medium-Term Plan to the Welsh Government. The plan however does not meet the financial requirements set by Welsh Government and therefore remains unapproved. We discuss the Health Board's financial position in more detail in **paragraph 71**.

61 The overall planning approach is unchanged. Plans continue to be developed with good engagement and collaboration with the Board and Clinical Care Groups. Oversight arrangements for development and delivery appropriately reflect the new committee structure. In April 2025, Internal Audit issued a reasonable assurance report on the annual planning process and assumptions for 2025-26. It gave substantial assurance to oversight arrangements but raised an issue on identifying savings schemes.

62 To strengthen its planning approach for 2026-27, the Health Board has created a risk stratification system. This will form the basis of planning and help manage competing priorities within limited resources. The Planning Prioritisation Matrix categorises risks (582 risks) into three levels:

- Route 1 (Green) - Issues that can be resolved within current resources and governance.
- Route 2 (Amber) - Challenges that need extra funding or workforce support.
- Route 3 (Red) - Major system-wide issues needing transformation or external intervention, such as support from Welsh Government.

63 The plan will also focus on wider objectives such as population health and prevention.

Board assurance on partnership working

64 The Board receives routine assurance on partnership working through updates on joint committees of the Board, regional collaboratives, and statutory partnerships. This includes the regional partnership board, public services boards, and collaboration with neighbouring health boards.

65 Since last year, the Health Board has set up a formal Regional Joint Committee with Swansea Bay University Health Board. The committee met for the first time in January 2025 and meets quarterly. Its terms of reference, agreed by the two Boards, sets out five regional objectives.

66 These focus on the regional health economy, clinical services, corporate functions, the regional capital programme, and research, innovation, and excellence. A dedicated work programme with clearly defined joint leadership supports each objective. However, progress across the five programmes varies, as they are at various stages of development.

67 The Regional Joint Committee has met three times since its establishment and is still embedding its processes. Our observation found robust scrutiny, a shared sense of responsibility between the two health boards and an increased willingness to work together.

68 While regional solutions are expected to support long-term service sustainability, concerns were raised by executives and Independent Members about the capacity to develop and deliver these programmes whilst also managing immediate operational pressures.

69 The Mid Wales Joint Committee is a collaborative with Betsi Cadwaladr University, Powys Teaching Health Board, Welsh Ambulance Services University NHS Trust and the three relevant local authorities[4]. It is not a formal committee of the Board. It aims to strengthen the planning and delivery of health care services in mid-Wales, with priorities including urology, rheumatology, and addressing social care challenges like delayed pathways of care.

[4] Ceredigion County Council, Gwynedd Council and Powys County Council are members of the Mid Wales Joint Committee.

70 While there has been some progress, the committee has several competing workstreams, which limits its ability to use available resources effectively to deliver the intended outcomes.

Monitoring delivery of strategies/plans

71 The Health Board continues to have robust arrangements for monitoring and overseeing its strategies and plans. The 2025–26 Annual Plan focuses on ten planning objectives, each addressing ministerial priorities, statutory duties, targeted intervention requirements, or critical enablers. Many of the planning objectives are change programmes or corporate plans. For example, Clinical Services Plan, Digital Plan and Estates Plan. This ensures clear oversight.

72 Each planning objective is aligned to an oversight committee and supported by a clear delivery plan. The Board and its committees routinely receive updates on the plan's delivery through the Planning Objective Assurance Report, the BAF and IPAR. The Strategy and Planning Committee maintains overall oversight of Annual Plan development and delivery. There is clear executive oversight through the Executive Improving Together sessions and executive team sub-groups[5].

73 The Well-being Objectives Annual Report, presented to the Board each November, continues to provide assurance on progress against the Health Board's eight well-being objectives. As part of its strategic refresh, the Health Board is reviewing these objectives to ensure they align with its strategic objectives.

[5] These are the Integrated Quality, Finance, Performance and Delivery; A Healthier Mid and West Wales and Value and Sustainability groups.

Managing finances

While appropriate financial oversight, control and management processes are in place, the financial position remains challenging

Meeting financial objectives and duties

74 The Health Board did not meet all its financial duties in 2024-25. Of the three duties, it met its capital resource limit, reporting a small underspend of £86,000. However, it did not:

- spend within its revenue resource limit for the period 2022-25; and
- have an agreed three-year Integrated-Medium Term Plan for 2024-27.

75 The Welsh Government set the Health Board a target deficit of £31.5 million for 2024-25. The Health Board surpassed this, reporting a year-end deficit of £24.1 million. This improvement was supported by additional in-year funding from Welsh Government, which reduced the original financial plan from a £64 million planned deficit to £31.5 million. The Health Board also made further savings.

76 The Health Board does not have a balanced financial plan for 2025-2026. In March 2025, the Board approved its Annual Plan for submission to Welsh Government, forecasting a deficit of £31.5 million. While this meets Welsh Government's control target, the Board acknowledges the financial deficit is unacceptable.

77 In July 2025, Welsh Government communicated to the Health Board a revised expectation for 2025-26. This being, the year-end deficit, at a minimum, must be equal to the 2024-25 outturn position of a £24.1 million deficit. In response, the Health Board assessed a range of cost-reduction options over the summer. These proposals, supported by quality impact assessments, were presented to the Board in September 2025.

78 At month seven, the Health Board has reduced its forecast deficit to £28.3 million, which includes the additional Welsh Risk Pool risk share of £4.2 million. The Health Board is reporting an underspend of £1.2 million on its year-to-date position. It will need to further reduce operational spend to meet its revised deficit plan.

Financial planning arrangements

79 Aligned to its annual planning process, the Health Board maintains a clear process for developing its financial plan. Corporate teams, Clinical Care Groups and finance business partners continue to identify strategic and operational savings collaboratively. Appropriate Board and executive level groups oversee the plans development and delivery.

80 Work to develop the 2026–27 annual financial plan has started. In October 2025, the Finance and Performance Committee approved the planning principles, timelines, and approach. The committee will receive the draft financial plan for 2026-27 in December 2025. The Health Board does not yet have a long-term financial plan, but it is developing a three-year financial roadmap aiming to achieve a recurrent breakeven position by 2028-29. The draft three-year roadmap was discussed at the Finance and Performance Committee and Board Seminar in October 2025 and will be considered again at the Board meeting in November 2025.

81 For 2025-26, the Health Board has a revised savings target of £46.4 million, broken down as £19 million recurrent and £27.4 million non-recurrent. At month seven, it has delivered £31.5 million of savings. The Health Board has identified £48.4 million of savings, £2 million over its target. However, a £4.7 million gap in recurrent savings remains. Of the savings identified, the Health Board expects to deliver £48.1 million.

82 To bridge the gap, the executive team requested further savings options from escalated services. Overseen by the executive level Financial Control Sub-Group, the Health Board is also taking ‘grip and control’ measures focused on recruitment, training, and procurement. The Board and Finance and Performance Committee receive routine updates on savings plans, delivery, risks and mitigating actions.

83 In 2024, Audit Wales reviewed the Health Board's approach to cost savings. The review made ten recommendations aimed at strengthening the Health Board's savings approach. The Health Board reported that it has completed all recommendations. **Appendix 2** shows the recommendations and current status.

Financial management arrangements

84 The Health Board has the expected financial controls in place, with ARAC receiving assurance via the Financial Assurance Report and counter fraud updates. The FPC and ARAC oversee the review of financial procedures and policies.

85 In April 2025, Internal Audit issued a reasonable assurance report on financial management for 2024–25, with one high and three medium-priority recommendations. These focused on budget delegation, budget holder training and use of budget monitoring systems and operational oversight of saving schemes.

86 In February 2025, accountability letters were issued to all Clinical Care Groups and Corporate Directorates. While budget holders signed and returned the letters, several missed the deadline due to ongoing conversations about savings.

87 The Health Board is still committed to delivering its financial plan. Like last year, oversight of the financial position is maintained through several executive-level groups, including the Executive Improving Together Sessions and the Value and Sustainability, and the Integrated Quality, Finance and Performance Delivery groups. Improved clinical care group governance, and internal escalation arrangements further support oversight.

88 The Financial Performance Assurance Report provides detailed analysis of the key drivers of spend, highlighting operational cost pressures. Understanding cost drivers also forms part of the annual financial planning process.

89 The Health Board submitted good quality draft financial statements for external audit within the required timescales. Our audit found no material misstatements but did find some areas where corrections needed to be made. We issued an unqualified opinion in respect of the true and fairness of the accounts but a qualified regularity due to the Health Board breaching its revenue resource limit over the three-year period 2022–2025. This is irregular expenditure which required the regularity opinion to be qualified.

Monitoring financial performance

90 The Board and Finance and Performance Committee maintain good oversight of the Health Board's financial position. The Financial Performance Assurance Report provides a clear overview of revenue and capital and forecast positions, savings progress, and key cost pressures. There is good use of charts, dashboards, and analysis of operational performance, which helps highlight key risks and actions.

91 Financial updates via reports such as the Integrated Performance Assurance Report and targeted intervention updates further support oversight. The Health Board's principal risk register includes a high-level risk on achieving financial sustainability.

92 The Board and Finance and Performance Committee provide good challenge on the financial position. In recent months, the Board and Committee have held difficult discussion about options to meet Welsh Government's year-end expectation. These discussions have either taken place in public or, when held privately, have been reported at the next public meeting. This shows the Health Board's commitment to transparency.

Recommendations

93 The following table details the recommendations arising from our work.

Recommendations

R1	The Health Board should hold a briefing session with Independent Members to clarify the 'Triple A' (Alert, Advise, Assure) process (see **paragraphs 24 and 25**).
R2	The Health Board should update the Board Assurance Framework Dashboard to include committee oversight arrangements (see **paragraph 37**).

Appendices

1 About our work

Scope of the audit

We looked at the following areas for the period May 2025 to October 2025:

- How well the board works.
- How well the board oversees risks, performance, and the quality and safety of services and tracks recommendations.
- How well the body prepares key strategies and plans.
- How well the body manages its finances.

We did not look at the body's operational arrangements.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Does the Board conduct its business appropriately, effectively, and transparently?
- Is there a sound corporate approach to managing risks, performance, and the quality and safety of services?
- Is there a sound corporate approach to producing strategic plans and overseeing their delivery?
- Is there a sound corporate approach to financial planning, management, and performance?

Criteria

Our audit questions were shaped by:

- Model Standing Orders, Reservation and Delegation of Powers.
- Model Standing Financial Instructions.

- Relevant Welsh Government health circulars and guidance.
- The Good Governance Guide for NHS Wales Boards (Second Edition).

Methods

We reviewed a range of documents, including:

- Board and committee papers and minutes.
- Key governance documents, including Standing Orders and Standing Financial Instructions.
- Key strategies and plans, including the IMTP.
- Key risk management documents, including the Board Assurance Framework.
- Annual Report, including the Annual Governance Statement.
- Relevant policies and procedures.
- Reports prepared by other relevant external bodies.

We interviewed the following key stakeholders:

- Chief Executive Officer
- Deputy Chief Executive
- Chair of the Board
- Vice-Chair
- Board Secretary / Director of Corporate Governance
- Executive Director of Finance
- Deputy Director of Finance
- Executive Director of Strategy and Planning
- Executive Director of Nursing, Quality and Patient Care
- Chair of Quality, Safety and Experience Committee
- Chair of Audit and Risk Assurance Committee
- Chair of Finance and Performance Committee
- Chair of Strategy and Planning Committee

- Independent Member - Community

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

- Audit and Risk Assurance Committee
- Digital, Data and Innovation Committee
- Finance and Performance Committee
- Mental Health Legislation Committee
- People, Organisational Development and Culture Committee
- Quality, Safety and Experience Committee
- Regional Joint Committee of Swansea Bay and Hywel Dda University Health Boards
- Mid Wales Joint Committee Board

2 Previous audit recommendations

Outstanding recommendations from previous structured assessment reports

The table below sets out the progress made by the Health Board in implementing outstanding recommendations from previous structured assessment reports.

2024 Recommendations	
R1	The Health Board should update its Improving Together Framework documentation, ensuring it adequately reflects current performance management and internal escalation arrangements. In updating the framework, the Health Board should also ensure documentation includes arrangements for (**complete, paragraph 43**): • de-escalating and supporting directorates at the highest level of escalation for extended periods; and • co-ordinating support for directorates escalated over several domains
R2	The Quality, Safety and Experience Committee should receive, at least annually, a standalone update on Quality Improvement activities, including the Health Board's progress in implementing the Quality Improvement Strategic Framework (2023-2026), a roundup of improvement initiatives and the impact they are having to date (**complete, paragraph 48**).
R3	To ensure the sustainable development principle is central to its long-term vision, the Health Board should review its well-being objectives as part of its planned long-term strategy refresh (**in progress, paragraph 71**).

2023 Recommendations

R3 Given the Health Board is under the Welsh Government's Enhanced Monitoring arrangements for some service areas, there is scope to demonstrate the effectiveness of the Improving Together Framework. The Health Board should develop a mechanism for periodically providing assurance that its performance management arrangements are working as intended (**complete, paragraph 44**).

2022 Recommendations

R2 While some changes have been made, the operational structure still poses risks to confused and inconsistent governance structures. Given the scale and complexity of the challenges and risks facing the Health Board, it is important that planned work to revise the operational structures and associated governance arrangements progresses as a matter of urgency (**complete, paragraph 34**).

R6 The Health Board's longer-term financial recovery plan has not been updated to reflect the financial challenges being experienced in 2022-23. The Health Board needs to update its longer-term financial recovery plan for 2023 onwards, ensuring that its improvement opportunities are reflected (**superseded, paragraph 78**).

Recommendations from our 2024 Review of Cost Savings Arrangements

The table below sets out the progress made by the Health Board in implementing recommendations from our 2024 Review of Cost Savings Arrangements.

R1	The Health Board should ensure that where appropriate Directorates routinely consider and implement its central work on cost savings benchmarking, and variation analysis (**complete**).
R2	The Health Board should ensure the Opportunities Framework includes a more systematic approach to canvassing the views of stakeholders, staff, and service users in the generation of savings ideas (**complete**).
R3	The Health Board should strengthen both its guidance and governance around the Project Initiation Document and Quality Impact Assessment processes for savings. This will ensure a consistent and clearly documented and understood approach for considering quality, patient safety, and intra Health Board impacts of savings decisions (**complete**).
R4	The Health Board should make improvements to the way it plans for its savings by strengthening the integration between its annual financial operational planning and savings planning arrangements. This should provide greater clarity over the interdependency between delivering annual budgets and savings and ensure that savings plans fully reflect the specific savings opportunities that exist within individual Directorates (**complete**).
R5	The Health Board should develop sufficient transformational capabilities and capacity to support Directorates to identify and deliver broader transformational savings (**complete**).

R6 The Health Board should explore ways of enhancing clinical engagement in the identification and delivery of savings to increase the potential for the savings schemes to deliver their full benefits (**complete**).

R7 The Health Board should make improvements to how it reports on cost savings by:

7.1 Ensuring that future savings reports articulate all the savings the Health Board needs to deliver in a given year to meet its Welsh Government control total (**complete**).

7.2 Supporting Board members to deepen their financial literacy skills to enable them to better understand the content of finance reports and provide effective oversight and scrutiny (**complete**).

7.3 Prioritising work on its “single version of the truth” to establish a comprehensive picture of savings across the Health Board to strengthen monitoring, reporting, and shared learning (**complete**).

R8 The Health Board should ensure that its savings planning for 2025-26 commences earlier and puts a greater emphasis on delivering recurrent savings opportunities through service transformation and reconfiguration (**complete**).

R9 The Health Board needs to implement effective actions to manage the inherent risk that the Health Board is currently carrying within its 2024-25 savings schemes, by prioritising how best to turn its current red and black savings schemes into recurrent green and amber schemes that have a realistic chance of delivering the identified savings (**complete**).

R10 The Health Board should develop a more systematic approach to the sharing of learning on savings between Directorate and continue to implement the learning from its recent internal reviews into its savings arrangements, and its learning from the recent changes brought about by the discovery of RAAC (**complete**).

3 Key terms in this report

Term	Description
Board Assurance Framework	A Board Assurance Framework 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.
Counter Fraud	Counter fraud refers to the activity undertaken by the organisation to prevent, detect, and investigate fraud, bribery, and corruption. This work is led by the NHS Counter Fraud Service (CFS) Wales, which operates under the NHS Wales Shared Services Partnership.
Integrated Medium Term Plan	An Integrated Medium-Term Plan is a three-year plan that sets out how the organisation will deliver its services, manage its workforce, and meet its financial duties to break even. The organisation submits its plan to the Welsh Government for approval.
Quality Governance	Quality governance is the combination of structures, processes, and behaviours used by an organisation, particularly its board, to lead on and ensure high-quality performance, including safety, effectiveness, and patient experience.
Register of Interests	The Register of Interests helps ensure transparency by recording any personal or business interests of Board members and staff that could influence decisions.

Term	Description
Scheme of Reservation and Delegation	The Scheme of Reservation and Delegation sets out which responsibilities stay with the Board and which are passed to committees and executives, along with reporting arrangements to ensure proper oversight.
Standing Financial Instructions	Standing Financial Instructions set out the financial responsibilities, policies, and procedures adopted by the organisation.
Standing Orders	Standing orders set out the rules and procedures by which the organisation operates and make decisions.
Well-being of Future Generations Act (2015)	This Act requires public bodies in Wales to work sustainably and collaboratively to improve well-being across social, economic, environmental, and cultural areas, by setting long-term goals (called well-being objectives), involving citizens, and making decisions that consider the impact on future generations.

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

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

Management response form

Audited body	Hywel Dda University Health Board
Audit name	2025 Structured Assessment
Response received	19 November 2025

Ref	Recommendation	Commentary on planned actions	Completion date for planned actions	Responsible officer (title)
R1	The Health Board should hold a briefing session with Independent Members to clarify the 'Triple A' (Alert, Advise, Assure) process.	To hold a session at an Independent Member Development Session on the correct and consistent use of the 'Triple A' assessments at meetings. To include the 'Triple A' criteria on Chair's Briefs as a prompt for Chairs to make an assessment at the end of each agenda item.	31 January 2026	Director of Corporate Governance
R2	The Health Board should update the Board Assurance Framework (BAF) Dashboard to include committee oversight arrangements.	Committee oversight arrangements of the BAF have been included in the supporting information on the BAF Dashboard to the Board in November.	30 November 2025	Director of Corporate Governance

3.3 **10:35, 0 Mins**

3.3 - Review of the Management of Outpatients

Anne Beegan, Urvisha Perez, Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Keith Jones (Hywel Dda UHB - Director of Operational Planning & Performance), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care), Lisa Humphrey (Hywel Dda UHB - General Manager)

DEFERRED to 10 February 2026 meeting

For assurance

3.4

10:35, 20 Mins

3.4 - Review of Urgent and Emergency Care - Patient Flow (Regional Report)

Anne Beegan, Urvisha Perez, Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Gareth Cottrell (Hywel Dda UHB - Deputy Chief Operating Officer), Peter Skitt (Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine), Anna Chiffi (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality), Thomas Alexander (Hywel Dda UHB - Principal Programme Manager), Linda Jones

For assurance

Attachments

3.4 West Wales Region Patient Flow out of Hospital Report.pdf

Archwilio Cymru
Audit Wales

Urgent and Emergency Care: Flow out of Hospital – West Wales Region

Date issued: August 2025

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS and local government bodies, and reporting to the Senedd on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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Mae’r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

Summary report

About this report

1 Once a patient is considered clinically well enough to leave hospital (also referred to as clinically optimised) the timely discharge of that patient to the right setting for their ongoing needs is vital. Timely, effective, and efficient moving of patients out of an acute hospital setting holds important benefits for patient care and experience as well as for the use of NHS resources.

2 When the discharge process takes longer than it should there can be significant implications for the patient in terms of their recovery, rehabilitation, and independence. Delayed discharges will also have implications for other patients coming into the urgent and emergency care system[1] who need a hospital bed. Poor patient "flow" creates bottlenecks in the system that contribute to well documented problems such as over-crowded emergency departments and an inability to secure timely handover of patients from ambulance crews.

3 Our work has looked to examine whether health boards and local authorities have effective arrangements in place to ensure the timely discharge of patients out of hospital. We set out the approach we adopted to deliver our work in **Appendix 1.**

4 This work is part of a broader programme of work the Auditor General has been undertaking in respect of urgent and emergency care services in Wales. We have also examined the arrangements in place to help manage urgent and emergency care demand, and to direct patients to the care setting that is most appropriate to their needs. We have reported the findings from that work separately.

5 The Auditor General's work on urgent and emergency care aims to help discharge his statutory duty to be satisfied that NHS bodies and local authorities have proper arrangements in place to secure the efficient, effective, and economical use of resources.

6 This report sets out the findings from the Auditor General's review of the arrangements to support effective flow out of hospital in the West Wales region (the region). The region encompasses:

- Hywel Dda University Health Board (the Health Board);
- Carmarthenshire County Council;
- Ceredigion County Council; and
- Pembrokeshire County Council.

7 In undertaking this work, we have also considered progress made by the Health Board against previous recommendations made in our 2017 report on discharge

[1] Urgent and emergency care describes any unplanned, urgent, and emergency care provided by health and social care services. The urgent and emergency care system is complex with numerous organisations involved in providing services and it deals with acutely unwell, vulnerable, and distressed people in need of urgent assistance.

planning. Our findings from this work are set out in a separate report to the Health Board.

Key findings

8 Overall, we 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.**

9 In line with trends across Wales, the number of patients experiencing a delayed discharge from hospital in the West Wales region has grown significantly in recent years. Between April 2023 and April 2025, 221 clinically optimised patients on average each month experienced delayed discharges, with the rate of delayed discharges one of the highest in Wales. While the completion of social care assessments has previously been the main cause for delayed discharges, access to domiciliary care and completion of nursing assessments are now the top causes. The total number of bed days lost due to delayed discharges for the financial year 2024-25 equated to 55,482 and a full year associated cost of £27.7 million.

10 Delayed discharges are having a consequential impact on ambulance handovers and waiting times for emergency departments, with performance falling significantly below national targets. However, the Health Board however has been able to minimise the impact of delayed discharges on planned care.

11 Several factors are contributing to delayed discharges. The nature of demand is increasing, including the number of people needing support for complex conditions such as dementia. Workforce challenges are a significant risk which are affecting the timely completion of both nursing and social care assessments, with waits for social care assessment in Pembrokeshire the highest in Wales until recently. Care sector capacity is also affecting delays. Whilst care home provision is greater in West Wales than most other parts of Wales, there is a shortage in domiciliary care, particularly in Ceredigion and reablement care in Carmarthenshire. At the time of our work, the Health Board lacked a standard discharge policy and inconsistent discharge training has led to weaknesses in the documentation and application of the discharge process. Difficulties communicating and sharing relevant information across organisational and site boundaries are also compounding delays.

12 Addressing patient flow is a key feature of plans across all regional partners, with clear links to the Welsh Government's Six Goals for Urgent and Emergency Care but translating the West Wales Area Plan into operational delivery is underdeveloped. Partners are working together to improve patient flow, although short term funding risks third sector involvement and system pressures can create

an unhelpful blame culture. The Health Board's previous operational structure has affected accountability and improvement in patient flow, but there are now clear structures in place although the Integrated Strategic Group to oversee urgent and emergency care has not yet met.

13 Partners are using financial resources to support discharge planning through the Regional Partnership Board (RPB); however, it is unclear how successful projects funded by additional monies will be mainstreamed into base budgets and become sustainable going forward. There is mixed corporate oversight and scrutiny of activities to improve patient flow, with much greater oversight in the Health Board than in local authorities and scope to make better use of outcomes to show impact.

14 Whilst partners understand the need to drive improvements and have shown good intentions and some action to date, the number of patients experiencing discharges across the region has not significantly reduced. Continued action is needed across a range of areas to secure the sustainable improvements which are necessary for patients, their families, and the wider urgent and emergency care system.

Recommendations

15 Recommendations arising from this audit are detailed in Exhibit **1**. The combined management response by the statutory bodies included in this review to these recommendations will be summarised in **Appendix 5** once considered by the relevant committees.

Exhibit 1: recommendations

Recommendations
Managing demand R1 To ensure that only those with a service need are on the relevant waiting lists, the Health Board should ensure its staff only place patients on a waiting list that is relevant to their specific post discharge care needs, rather than placing them on multiple different waiting lists as a means of simple securing earlier discharge (paragraph 38).
Planning for current and future demand R2 To inform strategic and operational decision making at a regional level, the Health Board and local authorities should develop a usable data set which captures information on the volume and complexity of whole system demand across the region (paragraph 45).

Recommendations

Addressing key gaps in capacity

R3 To enable timelier discharge of patients to their own home, the Health Board and local authorities need to work together to develop joint solutions to address key gaps in service capacity, in particular, domiciliary care and reablement services (paragraph 62).

R4 To ensure effective use of limited resources, Ceredigion County Council should ensure the higher-than-average hours provided per adult in receipt of domiciliary care are appropriate to their needs (paragraph 65)

Developing and embedding policies

R5 To embed a consistent approach to discharge planning, the Health Board and local authorities should ensure processes are in place to communicate the new discharge planning guidance to all relevant health and social services staff, including those working on a temporary basis. Roll out of the guidance should be supported by an ongoing programme of refresher training and induction training for new staff (paragraph 69).

R6 To provide clarity to all staff on how the referral process for social care should work across the region, the Health Board, working with local authorities, should ensure that the new discharge planning guidance clearly sets out the point in the discharge planning process referrals for social care should be made (paragraph 73).

Improving quality of record keeping

R7 To improve the quality of information contained in patient case notes, the Health Board should ensure all staff involved in discharge planning fully understand the importance of documenting comprehensive information in patient case-notes, and in addition implement a programme of case-note audits focused on the quality of record keeping (paragraph 70).

Enhancing multi-disciplinary ward rounds

R8 To encourage collaborative solutions to discharge planning and data sharing, the Health Board and local authorities should ensure relevant professionals from key partners, who can share information and enable efficient discharge, attend relevant multi-disciplinary ward rounds at all acute hospital sites, as is the case in Glangwili Hospital. This may include physiotherapists, social workers, occupational therapists, care and repair or other relevant professionals (paragraph 79).

Recommendations

Improving the quality of social care referrals

R9 To enable social workers to effectively triage patients at the point of referral, the Health Board, working with local authorities, should improve the completeness of referrals from ward staff to social care (paragraph 80)

Improving the sharing of information

R10 To ensure effective sharing of information, the Health Board and local authorities should implement ways in which information can be shared between organisations, including opportunities to provide multi-agency access to existing access to organisational systems and ultimately joint IT solutions (paragraph 81).

R11 To ensure consistency across acute hospital sites, the Health Board should apply a standard approach to recording patient discharge information on hospital wards using digital solutions (paragraph 82).

R12 To ensure that opportunities to secure earlier discharge with support from services beyond social care are not missed, the Health Board and local authorities should ensure that all relevant staff across each organisation has routine access to up-to-date information on services available in the community that support hospital discharge (paragraph 83).

Developing the West Wales Area Plan 2023-28 implementation plans

R13 To strengthen delivery of medium-term planning objectives, the Health Board and local authorities should ensure the implementation plans which underpin the West Wales Area Plan 2023-28 are fully developed and up to date (paragraph 89)

Improving scrutiny

R14 To enable impact to be demonstrated, the Health Board should ensure that its updates on delivery against the Six Goals Programme contain anticipated outcomes (paragraph 110).

R15 To strengthen scrutiny and oversight, the local authorities should ensure that regular updates on RPB activities related to patient flow are received by the most appropriate committee (paragraph 111).

Detailed Report

What is the scale of the challenge?

16 This section sets out the scale of the challenge that the region is facing in respect of delayed discharges and the subsequent impact on patient flow and the patient experience.

17 We found that **the region has some of the highest rates of delayed discharges in Wales. These are affecting patient flow through the emergency department and the release of ambulances. Waiting for new community care packages and nursing assessments are now the top causes of discharge delay across the region.**

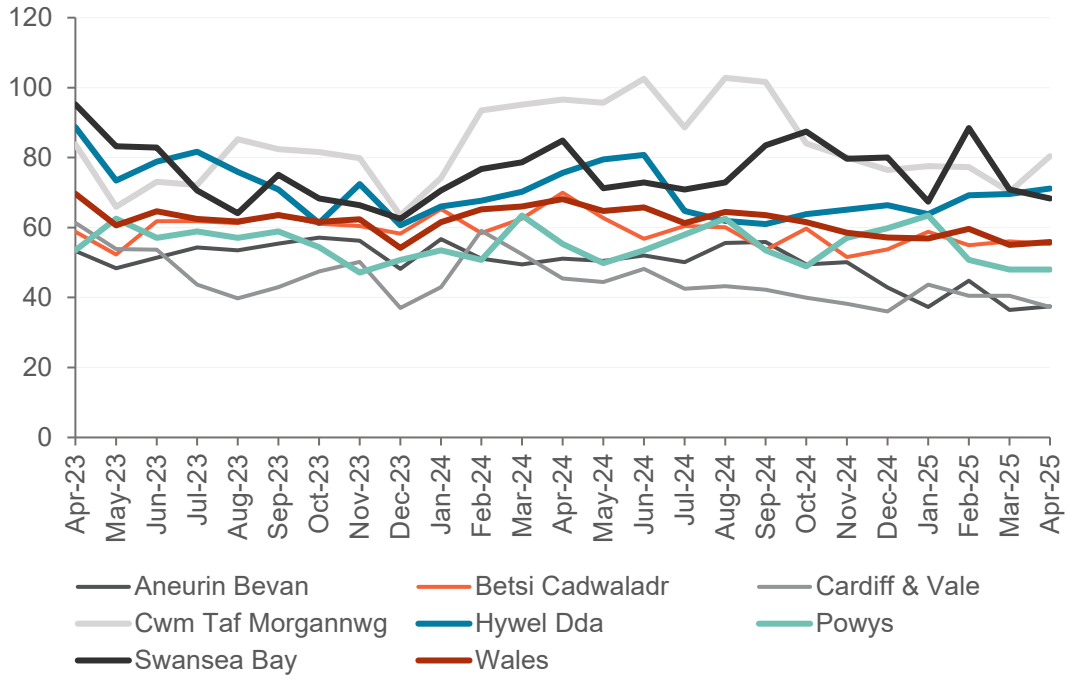
Delayed discharges

18 We found that **significant numbers of patients are not leaving hospital in a prompt way once they are well enough to do so, with waits for new community care packages and completion of nursing assessments top causes for delay.**

19 Delays discharging patients from hospital has been a longstanding issue for bodies in Wales and other parts of the UK. The available data shows that this issue has become significantly worse in recent years.

20 **Exhibit 2** sets out the rate of delayed discharges experienced by the Health Board between April 2023 and April 2025, compared with other health boards across Wales. These relate to patients considered ‘clinically optimised’ but who remain in a hospital bed 48 hours after clinical teams have decided that they are well enough to leave hospital. Up until June 2024, the rate of delayed discharges had been one of the highest in Wales, but rates decreased to the all-Wales average until September 2024. Rates have since increased and are now the second highest in Wales.

Exhibit 2: number of delayed discharges per 100,000 head of population (April 2023 – April 2025)



Source: Welsh Government

21 Since the pandemic, the way NHS bodies count delayed discharges has changed. Welsh Government did not formally report delayed discharges between March 2020 and March 2023. Prior to the pandemic, delayed discharges were reported as 'delayed transfers of care'. These were patients who continued to occupy a bed after the date clinical teams declared them ready to move on to the next stage of their care. This compares with the current method for counting delays which focuses on patients who stay in a hospital bed 48 hours after clinical teams identify them as 'clinically optimised'.

22 Although not a direct comparison, in February 2020 the Health Board reported 65 delayed transfers of care. The position at the end of April 2025 of 223 delayed discharges equate to 22.0% of the Health Board's total bed capacity[2]. This is the second highest in Wales compared with an all-Wales average of 15.4% (ranging between 8.6% and 29.6%).

[2] Based on general and acute bed availability data in July 2023, StatsWales website (https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Activity/NHS-Beds/nhsbeds-by-organisation-site)

23 The reasons for delays are categorised. The top five reasons for delayed discharges are set out in **Exhibit 3**, with the most common reasons being awaiting the start of new community care packages and completion of nursing assessments. Up until January 2025, the main reason for delay was awaiting completion of social care assessments. A full list of reasons for delay in the Health Board are set out in **Appendix 2,** and by local authority.

Exhibit 3: top five reasons for delayed discharges for the Health Board compared to the all-Wales position (April 2025)

Reason for delay	Percentage delayed	All-Wales average
Awaiting start of new community care package funded by social care	15.8	9.8
Awaiting completion of nursing assessment	10.4	7.1
Awaiting continuing healthcare (CHC) assessment	8.6	3.1
Awaiting completion of social care assessment	8.1	11.6
Awaiting completion of allied health professional assessment	6.8	4.7

Source: Welsh Government

24 When broken down by local authority, the rate of delayed discharges per 100,000 head of population is above the all-Wales average in Carmarthenshire and Pembrokeshire. Ceredigion is just below the all-Wales average. The rates in Pembrokeshire and Carmarthenshire are the second and fourth highest in Wales at 76.4 and 70.2 respectively (compared to the all-Wales average of 54.6). Awaiting completion of nursing assessment is the highest cause of delay in Ceredigion and Pembrokeshire, while awaiting the start of a new community care package funded by social care is the highest cause of delay in Carmarthenshire.

25 Based on data reported in April 2025, the total number of patients delayed accounted for 4,511 bed days. Based on a typical cost per bed day[3], this equates to costs in the region of £2.256 million for the month. The total number of bed days lost due to delayed discharges for the financial year 2024-25 equated to 55,482 and a full year associated cost of £27.741 million. Given the financial pressures facing the public sector, this is a significant amount of NHS resource that is being used sub-optimally and which should be employed in other ways to meet other demand in the system.

[3] Based on £500 per bed-day as set out in the NHS Confederation briefing for the statement by the Minister for Finance and Local Government on the 2023-24 financial position

Impact on patient flow

26 We found that **delayed discharges are having a wider impact on patient flow with knock-on effects on ambulance handovers and waiting** times **in emergency departments, although planned care is largely being protected.**

27 Delays in discharging patients from hospital have consequences for patient flow and in particular the ability for patients to access services when they need them. Beds occupied by patients who no longer need them means that they are not available for those who do, resulting for example, in longer waits in emergency departments. This in turn impacts on the ability for ambulance crews to handover patients and respond to 999 calls in the community.

28 **Appendix 3** sets out the region's performance across a range of urgent and emergency care performance indicators in comparison to the position across Wales since April 2022. In summary:

- the percentage of ambulance red calls responded within eight minutes has gradually improved and over recent months has been above the all-Wales average at around 50%, although it continues to fall short of the national target of 65% (**Exhibit 15**);
- the median response time for amber calls is broadly in line with the all-Wales average, although response times continue to fall short of the national target of 20 minutes (**Exhibit 16**);
- the percentage of ambulance handovers within 15 minutes at the Health Board's major emergency departments has generally been below the all-Wales average except for Withybush Hospital. Performance remains significantly below the national target (**Exhibit 17**);
- the percentage of ambulance handovers over one hour has generally been above the all-Wales average, fluctuating between 35% and 64%, compared to a national target of zero[4], (**Exhibit 18**);
- the total number of hours lost following notification to handover over 15 minutes is broadly in line with the all-Wales average, dipping to 2,200 hours in August 2024 (**Exhibit 19**);
- once the patient is in the emergency department, the median time from arrival to triage has been longer than the all-Wales average, fluctuating between 23 and 33 minutes (**Exhibit 20**);
- the median time from arrival to assessment by a senior clinical decision maker peaked to just over an hour and a half in June 2024 and has since been fluctuating between an hour and an hour a half. Performance had been much better than the all-Wales average until recent months (**Exhibit 21**);

[4] Welsh Government introduced the target for no patient handover to take longer than one hour as an additional metric within the NHS planning framework in 2023-24 as part of work to try and reduce the increasing trend of lost hours.

- the percentage of patients spending less than four hours in a major emergency department is in line with the all-Wales average. Performance varies across the three hospital sites, with performance better in Bronglais Hospital, and worse in Glangwili Hospital (**Exhibit 22**);
- the percentage of patients spending less than 12 hours in an emergency department is also broadly in line with the all-Wales average, with performance better in Bronglais Hospital, and worse in Withybush Hospital (**Exhibit 23**);
- the proportion of bed days accrued by patients with a length of stay over 21 days is improving and is now slightly below the all-Wales average (**Exhibit 24**). Our review of a sample of the Health Board's emergency medical admissions highlighted that the average length of stay was higher in the Carmarthenshire acute sites (61 days at Glangwili Hospital, and 81 days at Prince Philip Hospital), compared to Bronglais and Withybush Hospitals at 45 days and 44 days respectively.

29 The Health Board's total bed capacity has fluctuated over recent years, with 1,175 beds available in 2023-24. Almost two thirds of the Health Board's beds are allocated to acute medicine (708). The number of beds allocated to acute medicine has increased from 577 beds in 2012-13. Bed occupancy in the acute medicine beds has been at 87%, compared with an optimal level of 85%. This increases to 91% in Glangwili and 94% in Withybush Hospital.

30 The Health Board is one of four health boards to have community hospital beds. These beds provide step-down facilities for patients who no longer need acute care. The number of beds available in the Health Board has remained relatively static between 2016-17 and 2022-23 at around 90 beds. However, occupancy levels have varied considerable between hospital sites, ranging between 23% in Amman Valley Hospital and 99% in South Pembrokeshire Hospital in 2022-23. The number of beds in South Pembrokeshire Hospital temporarily increased during 2023-24 following the impact of the discovery of Reinforced Autoclave Aerated Concrete (RAAC) at Withybush Hospital[5]. In September 2024, the Health Board announced that the beds in Tregaron Hospital would be closing, reducing the total number of community beds to 78.

31 Pressure on available beds because of delayed discharges means that health boards are not always able to ensure that patients are placed on the best wards for their clinical needs. For example, health boards will usually hold vacant beds on stroke units to ensure that stroke patients have fast and direct access, enabling them to access stroke specialists and equipment. Health boards have increasingly experienced difficulties in admitting stroke patients to stroke wards as problems

[5] In August 2023, RAAC was discovered in Withybush Hospital which resulted in the temporary closure of six wards, and the reconfiguration of South Pembrokeshire Hospital to support the provision of services. All the affected wards in Withybush Hospital were reopened by March 2024.

with patient flow and bed availability mean that non-stroke patients have needed these beds. Although the Health Board's performance is one of the best in Wales, typically only half of stroke patients have direct admission to a stroke unit within the target of four hours.

32 Poor patient flow can also affect scheduled (or planned) care, as patients with booked procedures are increasingly having their admissions cancelled due to the lack of available beds. This is poor patient experience and risks the conditions of planned care patients further deteriorating while they wait for their treatment to be rebooked.

33 The number of cancellations in the Health Board due to the lack of available beds however is one of the lowest in Wales. The number has also improved over the last three years. During 2024-25, there were 91 patients cancelled, compared to 150 patients in 2022-23[6]. Cancellations during the December and January months has also improved, reducing from 110 in December 2022 and January 2023, to 20 patients cancelled during December 2024 and January 2025.

Meeting patients' needs

34 We found that **delayed discharges present risks to patients physical and mental well-being.**

35 The pressure to discharge patients and the lack of available care options can lead to discharging patients to settings that are not always the most appropriate for their needs, including discharging:

- home before a proper care package is in place;
- to a residential care home when they could have gone home with a support package;
- to a temporary residential care home to await availability of longer-term placement;
- to a community hospital bed to await availability of a package of care; and
- to a setting which is far away from family and friends.

36 Patients who are delayed within hospital can become deconditioned, are at higher risk of experiencing an injury from a fall or contracting an infection which can exacerbate their care needs, lengthening their hospital stay and making them more vulnerable to readmission after discharge.

37 Within the region, the impact of delays on patient experience is something staff are acutely aware of. We saw the risks involved in patients staying longer than needed in hospital, such as deconditioning, reduced independence and loss of packages of care at the forefront of discussions. However, ward staff also spoke of a culture of risk aversion, whereby staff, particularly junior doctors, are reluctant to declare a

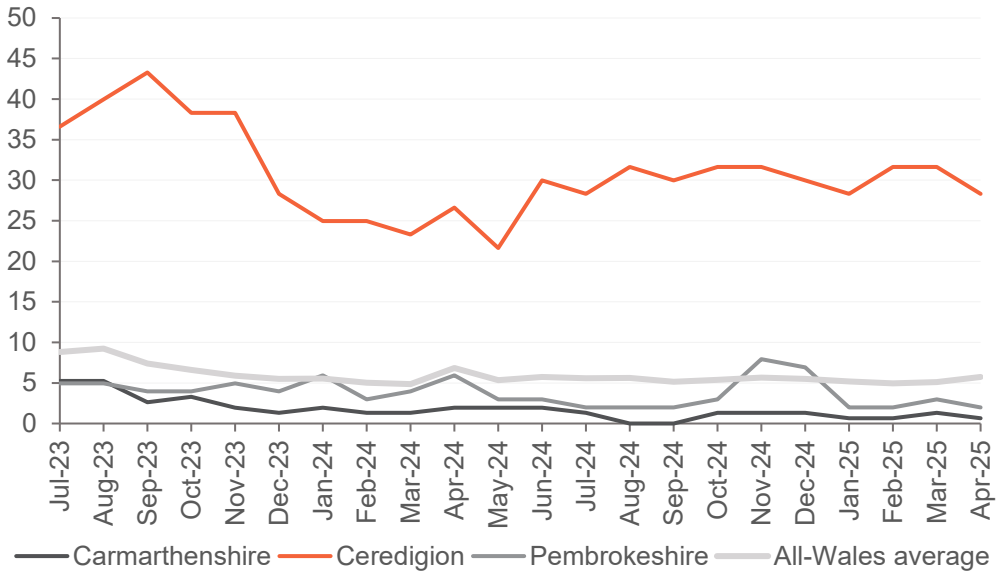
[6] The number of cancellations in 2023-24 due to the lack of available beds was impacted by the discovery of RAAC in Withybush Hospital in August 2023.

patient clinically optimised and discharge them because they fear the patient may not cope as well at home. There is a continued reluctance to take measured risks and to recognise the significant knock-on impact delayed discharges have on patient flow and the wider system.

38 We heard how managing patient and family expectations can also be difficult. Staff explained that since the pandemic, many families have returned to work and cannot provide the level of support they were providing to help meet patient need. We also heard of families leaving patients in hospital because they are going on holiday. As a result, difficult conversations were taking place with families around expectations of care. During intense periods we also heard of staff inappropriately discharging patients without completely considering their views. We heard that blanket referrals to multiple providers and disciplines were also taking place to try and find the quickest discharge pathway for a patient, even if that patient did not need the service (**Recommendation 1**). This is not a productive use of time and resources.

39 The region has been reporting significant variation in the use of unplanned short term care home accommodation. **Exhibit 4** sets out the extent to which adults were reported as being placed in unplanned short term care home accommodation for more than three months while waiting for a long-term placement. Since July 2023, the region has had some of the highest number of adults per 100,000 head of population placed in unplanned short term care home accommodation for longer than three months. This is particularly the case in Ceredigion which has the second highest number in Wales. However, this has since been reported as a data quality issue, and since June 2025, the number of adults per 100,000 head of population has significantly reduced to less than two per 100,000 head of population. This is now in line with Carmarthenshire and Pembrokeshire, which have been comparatively low when compared with the all-Wales average.

Exhibit 4: number of adults per 100,000 head of population waiting in temporary short term care home accommodation for more than three months with no planned end date (July 2023 – April 2025)



Source: Welsh Government

What is affecting effective and timely flow of patients out of hospital?

40 This section sets out the issues affecting effective discharge planning and the timely flow of patients out of hospital across the region.

41 We found that **increasing complexity of demand and capacity challenges** in **the care sector are affecting patient flow. A lack of a standard discharge policy, and weaknesses in the recording, communicating, and sharing of information are also leading to further delays.**

Volume and complexity of demand

42 We found that **the nature of demand is increasing with more people needing support for complex conditions such as dementia, however the Health Board recognises the need to better analyse and understand demand data to support planning and decision making.**

43 By 2043, current Welsh Government population projections predict an increase in the total population of West Wales to 396,000, with a predicted rise in those aged over 65 to 124,587 or 31.5% of the total population[7]. As people live for longer, there is a correlating increase in the number of people who live with multiple long-term conditions and complex health needs, and who will therefore need to rely on health and care services for support. There is also a correlating increase in the number of people living with dementia.

44 The 2022-27 Population Needs Assessment for West Wales also notes that Pembrokeshire has an older population than Carmarthenshire and Ceredigion, with an increase of people aged 85 and over, projected to be 33% by 2030. This compares to 25% for Carmarthenshire and 26% for Ceredigion.

45 Partners need to consider volume and complexity of demand needs for both the short and long-term. We heard how some care homes have adjusted the threshold for adults with complex care. This means that getting a patient with complex care into a sustainable placement is more difficult and takes longer as places are fewer. The Health Board and local authorities have access to significant amounts of data relating to demand. The Health Board accesses data which provides information on the current demand, but this is not yet at the granular level to understand what is driving that demand. There is also a manual complex discharge list compiled by discharge liaison teams allowing them to see complex discharges by hospital site. There is scope to bring all this data together into a useful data set to capture whole system demand across the region to underpin strategic and operational decision making (**Recommendation 2**).

46 The Health Board is keen to do more work on demand prediction in urgent and emergency care in the same way it does for planned care. Following on from the work done on rightsizing community resources which focused on resources needed to ease discharge out of hospital, the Health Board would like to ensure that the internal resources such as ward sizes and discharge units are aligned to the discharge pathways. To try and address this, the Health Board has started modelling via data analytics to try and set up the level of detail it needs to undertake demand predictions. If successful, this should help develop plans and allocate resources which address predicted population challenges. The challenge will be the capacity to develop and embed changes whilst the scale of demand on the system is so high.

Workforce capacity

47 We found that **workforce capacity challenges across all organisations are affecting the timeliness of discharge planning, particularly in Pembrokeshire adult social services, with waits for social care assessments the highest in Wales until recent months.**

[7] Executive summary - West Wales Care Partnership (wwcp-data.org.uk)

48 Increasingly staff involved in discharge planning are finding their capacity stretched due to factors such as high vacancy rates and unplanned absence rates. Reduced staffing leads either to a reliance on agency staff or to fewer permanent staff trying to manage increasingly complex patients and organise the ongoing care they need for discharge. High usage of agency staff has inevitable impacts on continuity within the workforce.

49 Recruitment and retention are a corporate risk for the Health Board to delivering high quality services. As of December 2024, the Health Board was reporting 7.4% vacancies as a percentage of its total establishment, with medical and dental vacancies at 19.1% and nursing and midwifery vacancies for registered and support staff at 5.2% and 10.7%, respectively. All vacancy rates were above the all-Wales average.

50 The unplanned absence rate was 8.5% for nursing and midwifery staff, and 11.6% for healthcare assistants and support workers. The unplanned absence rate was much lower at 3.1% for medical staff. Unplanned absence rates for registered nursing staff were below the all-Wales average, but above for healthcare assistants and support workers, and medical staff. Spend on nurse agency in December 2024 was running at 4.6% of the total nursing pay bill, which was in line with the all-Wales average. Since August 2024, the rate of nurse agency usage has substantially reduced, down to 1.9% of the total nursing pay bill by March 2025.

51 Recruitment and retention also feature on the corporate risk registers for all three local authorities. Carmarthenshire and Pembrokeshire have more detailed risks related to the social care workforce which reference the impact of delayed discharges on the health sector.

52 In June 2023[8], the West Wales local authorities were reporting between 5%-7% vacancies in adult social services, with the lowest rate in Pembrokeshire, and the other local authorities reporting 7%. Carmarthenshire and Pembrokeshire have experienced peaks in vacancies since January 2023, rising to 11% and 10% respectively and then reducing. Vacancy rates in Ceredigion had largely stayed static.

53 All three local authorities expressed difficulties in recruiting to social care posts, particularly home care workers, a position made worse by the pandemic and Brexit. There have been some financial incentives such as increasing wages but competing sectors such as retail, can offer similar or increased wages. There are also various local projects which aim to grow the workforce in social care either by offering apprenticeships or recruiting from overseas, such as the Care Academi however these initiatives take time, and none deal with the immediate and complex pressures of recruitment and retention. The Health Board has also been developing its own apprenticeship schemes to increase the workforce.

[8] There has been no data reported since June 2023.

54 In April 2025, the unplanned absence rate in adult social services[9] ranged between 4%-8%, as shown in **Exhibit 5.** The rate in Ceredigion has been above the all-Wales average since October 2023. The rate in Carmarthenshire and Pembrokeshire has been consistently below the all-Wales average, except for December 2024 when the rate in Pembrokeshire peaked to 11%.

Exhibit 5: percentage of unplanned absence in adult social services (April 2025)

Local authority	Unplanned absence
Carmarthenshire	5
Ceredigion	8
Pembrokeshire	4
All-Wales average	**7.1**

Source: Welsh Government

55 Workforce capacity constraints inevitably affect the discharge planning process. For example, pressure on ward nursing numbers means that time for proper discharge planning is constrained, worsened by using agency staff who are less familiar with discharge processes. Social workers also may not be able to complete timely assessments for a patient. As highlighted in **Exhibit 3**, delays completing nursing assessments is one of the main reasons for delayed discharges across the region, accounting for 10.4% of all delays in April 2025. Delays in social care assessments account for 8.1% of all delays. Delays awaiting social care worker allocation account for a further 1.8% of all delays. **Exhibit 6** sets out the extent to which adult social services across the three local authorities can meet demand for assessments.

Exhibit 6: number of social care assessments completed and awaiting completion per 100,000 head of population (April 2025)

Local authority	Social care assessments completed	Adults waiting for a social care assessment	% of those waiting for a social care assessment that are in hospital
Carmarthenshire	415	62	8.5
Ceredigion	569	218	1.5
Pembrokeshire	182	280	2.8

[9] Refers to adult social services in general.

Local authority	Social care assessments completed	Adults waiting for a social care assessment	% of those waiting for a social care assessment that are in hospital
All-Wales average	**238**	**117**	**6.1**

Source: Welsh Government

56 Despite workforce challenges, the rate of social care assessments completed in Carmarthenshire and Ceredigion local authorities are some of the highest in Wales. Waits for these two local authorities have been below the all-Wales average, although waits in Ceredigion have been increasing since August 2024 and are now one of the highest in Wales. The rate of social care assessments completed in Pembrokeshire is below the all-Wales average. Waits for social care assessment in Pembrokeshire have consistently been the highest in Wales, and much higher than the number of assessments completed, suggesting that the service has struggled to keep on of top of demand. Waits in Pembrokeshire have however been gradually reducing and in recent months, performance has been just above the all-Wales average.

57 Overall, very few of those waiting for a social care assessment are occupying a hospital bed suggesting that those in hospital are being prioritised. There is a greater proportion of adults waiting who are in hospital in Carmarthenshire compared to the all-Wales average, although the proportion has significantly improved from 41% in October 2024.

Care sector capacity

58 We found that **care sector capacity varies across** the **region with a high level of long-term care home provision, but a shortage in domiciliary care, particularly in Ceredigion and reablement care in Carmarthenshire.**

59 Availability of home (domiciliary) care packages and long-term residential care home accommodation can be key causes of discharge delay across Wales. Within the region, we heard about capacity issues in the domiciliary care sector which were affecting patient flow. We also heard that care homes have become more cautious accepting patients as they have the same workforce challenges as the local authorities and the Health Board. In April 2025, delays due to awaiting home care or reablement packages, or residential care home availability accounted for 23.9% of all delays.

60 **Exhibit 7** sets out the number of adults receiving care sector support and the extent to which there are waits for provision. **Appendix 4** sets out waiting list performance for social care assessments and care packages since November 2022.

Exhibit 7: number of adults receiving (and waiting for) care packages and placements per 100,000 head of population (April 2025)

Local authority	Domiciliary care[10] in receipt (waits)	Reablement[11] in receipt (waits)	Long-term care home accommodation[12] receipt (waits)
Carmarthenshire	724 (12)	47 (15)	701 (5)
Ceredigion	501 (86)	71 (7)	674 (7)
Pembrokeshire	678 (41)	37 (6)	760 (3)
All-Wales average	**695 (22)**	**63 (8)**	**555 (9)**

Source: Welsh Government

61 The exhibit shows that the provision of long-term care home accommodation is greater in West Wales when compared with the all-Wales picture, with the rate of provision the highest in Wales after Gwynedd. Waits for availability of long-term care home accommodation across the region is below the all-Wales average.

62 The number of people in receipt of domiciliary care across the region is around the all-Wales average for Carmarthenshire and Pembrokeshire, with waits well below the all-Wales average in Carmarthenshire. However, the provision of domiciliary care in Ceredigion is the second lowest in Wales, and with the second highest waits suggests that there is insufficient capacity. A low rate of provision and higher than average waits also show that there is insufficient capacity for reablement in Carmarthenshire to meet demand (**Recommendation 3**).

63 **Exhibit 8** shows the extent to which there are domiciliary hours unfilled, and the average number of hours provided per adult.

[10] Includes domiciliary care both provided and commissioned by local authorities.

[11] Includes reablement provided by local authorities.

[12] Includes long-term care home accommodation commissioned by local authorities.

Exhibit 8: unfilled domiciliary hours and average hours of domiciliary care provided per adult, per 100,000 head of population (April 2025)

Local authority	Domiciliary care hours waiting to be filled	Average hours per adult in receipt of domiciliary care
Carmarthenshire	210	12.1
Ceredigion	1,024	13.7
Pembrokeshire	345	11.4
All-Wales average	**230**	**13.1**

Source: Welsh Government

64 The exhibit shows a mixed picture across the region. Carmarthenshire reported a lower level of unfilled domiciliary care hours, whilst the number of unfilled domiciliary care hours in Ceredigion was the second highest in Wales. The position across the region however is more positive than it has been, with the level of unfilled hours reducing significantly from the position in February 2023 when the rate of unfilled hours in Carmarthenshire and Pembrokeshire was 1,061 and 739 hours, respectively. Support from the local authorities to help private providers with training costs has helped increase domiciliary care capacity. While the rate of unfilled hours in Ceredigion had improved from the position in February 2023 (from 1,665 to 590 in March 2024), the rate has gradually been increasing to a peak in January 2025 of 1,163.

65 The average number of domiciliary care hours provided per adult in Carmarthenshire and Pembrokeshire is less than the all-Wales average. Whilst this may reflect the care that people need, it could also be indicative of problems with the supply of domiciliary care. Pembrokeshire may potentially be trying to spread a limited resource thinly to ensure that it is supporting as many people as possible with domiciliary care but not necessarily at the level that they need. The higher number of hours in Ceredigion may reflect a higher level of complex needs but may also reflect over prescribing of domiciliary care. Given the high level of unfilled hours, the low level of provision and high waits, the local authority needs to be assured that the level of domiciliary care it provides per adult is appropriate to need (**Recommendation 4**).

Discharge process

66 We found that **there are weaknesses in the application and documentation of the discharge planning process, worsened by inconsistent training and a lack of a standardised discharge policy.**

67 Good discharge planning is reliant on good communication and co-ordination across different professional groups, with consideration of discharge as soon as a

patient presents to services. Good discharge planning is also helped by having clearly documented processes which are shared with all staff involved to promote understanding and awareness of the different roles in the discharge process.

68 At the time of our review, there was no standard discharge policy embedded across the Health Board. Some sites were using the previously issued Welsh Government discharge policy and others were developing a standardised policy. As a result, awareness and compliance of discharge policy processes were variable, which we found reflected in the patient case notes. The Health Board has since addressed this following a limited assurance Internal Audit review of discharge planning, with new Health Board wide discharge guidance developed and approved in April 2025.

69 There is no consistent approach to training and in particular joint training. Staff recognised that there are training requirements for everyone involved in discharge to better understand the process, and roles and responsibilities at each stage **(Recommendation 5)**. For example, we heard how some patients are over promised packages of care by clinical staff which they may not get or need. This affects patient and family expectations which can delay patient discharge.

70 The case notes we reviewed generally had no expected date of discharge set within 48 hours of the patient's admission to hospital. Discharge was often not noted for some days after the patient's admission and even then, this was vague 'continue planning'. This gives no indication to other staff members of what they should do to speed up the process. We also found little reference as to whether patients' families were kept up to date with discharge plans, no 'What Matters' conversations were noted as having taken place and legibility of notes was variable **(Recommendation 7)**.

71 We also noted that discharging patients from hospital is still an activity which largely takes place on weekdays, with very few (and mostly simple) discharges occurring on weekends. Our review of a sample of the Health Board's emergency medical admissions showed that only 11% of patients were discharged at the weekend, most of which were on a Sunday. This is due to working patterns in both health and social care, as well as the fact that most providers will not accept admissions over the weekend. The percentage of discharges at weekends however was the highest in Wales.

72 When broken down by site, there were very few weekend discharges at Bronglais and Prince Philip Hospitals, and only Withybush Hospital discharged patients on a Saturday. During the week, discharges peak on a Monday at Bronglais, Glangwili and Withybush Hospitals, which would suggest that had services or staff been available, some of these patients could have been discharged over the weekend. Discharges also peaked on a Tuesday at Bronglais and Prince Philip Hospitals. There were no discharges on a Wednesday at Glangwili Hospital.

73 We also found differences of opinion across health and social care staff about when to make a referral to support discharge, and differences in arrangements between hospital sites and local authorities **(Recommendation 6)**. Some social

care staff are keeping separate lists, one for patients who are ready to receive care and one for those who they are repeatedly triaging because ward staff have made the referral to social services too early. Complexities of legal requirements, mental capacity assessments and accommodating patient wishes all contribute to differences of opinion about when is the appropriate time to refer patients in the discharge planning process.

74 Given some of the challenges with social worker assessment, the region has been slow to fully embed the Trusted Assessor Model. It is unclear why this has not been a priority to free up social worker capacity and enable patient flow. A task and finish group has now been established to agree a way forward and undertake a baseline assessment across each local authority area.

75 In 2018, the Welsh Government introduced the Discharge to Recover then Assess (D2RA) model, which aims to support people to recover at home before assessment for any ongoing need, thereby reducing length of stay in hospital. Welsh Government accelerated the implementation of the model during the pandemic and has since given additional monies to regions to embed D2RA further.

76 National data sent to Welsh Government has shown the Health Board has had difficulty in discharging patients to a suitable setting for their assessment, as is advocated by D2RA. High proportions of patients were waiting to transfer to D2RA pathways. Many of these patients were waiting discharge to their own homes, or existing care home placements. The Health Board continues to try and implement D2RA as an area of focus for managing complexity. However, there is tension with the capacity of the local authorities to be able to assess given current demand.

Information sharing

77 We found that **problems with the recording, communicating,** and **sharing of information across organisational boundaries is adding to delays.**

78 Professionals within and across organisations will typically need to share information about the patient to aid discharge arrangements and ongoing care, especially where the patient has more complex needs.

79 While multidisciplinary meetings take place, the acute hospital sites could do more to learn from good practice across the Health Board. There are positive examples of multidisciplinary information sharing across the region. Glangwili Hospital undertakes multidisciplinary ward rounds which include key partners to share information and enable discharge. These include physiotherapists, social workers, care and repair, occupational therapists, and members from the Delta Wellbeing team[13]. This encourages collaborative solutions and data sharing to help with

[13] Delta Wellbeing is a 24/7 information, advice and assistance service for individuals and organisations that promotes and maintains wellbeing and independence in the home.

discharge. Multidisciplinary ward rounds at other sites are largely attended by health professionals only **(Recommendation 8).**

80 Relationships between health and social care are not consistent across the region and the quality of referrals from health into social care varies. Referrals are often seen by health staff as a tick box exercise and are frequently incomplete or lack any detail, requiring social workers to seek further clarification before being able to make a triage decision (**Recommendation 9).**

81 Systems holding patient information are not connected or viewable by all staff involved in the care of individual patients. Digital recording systems are much more integrated in Carmarthenshire than Pembrokeshire. While Ceredigion has implemented the Welsh Community Care Information System[14], the others have not and although the Health Board adopted the system, it only adopted it in a handful of services (**Recommendation 10**). We heard that staff rely very much on personal contact with individuals to get the information they need to support the discharge process, but this can take time.

82 There are also inconsistencies in how ward staff are recording patient discharge information across the acute hospital sites, with some sites using the Frontier system and others using whiteboards. Not all sites are keen to switch to digital modes of record keeping. This affects the efficient and effective sharing of information both internally and across organisational boundaries **(Recommendation 11).**

83 Services run by the voluntary sector along with community-based services are fundamental to supporting discharge for many patients. It is therefore best practice to involve these services in the discharge planning process. Understanding of the landscape of services outside of hospital however was patchy, meaning opportunities to discharge earlier with support from services beyond social care were missed. We found that access to information on community and voluntary services was often variable and there was an absence of training to provide information to relevant staff **(Recommendation 12).**

What action is being taken?

84 This section considers the actions the statutory organisations are taking, including through the Regional Partnership Board, to improve the flow of patients out of hospital.

[14] The Welsh Community Care Information System (WCCIS) is a single system and a shared electronic record for use across a wide range of adult and children's services. The idea being that all 22 local authorities and seven health boards should implement it, with the initial intended implementation date of the end of 2018. A new national programme 'Connecting Care' was established in May 2024 to replace WCCIS from January 2026.

85 We found that patient **flow is a key feature across all regional partners and there are clear links to national goals in strategic plans, but the operational delivery of plans needs further work. Local projects are having a positive impact, but these need mainstreaming to ensure sustainable service delivery, and oversight needs to be strengthened to show whole system impact.**

Strategic and operational plans

86 We found that **addressing** patient **flow is a key feature of plans across the partners in line with the Welsh Government's ambitions but translating the West Wales Area Plan into operational delivery needs further work.**

87 We reviewed relevant health board and local authority plans in relation to discharge planning, and urgent and emergency care more generally. We found that plans in the region generally reflect a good understanding of the challenges affecting patient flow.

88 The Health Board's Annual Plan 2024-25 had a specific aim to transform urgent and emergency care and improve patient flow, aligned with the Welsh Government's Six Goals Programme for Urgent and Emergency Care (the Six Goals Programme), including rolling out integrated care pathways, fully utilising the Frontier digital platform and strengthening community capacity. Bespoke aims were also set out for each of the counties, including opening the frailty assessment unity in Pembrokeshire, and implementing early supported discharge for stroke patients in Carmarthenshire. These aims are set out in more detail in county operational plans. The corporate strategies for each of the local authorities all reference the need to support timely discharge home from hospital to ensure that those that need hospital care can access it, and to support people to remain independent and in their own homes.

89 The West Wales Area Plan 2023-28 sets out the ambition to develop and implement the 'Home First' approach to deliver an integrated health and care system for older people. Implementation of the strategic West Wales Area Plan 2023-28 through operational delivery plans however is unclear and out of date. The West Wales Area Plan 2023-2028 is the strategic plan developed with the Health Board and all three local authorities as intended as an integrated approach for delivering on the challenges from the Population Needs Assessment. There are strategic priorities within the delivery plan and references for each strategic priorities to national outcomes. This is underpinned by a delivery plan which includes objectives linked to timeframes (short, medium, and long) and delivery groups. There are some links to various implementation plans but some of these are 'under development' or out of date which makes it difficult to see how or when these objectives are to be delivered (**Recommendation 13**).

90 The Six Goals Programme has two goals linked to improving discharge: 'goal five – optimal hospital care and discharge from the point of admission', and 'goal six - home first approach and reduce risk of readmission'. The Health Board has a

specific Six Goals Portfolio Plan (the Plan) which is separate to its annual plan and is a one-year delivery plan. The Six Goals Portfolio Plan 2025-26 usefully sets out key achievements against each of the goals managed through four workstreams, two of which focus on goals five and six – Safe Hospital Care (Inpatient Response) and Hospital @ Home (Domiciliary Response). The Plan also sets out the expected impact, measures, and quarterly deliverables, as well as performance targets to check progress. Initiatives such as the implementation of SAFER principles[15] and clinical criteria for discharge are just some of the areas of focus within the Plan but arguably, these are fundamental principles of good discharge planning and should already be fully embedded.

91 The robustness of all these plans is tested by the recognition that recruitment, especially relating to follow on from hospital services, is incredibly difficult. The RPB's Transforming Urgent and Emergency Care Delivery Group recognise this as a risk. The group also recognises the need for senior operational leadership to drive implementation of plans.

Partnership working

92 We found that **partners are working together to improve patient flow, although short term funding creates risks for third sector involvement and system pressures can create an unhelpful blame culture**.

93 At a strategic level, there is evidence of regular engagement and partnership working between the Health Board and the three local authorities. As well as attending the RPB, the Directors of Social Services and several of the Health Board Directors, along with third sector representatives attend regular meetings of the Integrated Executive Group (IEG). The IEG advises the RPB on priorities for integration, monitors progress of the regional programmes, deploys regional funding and tackles operational challenges.

94 Our observation of meetings reflected constructive discussions taking place, with clear evidence of collaboration on items and good discussion including constructive challenge. Those attending can influence change and drive action, although we noted that there is no executive representation for secondary care services. The Health Board's Transforming Urgent and Emergency Care Lead attends the IEG who can influence the delivery of the Six Goals Programme but at the time of our work was not able to enforce change at an operational level. The three County Directors also did not attend despite a significant part of their role relating to delivery of community services in the local authority areas. The Health Board has since implemented a new operational structure, and the new Clinical Care Group Service Director for Community & Integrated Medicine now attends the IEG. The Service Director is now also the Health Board's Transforming Urgent and Emergency Care Lead.

[15] Seen, Aim, Flow, Early Discharge and Recovery

95 Third sector providers are key partners in the work of the RPB, but longer-term funding arrangements for third sector activity are needed to embed partnership working and improve patient flow. The Regional Integration Fund (RIF) funds much of the activity delivered by the third sector in relation to patient flow but there are no plans to mainstream activities. Not embedding third sector activity risks a potential loss of services affecting patient flow further and a loss of future integration between partners.

96 Operationally, relationships between health and social care staff vary. Due to the high volume of complex discharges which require multidisciplinary input, health and social care staff are in regular contact, and many told us they had positive working relationships. However, it was clear from our fieldwork that as problems with discharge delays become more acute, there is increased tension in working relationships. Staff spoke of the pressure they face to get patients out of hospital, and how that can lead to a blame culture between health and social care whereby another professional or their organisation is seen as the cause of the delay. This blame culture, in turn creates a defensiveness which can have a negative impact on how staff interact with each other during the discharge process.

Operational structures

97 We found that **while changes to the** Health **Board's operational structure have helped clarify accountabilities and support improvement, although the Integrated Strategic Group had yet to meet at the time of our audit**.

98 The RPB has developed Integrated Programme Boards which are specific to the priorities of the RPB developed from the Population Needs Assessment. One of which is the 'Transforming Urgent and Emergency Care Delivery Group' which oversees projects which have clear links to the Six Goals Programme. The Transforming Urgent and Emergency Care Delivery Group links to the Health Board's Urgent and Emergency Care Delivery Programme as part of its Integrated Quality, Financial Performance and Delivery (IQFPD) Group structure which also oversees the Health Board's Six Goals Programme.

99 The Health Board has updated the governance structure supporting the Six Goals Programme during 2024-25 to include an Integrated Strategic Group and an Integrated Operational Group which brings together health and social care. The Integrated Operational Group has been in place for some time, but the Integrated Strategic Group had not been set up by the end of the financial year.

100 The operational structure for urgent and emergency care in the Health Board has been complex, making it difficult to see clear lines of responsibility, and accountability locally and across the services. Each county area within the Health Board was driving activity relating to patient flow in different ways and with different success levels. The Health Board has since addressed this, with a new operational structure launched in April 2025. The new structure includes a Clinical Care Group for Community and Integrated Medicine, which brings together the former county

and acute hospital directorate structures responsible for urgent and emergency care.

Use of funding

101 We found that **partners are using financial resources to support discharge** planning**, however, it is unclear how funding for successful projects will be mainstreamed into base budgets to support sustainable change going forward.**

102 The region makes use of the RIF to support schemes aimed at improving discharge planning. The RIF is a Welsh Government five-year fund from April 2022 to March 2027. The aim of the fund is to set up and mainstream at least six new national models of integrated care to provide a seamless and effective service for the people of Wales. Two have a clear link to improving flow out of hospital for patients, namely: Home from Hospital Services; and Accommodation Based Solutions.

103 There is a clear expectation within the RIF guidance that partners 'match fund' projects up to 50% by the end of year five, with the Welsh Government funding for each project tapering each year to allow for successful projects to become business as usual. However, due to the financial pressures that the public sector is currently facing, Welsh Government have relaxed the match funding expectation.

104 The region received £15.7 million of RIF monies in 2022-23 and £15.8 million in 2023-24 to deliver the six national models. The RPB allocated about 40% of the funding (£6 million) in 2023-24 to the Home from Hospital model, with a further 7% of the funding (£1 million) allocated to projects to support the delivery of the Accommodation Based Solutions model, including step-down care. A further 10% (£1.6 million) of RIF funding was allocated to the 'Complex Care Closer to Home' model which predominately supports implementation of D2RA.

105 Projects are based on local needs assessments, including the Population Needs Assessment and Market Stability Report. Oversight of the funding is through the Funding Transformation Steering Group. The group consists of change and transformation leaders across the bodies including funding officers, with progress reported into the Integrated Executive Group.

106 Current projects include PIVOT (Pembrokeshire Integrated Voluntary Organisations Scheme) which coordinates projects delivered by partners such as Red Cross, and Care and Repair who work closely with the discharge teams to aid early discharge. The CWTCH project in Ceredigion also run by Red Cross with help from Care and Repair aims to prevent unnecessary admission to hospital and aid early discharge from hospital. The latest West Wales Regional Partnership Board Annual Report for 2023-24 recognises this project as 'a critical component of demand management from the perspective of the hospital and social care teams.'

107 Partners will need to adopt and embed the relevant programmes currently supported by RIF funding by 2027. Whilst the RPB recognises this, it is not clear

what arrangements are in place to integrate effective projects into business as usual. A continuation of the use of project funding for existing projects beyond March 2027 limits the ability to make use of the funding to introduce other new, innovative schemes to better manage demand.

Scrutiny and assurance

108 We found that **there is mixed** oversight **and scrutiny of activities to improve patient flow, with much greater oversight in the Health Board and scope to make better use of outcomes to show impact.**

109 We reviewed the level of information that partners' committees, Board and Cabinet receive in relation to flow out of hospital and found a mixed picture. Delivery against key national urgent and emergency care targets is presented at each Board meeting in the Health Board through the Integrated Performance Assurance Report (IPAR). Board members also discuss the IPAR in more detail at the committee responsible for performance[16], supported by periodic deep-dive presentations on delivery of the Six Goals Programme. The information provided sets out patient delays at a Health Board and local authority level which enables the committee to understand regional variances. There is evidence that the committee members scrutinise the data and ask for updates. Action plans are in place to try and tackle areas of biggest delay. Whilst it is useful to understand the areas of delay, the Health Board have actions such as 'set up formal arrangements between senior NHS and LA officers'. This level of basic integration is surprising as this should already be in place. We found limited reference to patient flow in papers presented to committees and Cabinets in the three local authorities.

110 The Health Board's Urgent and Emergency Care Delivery Programme provides detailed update reports on progress against the Welsh Government's Six Goals Programme to the Integrated Quality, Finance and Performance Delivery (IQFPD) meetings monthly. The IQFPD meetings were set up in 2024 in response to the Health Board's escalation status. The meetings report to the Executive Team. Updates provide a Red/Amber/Green status against each activity within the goal workstreams accompanied by an overview, current delivery status, risks and mitigations, and next steps. More detailed reports for each local authority area are also presented setting out specific challenges and risks for each area and what is being done to address them. Whilst these reports provide useful commentary on progress, the activities within the updates include cultural shifts and changing clinical appetites to risk relating to discharge. Scrutinising this provides useful context to the issues but there are no measurable outcomes to show the impact (**Recommendation 14**).

[16] Prior to 1st April 2025, oversight and scrutiny of performance was through the Strategic Development and Operational Delivery Committee. From 1st April 2025, oversight and scrutiny of performance moved to a new Finance and Performance Committee.

111 The RPB hosted a workshop at the end of 2022 to reflect on its role and achievements over the previous year and consider its priorities. One of the reflections was the need to identify and avoid duplication and focus on an outcomes framework. The RPB also reflected that it had lots of projects but needed more of a 'programme approach'. This resonates with what we saw during the review and whilst there is scrutiny and assurance at project level, significant challenges are still across the whole system, and better grip is needed to assure actions being taken are helping improve patient flow. While there is oversight of RPB activity within the Health Board, oversight at local authority level is variable especially within scrutiny committees (**Recommendation 15**).

What more can be done?

112 Whilst there is a clear recognition by regional partners of the problems associated with discharge, a desire to address them with the right focus within strategies and plans, impactful projects and good strategic relationships, the number of delayed discharges across the region have not significantly reduced.

113 Our work has found that there are several further actions that partners could take which would help improve timely and effective flow out of hospital across the region and reduce some of the challenges facing the health and social care system. These actions are set out in the following exhibit and align with the recommendations that are set out earlier in the report.

Exhibit 9: further actions for partners to help tackle the challenges for patient flow out of hospital

Managing demand to provide better outcomes for patients	**Minimising multiple referrals** and ensuring only those people who need the service are on waiting lists for reablement, home care packages and residential care, would minimise inefficiencies resulting from inappropriate referrals and provide better outcomes for patients.
Planning for current and future demand	**Bringing together data** which captures whole system demand across the region would support more effective strategic and operational decision making.
Addressing key gaps in capacity	Looking at **joint solutions across sectors** to address key gaps such as domiciliary care and reablement services would enable timelier discharge of patients' home. Ensuring domiciliary provision is **appropriate to need** would enable more effective use of limited resources.

Improving training and guidance	Offering **clear communication and training** for everyone involved in patient flow, including bank and agency staff as well as new starters, would ensure guidance is embedded. Making sure **guidance is comprehensive** would ensure everyone involved in the discharge process understands what is expected of them.
Improving the quality and sharing of information	Having an improved **understanding of the range of community services** that could support effective and timely discharge and how these can be accessed, would enable staff to make more informed decisions when planning for discharge. Having **clear and comprehensive information** within patient case-notes which sets out the actions being taken to support discharge, would enable a clearer understanding of what is happening with a patient by all professionals involved in the care of patients whilst in hospital. Having **standardised and joined-up systems** that are accessible by all staff (regardless of organisation) involved in the care of individual patients would enable effective and efficient methods of communication between organisations and supports effective flow out of hospital. Having **good quality referrals** would enable more effective triage and timelier assessment for those who need social care.
Improving joint working	Greater **involvement by multidisciplinary professions** in ward rounds would support collaborative solutions, sharing of information and more effective discharge planning.
Improving oversight and impact	Having **comprehensive and up-to-date implementation plans** would enable partners to understand how the West Wales Area Plan is being delivered. **Focusing on outcomes** would enable those providing oversight and scrutiny to understand whether actions are making a difference.

Ensuring **oversight of RPB activities** in local authorities would support a greater understanding of the contribution of those activities to core services and the wider contribution to patient flow.

Appendix 1

Audit methods

Exhibit 10 sets out the methods we used to deliver this work. We have limited our evidence to the information drawn from these methods.

Exhibit 10: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Board and committee papers; • operational and strategic plans relating to urgent and emergency care; • updates on the Six Goals Programme and urgent and emergency care to committees; and • discharge procedures and guidance.
Interviews	We interviewed the following: • Chief Operating Officer; • Deputy Director of Nursing; • Director of Primary Care, Community and Long-Term Care; • Programme Manager for Six Goals; • County Directors for Pembrokeshire, Ceredigion, and Carmarthenshire; • General Managers for Bronglais, Glangwili, and Withybush Hospitals; • Director of Social Services and Housing, and Head of Adult Services - Pembrokeshire County Council; • Director of Community Services, and Head of Integrated Services – Carmarthenshire County Council; • Director of Social Services, and Head of Adult Services – Ceredigion County Council; and • West Wales Regional Partnership Board Programme Manager.
Observations and Visits	We observed meetings of the following forums: • West Wales Regional Partnership Board; and • West Wales Integrated Executive Group.

Element of audit methods	Description
	We also observed Discharge Liaison Nurses at Glangwili and Withybush Hospitals.
Data analysis	We analysed the following national data: • Monthly social services dataset sent to the Welsh Government • Monthly delayed discharges dataset sent to the NHS Executive • StatsWales data • Ambulance service indicators We also analysed the following local data: • Relevant data provided by the Health Board and local authorities; and • Data provided by the Health Board relating to all emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died).
Focus groups	We undertook focus groups with the following: • third sector representatives; and • social workers at Carmarthenshire County Council, Pembrokeshire County Council and Ceredigion County Council
Case note review	We reviewed a sample of case notes relating to emergency medicine patients discharged in October 2022 with a length of stay greater than 21 days (excluding those who died).

Appendix 2

Reasons for delayed discharges

Reasons for delayed discharges in the Health Board

The following exhibit sets out the reasons for delayed discharges in the Health Board compared to the all-Wales position.

Exhibit 11: reasons for delay as a percentage of all delays (April 2025)

Reason for delay	Percentage delayed	All-Wales average
Awaiting start of new community care package funded by social care	15.8	9.8
Awaiting completion of nursing assessment	10.4	7.1
Awaiting continuing healthcare (CHC) assessment	8.6	3.1
Awaiting completion of social care assessment	8.1	11.6
Awaiting completion of allied healthcare professional assessment	6.8	4.7
Awaiting reablement community care package	5.9	4.6
Awaiting completion of best interest decision	3.6	3.1
Mental capacity	3.6	0.7
Patient/family disputing and/or delaying moving to any stage of care/next stage of discharge	3.2	2.4
Awaiting nursing home availability	2.7	3.1
Identifying residential home	2.7	1.7
No suitable abode – requires housing	2.7	1.5
Awaiting residential home availability	2.3	2.9
Mental capacity delays	2.3	0.6
Awaiting completion of self-funding arrangements to placement	1.8	2.1
Awaiting social worker allocation	1.8	4.1
Court of protection delays – post application	1.8	1.3
Awaiting assessment/discharge arrangements to existing care home	1.4	0.4
Awaiting dementia nursing availability	1.4	1.1
Awaiting funding decision - funded nursing care (FNC)/CHC	1.4	2.2

Source: Welsh Government

Note: where the reasons for delay relate to two or less patients, we have excluded these to minimise any risk of identifying individual patients.

Top five reasons for delayed discharges by local authority

The following exhibits set out the top five reasons for delayed discharges for each of the local authorities compared to the Health Board wide and all-Wales position.

Exhibit 12: top five reasons for delayed discharges as a percentage of all delays (April 2025) – Carmarthenshire

Reason for delay	Percentage delayed	Health Board average	All-Wales average
Awaiting start of new community care package funded by social care	23.4	15.8	9.8
Awaiting reablement community care package	10.3	5.9	4.6
Awaiting CHC assessment	9.3	8.6	3.1
Awaiting completion of social care assessment	7.5	8.1	11.6
Awaiting completion of allied health professional assessment	5.6	6.8	4.7

Source: Welsh Government

Exhibit 13: top five[17] reasons for delayed discharges as a percentage of all delays (April 2025) – Ceredigion

Reason for delay	Percentage delayed	Health Board average	All-Wales average
Awaiting completion of nursing assessment	15.6	10.4	7.1
Awaiting CHC assessment	9.4	8.6	3.1
Awaiting start of new community care package funded by social care	9.4	15.8	9.8

Source: Welsh Government

[17] All other reasons related to two or less patients.

Exhibit 14: top five reasons for delayed discharges as a percentage of all delays (April 2025) – Pembrokeshire

Reason for delay	Percentage delayed	Health Board average	All-Wales average
Awaiting completion of nursing assessment	16.9	10.4	7.1
Awaiting completion of allied health professional assessment	11.7	6.8	4.7
Awaiting completion of social care assessment	10.4	8.1	11.6
Awaiting start of new community care package funded by social care	9.1	15.8	9.8
Mental capacity	9.1	3.6	0.7

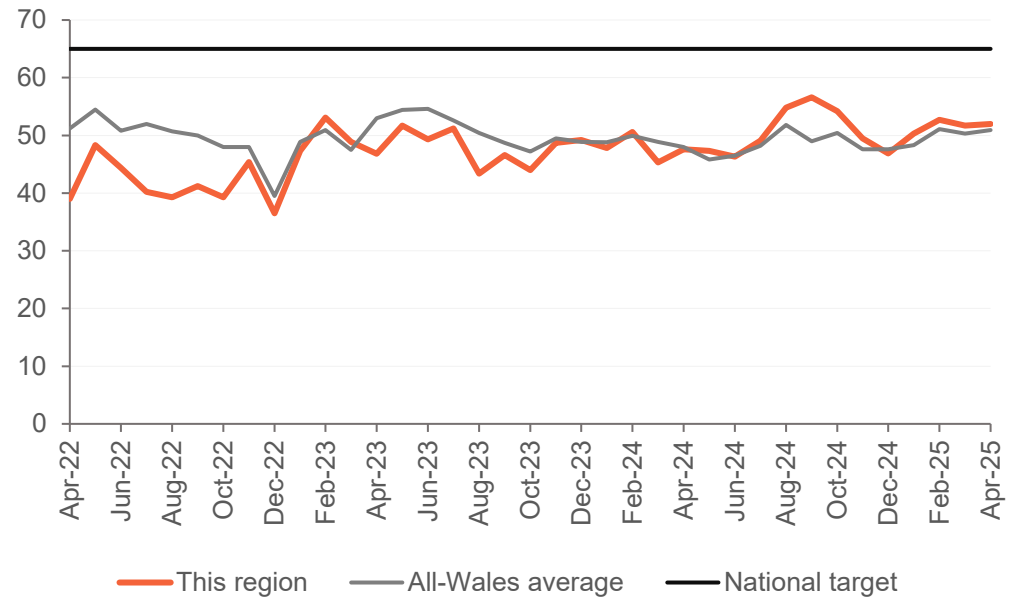
Source: Welsh Government

Appendix 3

Urgent and emergency care performance

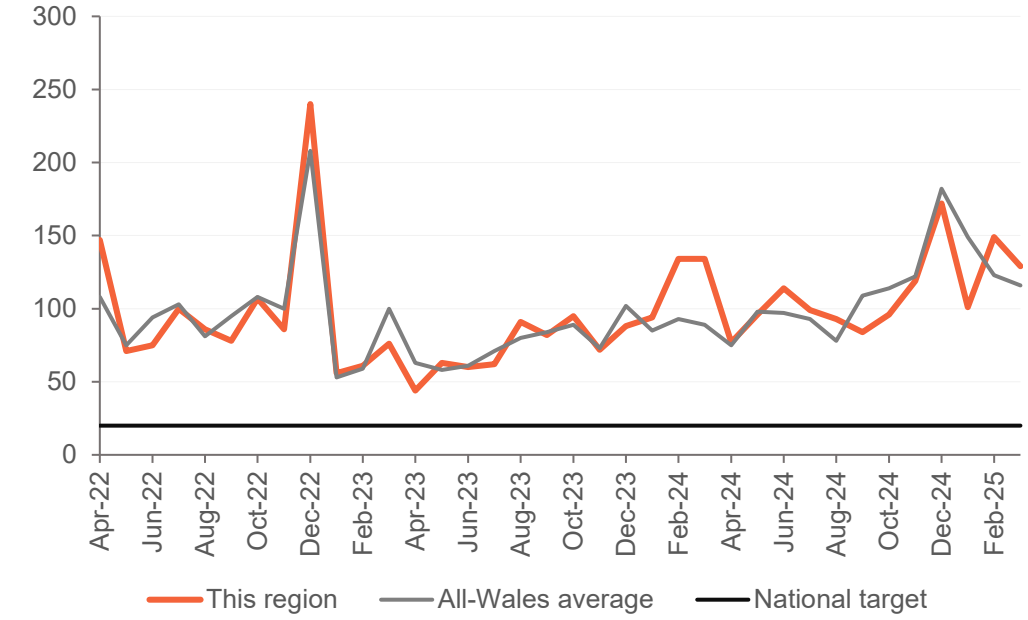
The following exhibits set out the region's performance across a range of urgent and emergency care performance indicators in comparison to the position across Wales since April 2022.

Exhibit 15: percentage of emergency responses to red calls arriving within (up to and including) eight minutes – national target of 65%



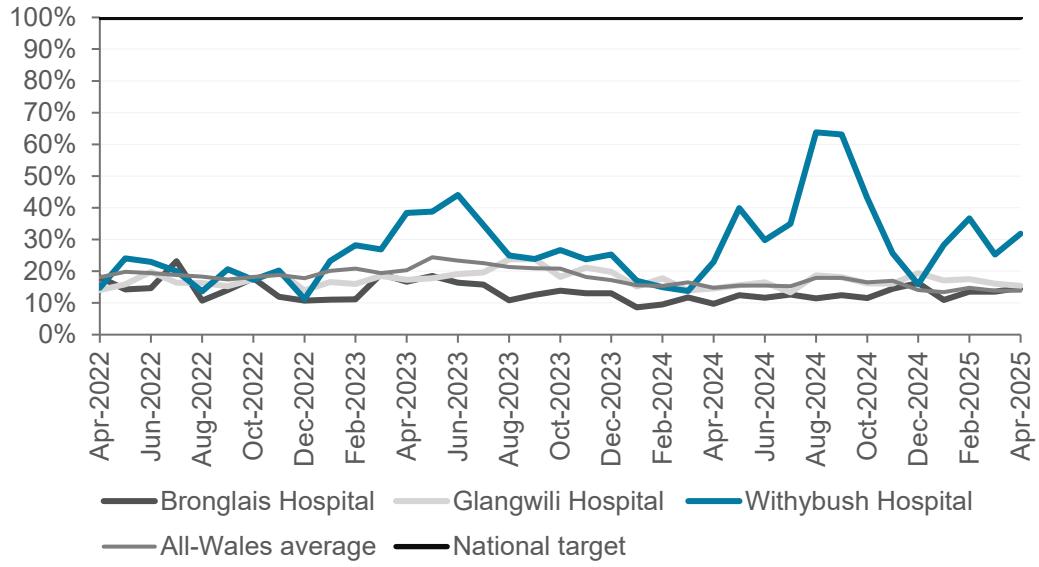
Source: StatsWales

Exhibit 16: median response time for amber calls (minutes) – 50th percentile – national target of 20 minutes



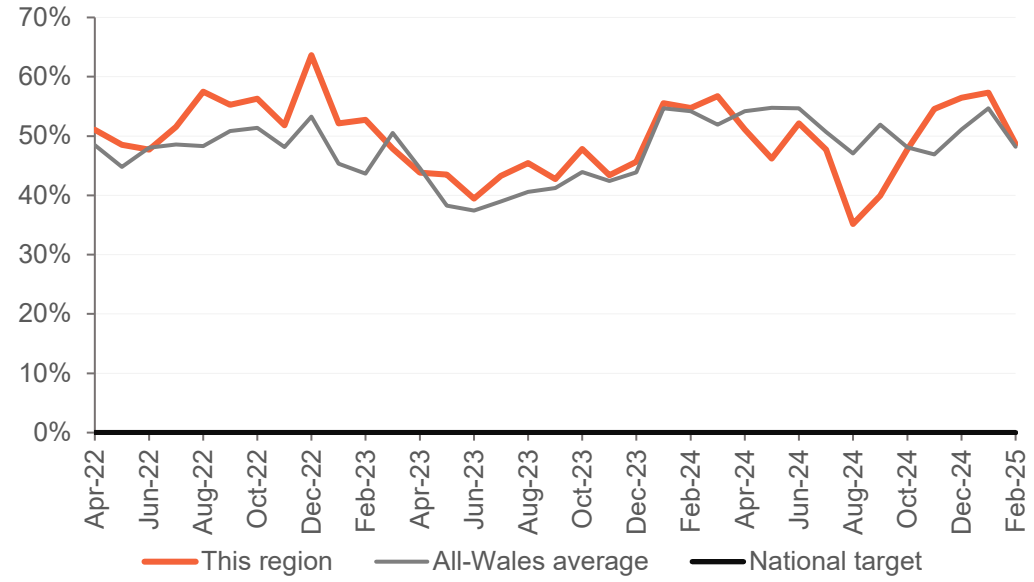
Source: Ambulance Services Indicators

Exhibit 17: percentage of ambulance handovers within 15 minutes at a major emergency department – national target of 100%



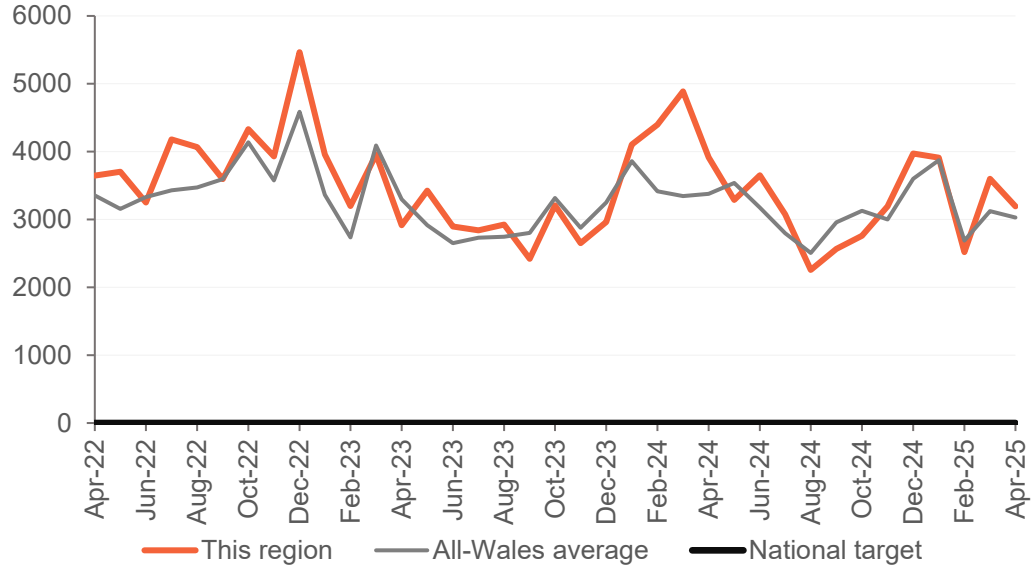
Source: Welsh Ambulance Services NHS Trust

Exhibit 18: percentage of ambulance handovers over one hour – national target of zero



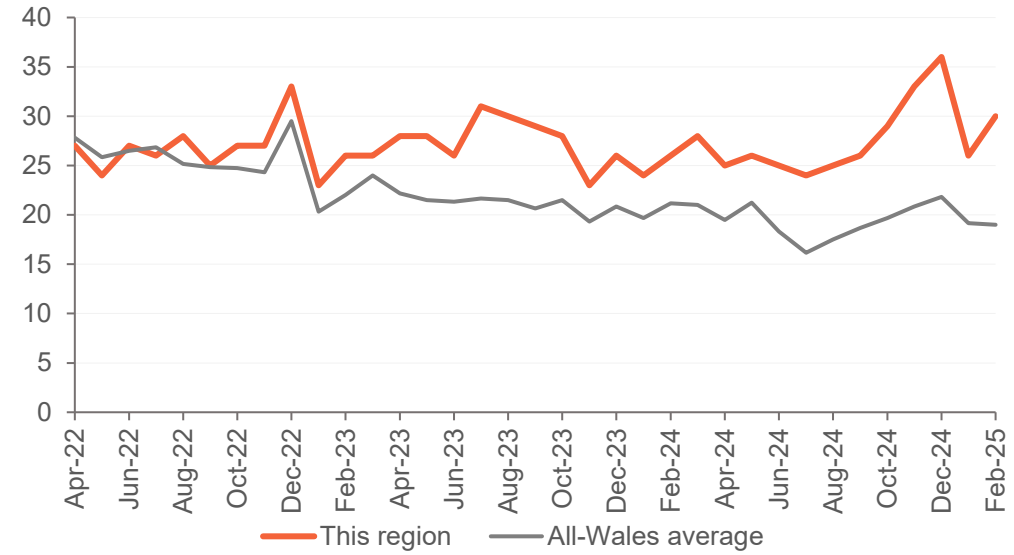
Source: Ambulance Services Indicators

Exhibit 19: total number of hours lost following notification to handover over 15 minutes



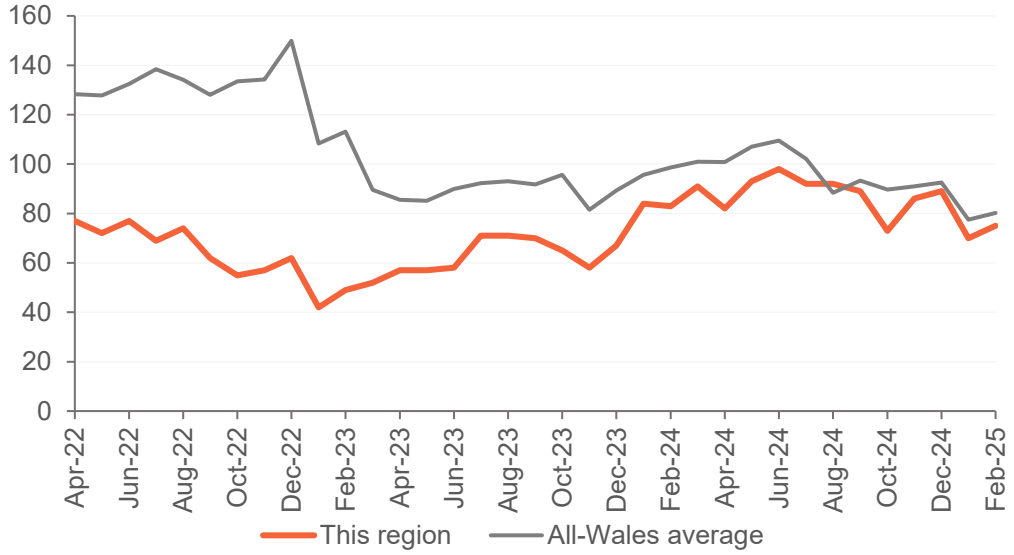
Source: Ambulance Service Indicators

Exhibit 20: median time (minutes) from arrival at an emergency department to triage by a clinician) – national target of 12-month reduction



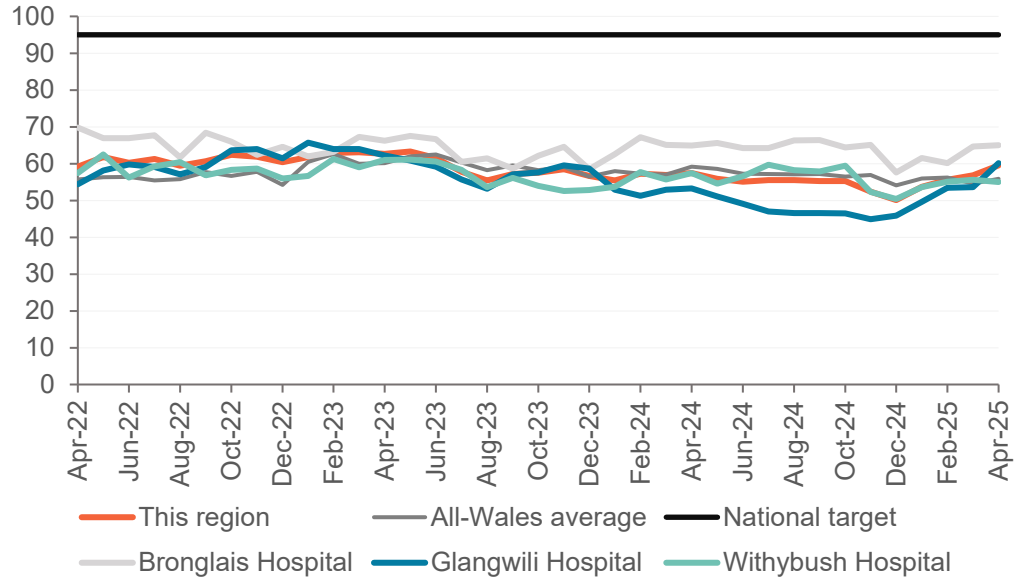
Source: Health Board performance reports

Exhibit 21: median time (minutes) from arrival at an emergency department to assessment by senior clinical decision maker – national target of 12-month reduction



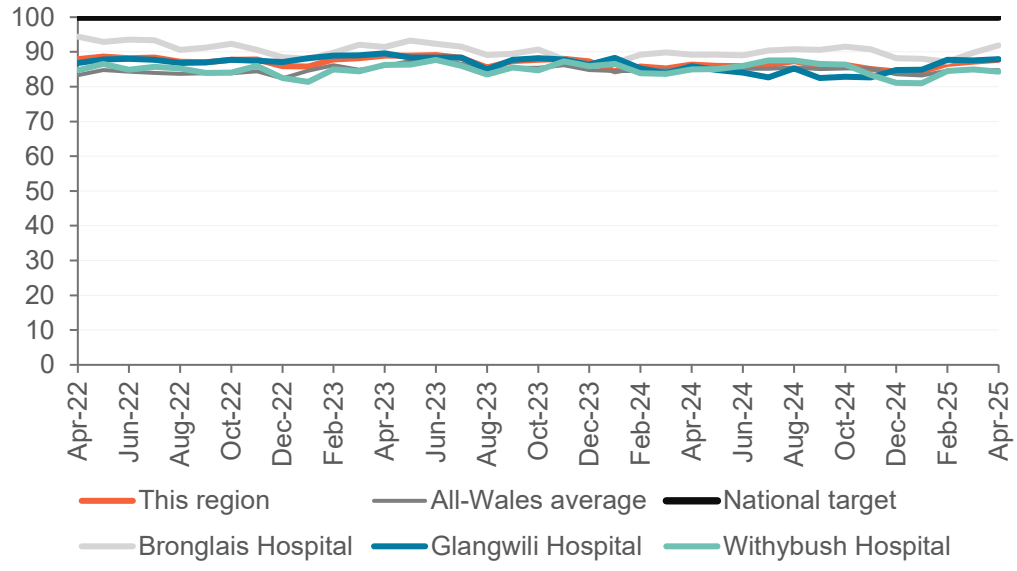
Source: Health Board performance reports

Exhibit 22: percentage of patients spending less than four hours in a major emergency department – national target of 95%



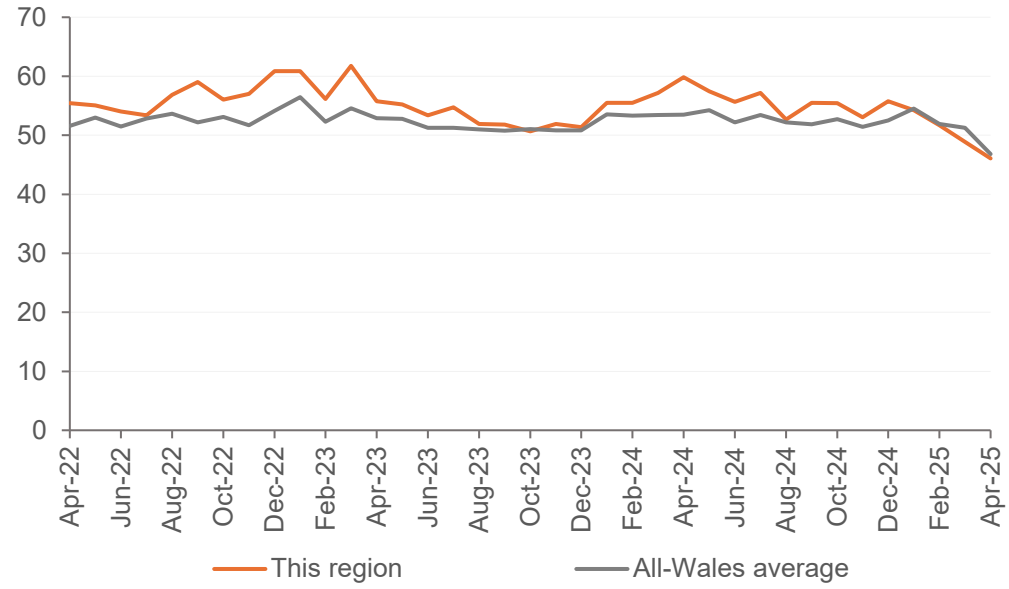
Source: StatsWales

Exhibit 23: percentage of patients spending less than 12 hours in a major emergency department – national target of 100%



Source: StatsWales

Exhibit 24: emergency admissions with length of stay over 21 days per 100 inpatient beds – national target of 12-month reduction



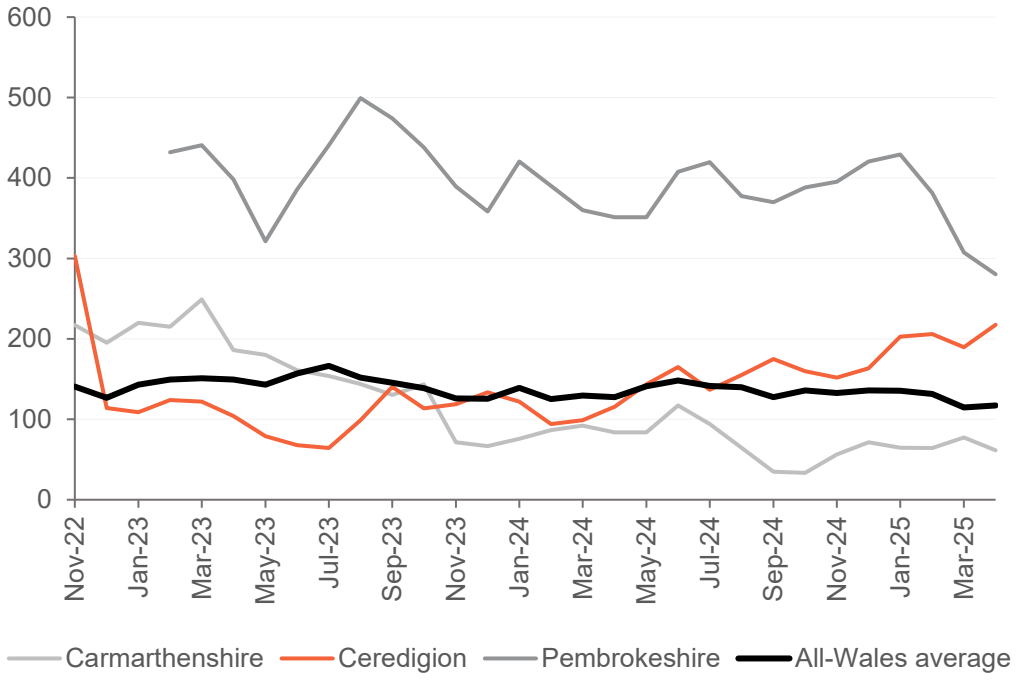
Source: DHCW

Appendix 4

Waits for social care assessments and care packages

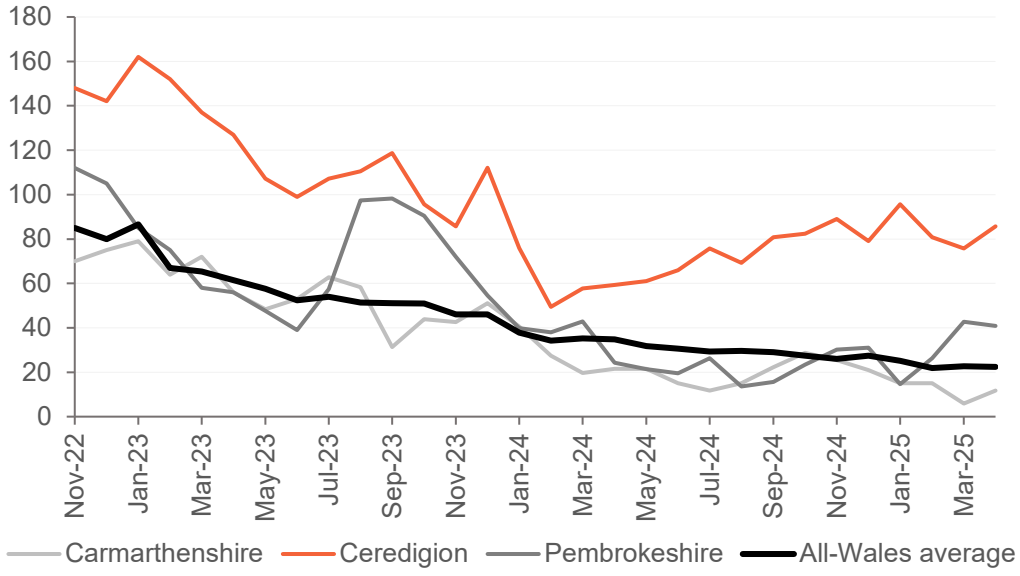
The following exhibits set out the region's waits performance for social care assessment and receipt of a range of care packages in comparison to the position across Wales since November 2022.

Exhibit 25: number of adults waiting for a social care assessment (per 100,000 head of population)



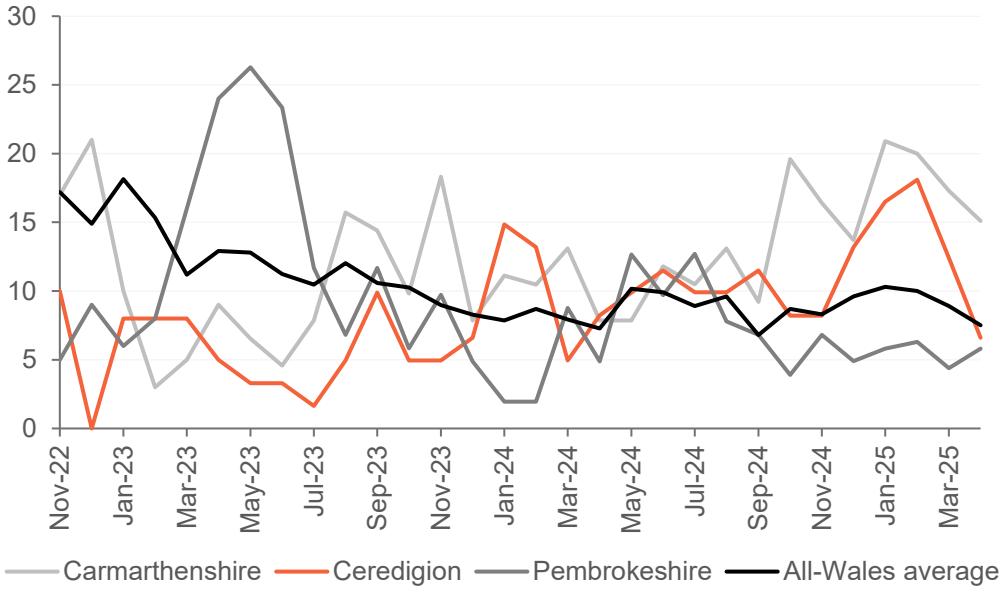
Source: Welsh Government

Exhibit 26: number of adults waiting for domiciliary care (per 100,000 head of population)



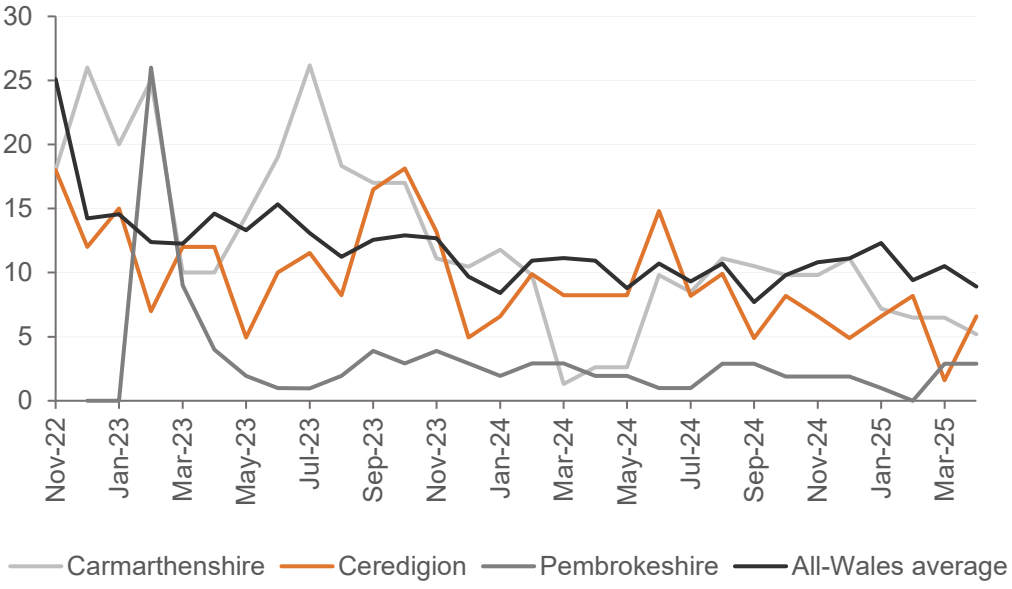
Source: Welsh Government

Exhibit 27: number of adults waiting for reablement (per 100,000 head of population)



Source: Welsh Government

Exhibit 28: number of adults waiting for long-term care home accommodation (per 100,000 head of population)



Source: Welsh Government

Appendix 5

Combined management response to audit recommendations

Exhibit 29: combined management response

Recommendation	Management response	Completion date	Responsible officer
Managing demand R1 To ensure that only those with a service need are on the relevant waiting lists, the Health Board should ensure its staff only place patients on a waiting list that is relevant to their specific post discharge care needs, rather than placing them on multiple different waiting lists as a means of simple	Regularly discussed at Pathway of Care Delays (POCD) groups to monitor and identify any issues. Health Board and Carmarthenshire/Pembrokeshire local authorities are rolling out the collaborative communication programme which has been identified as good practice. It supports person centred, multidisciplinary working, solution finding and positive risk. It has had a positive impact on individuals, process, and knowledge and understanding between professions, therefore	Ongoing- to review March 2026 Strength based communication has been rolled out - March 2026 is planned completion.	General Manager/Health Board Improvement and Transformation Lead Local Authority Heads of Service/ Health Board Improvement and Transformation Lead

Recommendation	Management response	Completion date	Responsible officer
securing earlier discharge (paragraph 38).	minimising the 'scattergun' approach to referrals. The training, and the development of mentors, is being rolled out across the region.		
	D2RA allocation – development of specific pathways across the HB, e.g. Rehabilitation pathway	Ongoing - to be reviewed monthly	General Manager/Health Board Improvement and Transformation Lead
	Home First hubs are established within each county and ensure that referrals are screened and directed appropriately to the right post-discharge care.	Ongoing – Home first is part-funded through RIF and is evaluated 6 monthly	General Manager/Heads of Service/ RPB lead
Planning for current and future demand			
R2 To inform strategic and operational decision making at a regional level, the Health Board and local authorities should develop a usable data set which captures information on the volume and complexity of whole system demand	The POCD meetings and UEC utilise data and 'deep dive' where there are changes or increases in specific categories to identify issues/ solutions.	Ongoing - as above will be reviewed March 2026	General Manager/Heads of Service/Health Board Improvement and Transformation Lead
	The RPB is also developing, with partners, a data portal that will enable us to capture and utilise data on capacity and demand that the Health Board and all three local authorities can use.	March 2026	RPB manager/ RPB performance lead

Recommendation	Management response	Completion date	Responsible officer
across the region (paragraph 45).	There is currently no integrated dataset encompassing both Health and Social Care. Significant restraints arising from information governance limits data sharing and integration. Addressing these challenges requires a coordinated National approach as highlighted during the National POCD Workshop. RPB is linking with WLGA on their new Digital programme one of the 'pillars' is around data systems.	Ongoing - to be reviewed January 2026	RPB leads
Addressing key gaps in capacity R3 To enable timelier discharge of patients to their own home, the Health Board and local authorities need to work together to develop joint solutions to address key gaps in service capacity, in particular, domiciliary care and reablement services (paragraph 62).	Collaborative communication is being rolled out across local authorities and the Health Board. POCD grants being utilised in each locality to increase capacity in domiciliary care, social work and Occupational therapy assessment and reablement. E.g. in Ceredigion incentive schemes for uptake in Dom care, and Technology approaches to supporting early discharge, Carmarthenshire are piloting new approaches such as long-term complex assessment beds and AI in addition to increasing capacity for	As above - March 2026 POCD grants have recently been allocated and so no confirmed completion date. Recruitment has begun to support the initiatives. Review January 2026	Heads of Service/Health Board Improvement and Transformation Lead Heads of Service Heads of Service/Health Board Improvement and Transformation Lead/Safe Hospital Care Leads

Recommendation	Management response	Completion date	Responsible officer
	assessment. The Health Board will consider a business case in January for seven day working to be rolled out and sustained. System wide prevention of deconditioning priorities and initiatives.		
R4 To ensure effective use of limited resources, Ceredigion County Council should ensure the higher-than-average hours provided per adult in receipt of domiciliary care are appropriate to their needs (paragraph 65)	POCD grant - increase assessment and reablement. Focus on a therapeutic approach across enablement and domiciliary care ensuring that packages are right sized in a timely manner. Wider programme of work being undertaken to review all care packages and care and support plans to ensure that packages are proportionate to level of need. There is a wider focus in Ceredigion, and across the region on prevention, early help, technology and proportionate care packages which means we are seeing the more complex coming through for domiciliary care requiring a significant higher number of hours to meet assessed needs.	Ongoing - as above review January 2026	Heads of Service

Recommendation	Management response	Completion date	Responsible officer
Developing and embedding policies			
R5 To embed a consistent approach to discharge planning, the Health Board and local authorities should ensure processes are in place to communicate the new discharge planning guidance to all relevant health and social services staff, including those working on a temporary basis. Roll out of the guidance should be supported by an ongoing programme of refresher training and induction training for new staff (paragraph 69).	Collaborative communication is being rolled out across the region.	March 26	Heads of Service/Health Board Improvement and Transformation Lead
	POCD grants being utilised in each locality to increase capacity in domiciliary care, social work and occupational therapy assessment and reablement. Also, in Ceredigion incentive schemes for uptake in domiciliary care, and technology approaches to supporting early discharge.	As above - review January 2026	Heads of Service
	In West Wales, we have integrated posts between health and social care. From a health perspective we have processes in place to support standardised discharge planning with agreed communication processes for each local authority. The live online discharge toolkit which contains key resource and guidance to support discharge planning is available to health and integrated staff via the internal SharePoint platform. However, access for social care remains limited due to platform restrictions.	Ongoing - review March 2026	Heads of Service/Health Board Improvement and Transformation Lead

Recommendation		Management response	Completion date	Responsible officer
		To further support understanding and implementation of discharge planning training videos are being developed. The videos will provide practical guidance and reinforce best practices. `	Ongoing - review March 2026	General Manager/Health Board Improvement and Transformation Lead
R6	To provide clarity to all staff on how the referral process for social care should work across the region, the Health Board, working with local authorities, should ensure that the new discharge planning guidance clearly sets out the point in the discharge planning process referrals for social care should be made (paragraph 73).	Ceredigion – New hospital based social workers will support the embedding of the discharge planning guidance in collaboration with Health Board colleagues. Early conversations and opportunities to consider prevention and early help opportunities will reduce formal referrals into social care. Carmarthen and Pembrokeshire have social work hospital teams, and all local authorities have a single point of access for hospital social work referrals. As a region, we are involved in the All-Wales single referral process which will be for all local authorities and the Health Board	Ongoing - will review recruitment and impact January 2026	Heads of Service

Recommendation	Management response	Completion date	Responsible officer
Improving quality of record keeping R7 To improve the quality of information contained in patient case notes, the Health Board should ensure all staff involved in discharge planning fully understand the importance of documenting comprehensive information in patient case-notes, and in addition implement a programme of case-note audits focused on the quality of record keeping (paragraph 70).	The Health Board 195, Clinical Record Keeping Policy (2023) is in place to provide clear professional and organisational standards for effective record keeping that all clinical staff must adhere to. With the aim that these standards will enable live, accurate, current and comprehensive information about the care provided to our patients. Our SharePoint page now holds a toolkit specifically appropriate to hospital discharge planning. An element of this is our organisation-wide discharge policy which was launched in 2025. This provides a platform on which performance will be monitored and audited. Discharge planning training is now also available via an e-learning package and also articulates the importance of accurate documentation. The ambition is that this will lead to a much more consistent approach across all professions.	Ongoing - regular auditing and review	Director of Nursing, Quality and Patient Experience/General Manager

Recommendation	Management response	Completion date	Responsible officer
	Performance reporting has changed significantly in line with new national models and programmes. The Health Board has implemented a digital platform to help better manage the discharge process and ensure audit and compliance of documentation.		
Enhancing multi-disciplinary ward rounds R8 To encourage collaborative solutions to discharge planning and data sharing, the Health Board and local authorities should ensure relevant professionals from key partners, who can share information and enable efficient discharge, attend relevant multi-disciplinary ward rounds at all acute hospital sites, as is the case in Glangwili Hospital. This may include physiotherapists, social	These meetings are already in situ across the HB footprint, and the roll out of collaborative communication is supporting a culture of info sharing and positive shared risk. Optimal flow - refers to board rounds not ward rounds. There is multidisciplinary team (MDT) representation at board rounds, but this is limited due to workforce challenges which is a constraint to attendance. Ad hoc board round audits are undertaken. To strengthen collaborative communication and joint working across MDTs, the Health Board, in partnership with local authorities, has launched an integrated training programme designed to bring	Ongoing Ongoing - review April 2026 after rollout of training. Ongoing - review April 2026	Heads of Service/ General Manager Heads of Service/ General Manager Health Board Improvement and Transformation Lead

Recommendation	Management response	Completion date	Responsible officer
workers, occupational therapists, care and repair or other relevant professionals (paragraph 79).	together professionals from both health and social care. This programme aims to build shared understanding of discharge planning processes, promote consistent practices, and enhance coordination between services.		
	Escalation process in place across the region for complex discharge planning, including multi-professional MDT's.	Ongoing - review March 2026	Heads of Service/ General Manager
	All local authorities have escalation meetings. E.g. Ceredigion has regular meetings with key officers from health and social care weekly (or more often if required) to manage escalation and routine planning to support early discharge and ensuring appropriate care is available at point of discharge.	Ongoing - review April 2026 to encompass impact of POCD plan	Heads of Service
Improving the quality of social care referrals R9 To enable social workers to effectively triage patients at the point of referral, the Health Board, working with local authorities, should	The POCD grant, awarded to all local authorities, will increase assessment capacity which includes additional social workers and other assessors, including AHP and the trusted assessor programme.	Ongoing - recruitment likely to be completed and additional resource in place by Q4 2025/26	Heads of Service

Recommendation	Management response	Completion date	Responsible officer
improve the completeness of referrals from ward staff to social care (paragraph 80)	Collaborative communication - supports knowledge and information sharing between health and social care. Identifying what a 'good' referral is and working with colleagues to identify this - this is part to the trusted assessor and competencies.	Ongoing - review March 2026 As above	Heads of Service/Health Board Improvement and Transformation Lead Heads of Service/ General Manager
Improving the sharing of information R10 To ensure effective sharing of information, the Health Board and local authorities should implement ways in which information can be shared between organisations, including opportunities to provide multi-agency access to existing access to organisational systems and ultimately joint IT solutions (paragraph 81).	Joint IT solutions, interoperability and sharing of info is a national issue and is one of the 'pillars' of the WLGA digital transformation. The RPB leads have been meeting with the Digital lead to identify how the RPB can support and facilitate this work. Interoperability between national systems e.g. WNCR, WCP, eclipse. There is currently no integrated IT solution for Health and Social Care. Significant restraints arising from information governance limits data sharing and integration. Addressing these challenges requires a coordinated National	Ongoing - review March 2026 Ongoing - issue to be raised in appropriate forums such as bi-monthly ICCS regional meetings and quarterly	WLGA/RPB lead RPB lead

Recommendation	Management response	Completion date	Responsible officer
	approach as highlighted during the National POCD Workshop. The Health Board has entered into a 10-year Digital Partnership with CGI who will support digital transformation across a number of key areas within the Health Board and will include working with local authority partners.	RPB chair/ minister meetings	
R11 To ensure consistency across acute hospital sites, the Health Board should apply a standard approach to recording patient discharge information on hospital wards using digital solutions (paragraph 82).	The Health Board currently utilises Frontier as its digital system for capturing patient data. This platform records the Optimal Hospital Flow indicators that support effective discharge planning, including clinical optimisation status, Red2Green actions, and Discharge to Recover to Assess (D2RA) pathway allocation. Next month, the Health Board is moving over to a new patient digital capture system. There is health and social care representation at Length of Stay discharge planning meetings to share and record patient discharge information.	Ongoing - reviewed monthly as part of POCD governance E-form rollout – November 2025 Reviewed as part of monthly POCD meeting	Health Board Director of Digital Services Health Board Director of Digital Services General Manager /Heads of Service/RPB lead

Recommendation	Management response	Completion date	Responsible officer
R12 To ensure that opportunities to secure earlier discharge with support from services beyond social care are not missed, the Health Board and local authorities should ensure that all relevant staff across each organisation has routine access to up-to-date information on services available in the community that support hospital discharge (paragraph 83).	Ceredigion – New hospital based social workers will support the embedding of the discharge planning guidance in collaboration with HB colleagues. Early conversations and opportunities to consider prevention and early help opportunities will reduce formal referrals into social care. Integrated community networks are pulling individuals who know their community. Information, Advice and Assistance (IAA) officers on the wards in Carmarthenshire (Blue army) support lower level need to understand what is available in the community and work as part of the ward-based teams and front doors. Pembrokeshire - care assessors – looking to develop them linked to every ward through POCD grant.	Ongoing - to be part of POCD grant review as above	Heads of Service

Recommendation	Management response	Completion date	Responsible officer
Developing the West Wales Area Plan 2023-28 implementation plans R13 To strengthen delivery of medium-term planning objectives, the Health Board and local authorities should ensure the implementation plans which underpin the West Wales Area Plan 2023-28 are fully developed and up to date (paragraph 89)	A monthly Integrated Pathways of Care Delay (POCD) Delivery Group is held with active attendance from both health and social care. A standing item on the agenda is the Regional POCD Action Plan which encompasses the local authorities POCD Transformation Grant initiatives. The group reviews the progress and status of the action plan, and an update is submitted to the national team on a quarterly basis for monitoring and reporting purposes.	Completed	Heads of Service/Health Board Improvement and Transformation Lead
Improving scrutiny R14 To enable impact to be demonstrated, the Health Board should ensure that its updates on delivery against the Six Goals Programme contain anticipated outcomes (paragraph 110).	The UEC Six Goals Programme now reports on detailed metrics at both the IQFPD and IQPD meetings monthly. These are centred on the Targeted intervention metrics of Ambulance Handover, ED waiting times, ED assessment times and Pathway of Care Delays. Additionally, information is provided around discharges before mid-day and Length of stay metrics. All information	Ongoing - this is reported and reviewed monthly	Six Goals Lead

Recommendation	Management response	Completion date	Responsible officer
	is presented with an explanation of the current status and corrective actions relating to the individual metric.		
R15 To strengthen scrutiny and oversight, the local authorities should ensure that regular updates on RPB activities related to patient flow are received by the most appropriate committee (paragraph 111).	There is a robust governance in situ, including the POCD delivery groups, the UEC/6 goals, and the newly established delivery and leadership groups in response to the winter planning self-assessment. It is acknowledged that more regular scrutiny and oversight by the local authorities is required on RPB activities (including patient flow) and 6-monthly updates to each local authority Scrutiny Committee has been offered - dates need to be agreed.	December 2025	RPB lead

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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

3.5

10:55, 5 Mins

3.5 - Audit Fees Consultation 2026-27

Anne Beegan, Urvisha Perez

For information

Attachments

3.5 AC528 - Letter on fee consultation.pdf

3.5 AC528 - Letter on fee consultation-cy.pdf

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Reference: AC528/caf
Date issued: 17 November 2025

Dear Colleagues

Audit Fees Consultation 2026-27

Over the summer we consulted all our audited bodies, along with other stakeholders, on our proposed fee rates for 2026–27 and the resulting fee scales for local government bodies. Our consultation proposal was to increase our fee rates (i.e. the charge out rates of Audit Wales staff) by 5.5%, This was driven by a combination of inflationary pressures on our cost base and heightened quality expectations.

We received 17 responses, 10 of which highlighted that the proposed fee rates for 2026-27 represent an increase greater than the expected rate of inflation. Respondents also queried how the cost of audit by Audit Wales compares with those from other providers and what Audit Wales is doing itself to minimise cost increases.

The Audit Wales Board and I are very grateful for all the feedback received and take the points raised extremely seriously. In the light of the consultation responses received, I am pleased to say that the final Fee Scheme that we will present to the Senedd's Finance Committee will reflect a lower fee rate increase of 5.3%. This will be achieved by Audit Wales increasing further what was already a stretching spending reduction and efficiency target for itself.

This letter sets out our responses to the main issues raised during the consultation and advice on how audited bodies can further minimise their audit costs.

How we set fees

It is important to note that an increase in fee rates does not necessarily mean that the audit fee for your organisation will rise by 5.3%. The fee charged is based on an estimate of the volume of work and the skills mix required to deliver the audit. For the audit of accounts in particular, this estimate is influenced by the quality of the

accounts and supporting working papers submitted for audit, as well as the timeliness with which audit queries are resolved. Similarly, the cost of a performance audit project can be reduced by timely submission by your organisation of information requested by the audit team and positive engagement with key officers. If the final cost of the audit is lower than estimated, we will issue a refund. Conversely, if the outturn exceeds the estimated fee, an additional charge may be necessary.

For the 2024-25 accounts audits, in some cases, we were able to set audit fees that were lower than those estimated in the previous year's audit plans. These reductions typically reflected efficiencies achieved in the accounts preparation and audit process, which had enabled us to refund part of the 2023-24 fee and rebase our estimate for 2024-25.

I cannot overstress how important this is in minimising the cost of audit. I am statutorily obliged to charge no more than the actual cost of the work we undertake. Hence, if your organisation is well prepared for audit, and if your accounts, systems and supporting information are of good quality and delivered in timely fashion, your audit should be smoother and swifter. If the opposite is the case, we will need to undertake more work and your audit fee will be commensurately higher. Your audit team will be happy to explore how such efficiencies might be identified within your organisation.

Why are Fees rates increasing more than inflation?

The top organisational priority for Audit Wales over the last two years has been to eliminate the backlogs of work that built up during and since the Covid pandemic. This is so that you have audited accounts on which to base decisions delivered in line with statutory deadlines, and performance audit work that is relevant and timely.

To tackle those backlogs we temporarily increased the number of CCAB qualified audit staff we employ. As our overheads must be recovered across the total number of audit staff, this increase enabled us to limit the rise in fee rates this year (2025-26) to just 1.7%, despite facing inflationary pressures of nearly 4%. Additionally, we identified efficiencies in our audit of accounts approach, allowing us to reduce fee scales for this work by an average of 3%, even with the modest increase in fee rates.

Next year we will see the opposite effect. By the end of 2026, we expect to have cleared most of the post-pandemic backlog, and we are reducing our audit staffing accordingly. This will mean fewer staff across whom overheads can be recovered. This is the main reason for the above-inflation increase in fee rates for 2026-27. Across the two years – 2025-26 and 2026-27 – however, you will note that next year's higher rate increase comes after a rise considerably lower than inflation in 2025-26.

To mitigate the impact of next year's increase, we have set an ambitious target to reduce our overheads by over 7% in 2026-27. As already mentioned, following the fee consultation, we have revisited our cost and savings assumptions and reduced our proposed increase in fee rates from 5.5% to 5.3% - although this remains subject to consideration by the Senedd Finance Committee.

Fee comparison

We are often asked how our fees benchmark against other audit providers.

Quality pressures, and the consequent fee increases, are common across both the public and private sectors. These pressures include more demanding auditing standards and enhanced regulatory oversight; responses to audit failures and public trust issues in the private sector that have impacted the entire profession; skills shortages leading to recruitment and retention challenges; and increased complexity within the audit environment.

A recent study by The Audit Reform Lab, based at the University of Sheffield, assessed the performance of the local public audit system in England and drew comparison with the position in Scotland and Wales.

One of the report's observations was that Wales:

"…appears to provide a cost effective, reliable and robust public audit of local authorities, that is now price and performance competitive with private auditors."

Annex 1 includes the relative fee rates from our fees consultation compared with those for English local government bodies. The tables in **Annex 1** show clearly that fee rates in Wales are very significantly lower than those being charged to English local government bodies.

While it is important to highlight how our fee rates compare with publicly available information on audit fees elsewhere, our primary focus remains ensuring that our audits deliver value for money for the Welsh taxpayer while enabling us to maintain a high-quality service. As Auditor General, I am very confident that this is the case.

Cost reduction

We recognise that public bodies are themselves facing considerable financial pressures and that any increase in audit fees will not be welcome. I fully understand, therefore, that we need to demonstrate what we are doing to control our own costs.

A significant focus for us is to reduce our cost base, while maintaining audit quality standards. Over the past ten years, we have reduced the cost of public audit in Wales by 4% in real terms, despite an expanded scope of work, and the higher audit quality requirements I have highlighted. Since I took up post as Auditor General in 2018, key savings we have delivered include:

Reshaping our workforce: We have reduced the proportion of directors and managers thus reducing the overall cost of audit.

Investing for the future: At the same time, we have also invested in our graduate and apprentice development programmes. These provide opportunities for school leavers and graduates in Wales, improve social mobility, and help develop auditors for the future and future financial managers for the Welsh public sector. Many of the people we have trained have moved successfully into finance positions in other Welsh public bodies.

In-sourcing audit work: Since 2021–22, we have ceased using private sector firms for audit delivery. This makes us unique among UK public audit bodies and has protected the public purse in Wales from the significant price increases charged by private providers contracted to deliver work in the public sector elsewhere in the UK.

Reducing travel costs: We have cut travel expenditure from £1.2 million in 2019-20 to just over £200,000 in our coming Estimate. This was achieved through a significant change in the terms and conditions of Audit Wales staff and by changing how we work to minimise travel, delivering both environmental and cost benefits.

Smaller, more efficient offices: We have moved to smaller, cheaper and more energy-efficient offices across Wales, saving around £250,000 annually despite rising utility costs.

Challenging non-pay budgets: More generally, we continually review our operating model and non-pay budgets to identify and deliver efficiencies wherever possible.

Investing in technology

Investing in technology is central to enhancing audit quality and efficiency, with data analytics playing an increasingly important role. However, inconsistent data quality across public bodies remains a challenge - one we are working to address in collaboration with other audit bodies across the UK and Republic of Ireland. A recent AI pilot has delivered promising results, although we are taking a cautious approach to development, mindful of the risks associated with AI adoption. In the shorter term, our focus is on delivering better quality outcomes through targeted improvements; in the longer term, we aim to embed sustainable efficiencies into our work through smarter use of digital tools.

Once again, however, our ability to apply the potential of technology to our work depends equally on the readiness of our audited bodies. Many audited bodies operate financial and management information systems that are outdated, meaning that the benefits of new technology on our part will be hard to achieve. Whilst I appreciate the financial pressure that public bodies face, I very much hope that investment in such infrastructure will be prioritised. A more efficient audit process would be one small benefit, but far more important, of course, would be the associated strengthening of organisational governance and informed decision-making for our audited bodies.

Proportionality

Some smaller bodies raised concerns during the consultation that their audit fees appeared disproportionate to their size. While I understand and empathise with these concerns, it is important to emphasise that our audit approach is determined by professional auditing standards, which do not permit the application of a different methodology for smaller organisations.

In practice, some smaller bodies can also present complexities and risks that are not necessarily reflected by their size, and these factors can influence the cost of audit delivery.

We are aware of various initiatives - both from the Financial Reporting Council and international standard-setters – which are exploring how audit can be made more proportionate. We are monitoring and engaging with these developments.

I hope this response helps to clarify the various issues raised during the fees consultation. If you have any further questions, please do not hesitate to contact either myself or Ann-Marie Harkin, Executive Director of Audit Delivery.

Yours sincerely

ADRIAN CROMPTON
Auditor General for Wales

Annex 1: fees comparison

Table 1: Audit Wales proposed fee rates 2026-27

Grade	Rate (£ per hour) 2026-27	Rate (£ per hour) 2025-26
Audit Director	189	183
Audit Manager	146	141
Audit Lead	120	115
Senior Auditor	96	91
Auditor	66	66
Graduate trainee	63	59
Apprentice	50	47

Source: Consultation on Fee Scales 2026-27

Table 2: PSAA rate card for 2024-25 audits

Grade of Staff	Hourly Rate
Partner/Director	£428
Senior Manager/Manager	£236
Senior Auditor	£153
Other Staff	£117

Source: Rate card - PSAA

Note

Public Sector Audit Appointments Ltd (PSAA) is an independent, not-for-profit company established by the Local Government Association (LGA) in England. One of its main roles is to set audit fees for local government bodies in England. PSAA reported that around 98% of eligible local government bodies have opted in to its fee scheme.

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Cyfeirnod: AC528/caf
Dyddiad cyhoeddi: 17 Tachwedd 2025

Annwyl cydweithwyr

Ymgynghoriad Ffioedd Archwilio 2026-27

Dros yr haf fe wnaethom ymgynghori â'n holl gyrff archwiliedig, ynghyd â rhanddeiliaid eraill, ar ein cyfraddau ffioedd arfaethedig ar gyfer 2026–27 a'r graddfeydd ffioedd sy'n deillio o hynny ar gyfer cyrff llywodraeth leol. Ein cynnig ymgynghori oedd cynyddu ein cyfraddau ffioedd (h.y. cyfraddau tâl staff Archwilio Cymru) o 5.5%, Cafodd hyn ei yrru gan gyfuniad o bwysau chwyddiant ar ein sylfaen costau a disgwyliadau ansawdd uwch.

Cawsom 17 o ymatebion, ac roedd 10 ohonynt yn tynnu sylw at y ffaith bod y cyfraddau ffioedd arfaethedig ar gyfer 2026-27 yn cynrychioli cynnydd sy'n fwy na'r gyfradd chwyddiant ddisgwyliedig. Gofynnodd ymatebwyr hefyd sut mae cost archwilio gan Archwilio Cymru yn cymharu â rhai gan ddarparwyr eraill a'r hyn y mae Archwilio Cymru yn ei wneud ei hun i leihau cynnydd mewn costau.

Mae Bwrdd Archwilio Cymru a minnau yn ddiolchgar iawn am yr holl adborth a gafwyd ac yn cymryd y pwyntiau a godwyd o ddifrif iawn. Yng ngoleuni'r ymatebion i'r ymgynghoriad a dderbyniwyd, mae'n bleser gennyf ddweud y bydd y Cynllun Ffioedd terfynol y byddwn yn ei gyflwyno i Bwyllgor Cyllid y Senedd yn adlewyrchu cynnydd is o 5.3% yn y gyfradd ffioedd. Bydd hyn yn cael ei gyflawni gan Archwilio Cymru gan gynyddu ymhellach yr hyn a oedd eisoes yn darged lleihau gwariant ac effeithlonrwydd iddo'i hun.

Mae'r llythyr hwn yn nodi ein hymatebion i'r prif faterion a godwyd yn ystod yr ymgynghoriad a'n cyngor ar sut y gall cyrff a archwiliwyd leihau eu costau archwilio ymhellach.

Sut rydym yn gosod ffioedd

Mae'n bwysig nodi nad yw cynnydd mewn cyfraddau ffioedd o reidrwydd yn golygu y bydd y ffi archwilio ar gyfer eich sefydliad yn codi 5.3%. Mae'r ffi a godir yn seiliedig ar amcangyfrif o faint y gwaith a'r cymysgedd sgiliau sydd eu hangen i gyflawni'r archwiliad. Ar gyfer archwilio cyfrifon yn benodol, mae'r amcangyfrif hwn yn cael ei ddylanwadu gan ansawdd y cyfrifon a'r papurau gwaith ategol a gyflwynir i'w harchwilio, yn ogystal â'r prydlondeb y mae ymholiadau archwilio yn cael eu datrys. Yn yr un modd, gellir lleihau cost prosiect archwiliad perfformiad trwy gyflwyno gwybodaeth a ofynnir gan y tîm archwilio gan eich sefydliad yn brydlon a thrwy ymgysylltu'n gadarnhaol gyda swyddogion allweddol. Os yw cost derfynol yr archwiliad yn is na'r amcangyfrif, byddwn yn rhoi ad-daliad. I'r gwrthwyneb, os yw'r alldro yn fwy na'r ffi amcangyfrifedig, efallai y bydd angen tâl ychwanegol.

Ar gyfer archwiliadau cyfrifon 2024-25, mewn rhai achosion, llwyddom i osod ffioedd archwilio a oedd yn is na'r hyn a amcangyfrifwyd yng ngynlluniau archwilio'r flwyddyn flaenorol. Yn gyffredinol, adlewyrchwyd y lleihad hwn yn effeithlonrwydd a gyflawnwyd yn y broses paratoi ac archwilio cyfrifon, a oedd wedi galluogi i ni ad-dalu rhan o'r ffi 2023-24 ac ailsefydlu ein rhagamcan ar gyfer 2024-25.

Ni allaf orbwysleisio pa mor bwysig yw hyn wrth leihau cost archwilio. Rwy'n rhaid i mi godi dim mwy na gwirioneddol gost y gwaith rydyn ni'n ei wneud. Felly, os yw'ch sefydliad wedi'i baratoi'n dda ar gyfer archwilio, ac os yw eich cyfrifon, systemau a gwybodaeth ategol o ansawdd da ac wedi'u cyflwyno mewn modd amserol, dylai eich archwiliad fod yn fwy llyfn a chyflymach. Os yw'r gwrthwyneb yn wir, bydd angen i ni ymgymryd â mwy o waith a bydd eich ffi archwilio yn gymesur uwch. Bydd eich tîm archwilio yn hapus i archwilio sut y gellid nodi effeithlonrwydd o'r fath yn eich sefydliad.

Pam mae cyfraddau ffioedd yn cynyddu mwy na chwyddiant?

Prif flaenoriaeth sefydliadol Archwilio Cymru dros y ddwy flynedd ddiwethaf yw dileu'r ôl-groniadau o waith a gronnwyd yn ystod ac ers pandemig Covid. Mae hyn er mwyn i chi gael cyfrifon archwilio ar gyfer seilio penderfyniadau a gyflwynir yn unol â dyddiadau cau statudol, a gwaith archwilio perfformiad sy'n berthnasol ac yn amserol.

Er mwyn mynd i'r afael â'r ôl-groniadau hynny, fe wnaethom gynyddu niferoedd staff archwilio cymwysedig CCAB yr ydym yn eu cyflogi dros dro. Gan fod yn rhaid adennill ein gorbenion ar draws cyfanswm nifer y staff archwilio, roedd y cynnydd hwn yn ein galluogi i gyfyngu'r cynnydd mewn cyfraddau ffioedd eleni (2025-26) i ddim ond 1.7%, er gwaethaf wynebu pwysau chwyddiant o bron i 4%. Yn ogystal, fe wnaethom nodi effeithlonrwydd yn ein dull archwilio cyfrifon, gan ein galluogi i leihau

graddfeydd ffioedd ar gyfer y gwaith hwn o 3% ar gyfartaledd, hyd yn oed gyda'r cynnydd cymedrol mewn cyfraddau ffioedd.

Y flwyddyn nesaf byddwn yn gweld yr effaith i'r gwrthwyneb. Erbyn diwedd 2026, rydym yn disgwyl clirio'r rhan fwyaf o'r ôl-groniad ar ôl y pandemig ac rydym yn lleihau ein staffio archwilio yn unol â hynny. Bydd hyn yn golygu llai o staff y gellir adennill gorbenion. Dyma'r prif reswm dros y cynnydd uwchben chwyddiant mewn cyfraddau ffioedd ar gyfer 2026-27. Ar draws y ddwy flynedd - 2025-26 a 2026-27 - fodd bynnag, byddwch yn nodi bod cynnydd uwch y gyfradd y flwyddyn nesaf yn dod ar ôl cynnydd sylweddol is na chwyddiant yn 2025-26.

Er mwyn lliniaru effaith cynnydd y flwyddyn nesaf, rydym wedi gosod targed uchelgeisiol i leihau ein gorbenion dros 7% yn 2026-27. Fel y soniwyd eisoes, yn dilyn yr ymgynghoriad ar ffioedd, rydym wedi ailedrych ar ein rhagdybiaethau cost ac arbedion ac wedi lleihau ein cynnydd arfaethedig mewn cyfraddau ffioedd o 5.5% i 5.3% - er bod hyn yn parhau i fod yn destun ystyriaeth gan Bwyllgor Cyllid y Senedd.

Cymhariaeth ffioedd

Gofynnir yn aml i ni sut mae ein ffioedd yn meincnodi yn erbyn darparwyr archwilio eraill.

Mae pwysau ansawdd, a'r cynnydd ffioedd dilynol, yn gyffredin ar draws y sectorau cyhoeddus a phreifat. Mae'r pwysau hyn yn cynnwys safonau archwilio mwy heriol a goruchwyliaeth reoleiddiol uwch; ymatebion i fethiannau archwilio a materion ymddiriedaeth y cyhoedd yn y sector preifat sydd wedi effeithio ar y proffesiwn cyfan; prinder sgiliau sy'n arwain at heriau recriwtio a chadw; a chymhlethdod cynyddol o fewn yr amgylchedd archwilio.

Asesodd astudiaeth ddiweddar gan The Audit Reform Lab, sydd wedi'i leoli ym Mhrifysgol Sheffield, berfformiad y system archwilio cyhoeddus leol yn Lloegr a chymharu â'r sefyllfa yng Nghymru a'r Alban.

Un o sylwadau'r adroddiad oedd bod Cymru:

“… seems to provide a cost effective, reliable and robust public audit of local authorities, that is now price and performance competitive with private auditors."

Mae **Atodiad 1** yn cynnwys y cyfraddau ffioedd cymharol o'n hymgynghoriad ffioedd o'i gymharu â'r rhai ar gyfer cyrff llywodraeth leol yn Lloegr. Mae'r tablau yn **Atodiad 1** yn dangos yn glir bod cyfraddau ffioedd yng Nghymru yn sylweddol is na'r rhai sy'n cael eu codi ar gyrff llywodraeth leol yn Lloegr.

Er ei bod yn bwysig tynnu sylw at sut mae ein cyfraddau ffioedd yn cymharu â gwybodaeth sydd ar gael i'r cyhoedd am ffioedd archwilio mewn mannau eraill, mae

ein prif ffocws yn parhau i sicrhau bod ein harchwiliadau yn darparu gwerth am arian i drethdalwr Cymru tra'n ein galluogi i gynnal gwasanaeth o ansawdd uchel. Fel Archwilydd Cyffredinol, rwy'n hyderus iawn bod hyn yn wir.

Lleihau costau

Rydym yn cydnabod bod cyrff cyhoeddus eu hunain yn wynebu pwysau ariannol sylweddol ac na fydd croeso i unrhyw gynnydd mewn ffioedd archwilio. Rwy'n deall yn llawn, felly, bod angen i ni ddangos yr hyn yr ydym yn ei wneud i reoli ein costau ein hunain.

Ffocws sylweddol i ni yw lleihau ein sylfaen costau, tra'n cynnal safonau ansawdd archwilio. Dros y deng mlynedd diwethaf, rydym wedi lleihau cost archwilio cyhoeddus yng Nghymru 4% mewn termau real, er gwaethaf cwmpas ehangach o waith, a'r gofynion ansawdd archwilio uwch yr wyf wedi'u hamlygu. Ers i mi ddechrau swydd fel Archwilydd Cyffredinol yn 2018, mae arbedion allweddol yr ydym wedi'u cyflawni yn cynnwys:

Ail-lunio ein gweithlu: Rydym wedi lleihau cyfran y cyfarwyddwyr a'r rheolwyr a thrwy hynny leihau cost gyffredinol archwilio.

Buddsoddi ar gyfer y dyfodol: Ar yr un pryd, rydym hefyd wedi buddsoddi yn ein rhaglenni datblygu graddedigion a phrentisiaid. Mae'r rhain yn darparu cyfleoedd i bobl sy'n gadael yr ysgol a graddedigion yng Nghymru, yn gwella symudedd cymdeithasol, ac yn helpu i ddatblygu archwilwyr ar gyfer y dyfodol a rheolwyr ariannol y dyfodol ar gyfer y sector cyhoeddus yng Nghymru. Mae llawer o'r bobl rydyn ni wedi'u hyfforddi wedi symud yn llwyddiannus i swyddi cyllid mewn cyrff cyhoeddus eraill yng Nghymru.

Mewnoli gwaith archwilio: Ers 2021–22, rydym wedi rhoi'r gorau i ddefnyddio cwmnïau'r sector preifat ar gyfer cyflawni archwiliadau. Mae hyn yn ein gwneud yn unigryw ymhlith cyrff archwilio cyhoeddus y DU ac wedi diogelu'r pwrs cyhoeddus yng Nghymru rhag y cynnydd sylweddol mewn prisiau a godir gan ddarparwyr preifat sydd wedi'u contractio i gyflawni gwaith yn y sector cyhoeddus mewn mannau eraill o'r DU.

Lleihau costau teithio: Rydym wedi torri gwariant teithio o £1.2 miliwn yn 2019-20 i ychydig dros £200,000 yn ein Amcangyfrif sydd i ddod. Cyflawnwyd hyn drwy newid sylweddol yn nhermau ac amodau staff Archwilio Cymru a thrwy newid sut rydym yn gweithio i leihau teithio, gan sicrhau buddion amgylcheddol a chostau.

Swyddfeydd llai, mwy effeithlon: Rydym wedi symud i swyddfeydd llai, rhatach a mwy ynni-effeithlon ledled Cymru, gan arbed tua £250,000 bob blwyddyn er gwaethaf costau cyfleustodau cynyddol.

Herio cyllidebau nad ydynt yn dâl: Yn fwy cyffredinol, rydym yn adolygu ein model gweithredu a'n cyllidebau nad ydynt yn dâl yn barhaus i nodi a chyflawni effeithlonrwydd lle bynnag y bo modd.

Buddsoddi mewn technoleg

Mae buddsoddi mewn technoleg yn ganolog i wella ansawdd ac effeithlonrwydd archwilio, gyda dadansoddeg data yn chwarae rôl gynyddol bwysig. Fodd bynnag, mae ansawdd data anghyson ar draws cyrff cyhoeddus yn parhau i fod yn her - un yr ydym yn gweithio i fynd i'r afael â hi mewn cydweithrediad â chyrff archwilio eraill ledled y DU a Gweriniaeth Iwerddon. Mae peilot AI diweddar wedi cyflawni canlyniadau addawol, er ein bod yn cymryd ymagwedd ofalus at ddatblygu, gan ystyried y risgiau sy'n gysylltiedig â mabwysiadu AI. Yn y tymor byrrach, ein ffocws yw cyflawni canlyniadau o ansawdd gwell trwy welliannau wedi'u targedu; Yn y tymor hwy, rydym yn anelu at ymgorffori effeithlonrwydd cynaliadwy yn ein gwaith trwy ddefnydd doethach o offer digidol.

Unwaith eto, fodd bynnag, mae ein gallu i gymhwyso potensial technoleg i'n gwaith yn dibynnu ar barodrwydd ein cyrff archwilio. Mae llawer o gyrff archwilio yn gweithredu systemau gwybodaeth ariannol a rheoli sydd wedi dyddio, sy'n golygu y bydd manteision technoleg newydd ar ein rhan yn anodd eu cyflawni. Er fy mod yn gwerthfawrogi'r pwysau ariannol y mae cyrff cyhoeddus yn eu hwynebu, rwy'n gobeithio'n fawr y bydd buddsoddiad mewn seilwaith o'r fath yn cael ei flaenoriaethu. Byddai proses archwilio fwy effeithlon yn un budd bach, ond yn bwysicach o lawer, wrth gwrs, fyddai cryfhau llywodraethu sefydliadol a gwneud penderfyniadau gwybodus ar gyfer ein cyrff archwilio.

Chymesuredd

Cododd rhai cyrff llai bryderon yn ystod yr ymgynghoriad bod eu ffioedd archwilio yn ymddangos yn anghymesur â'u maint. Er fy mod yn deall ac yn cydymdeimlo â'r pryderon hyn, mae'n bwysig pwysleisio bod ein dull archwilio yn cael ei bennu gan safonau archwilio proffesiynol, nad ydynt yn caniatáu cymhwyso methodoleg wahanol ar gyfer sefydliadau llai.

Yn ymarferol, gall rhai cyrff llai hefyd gyflwyno cymhlethdodau a risgiau nad ydynt o reidrwydd yn cael eu hadlewyrchu gan eu maint, a gall y ffactorau hyn ddylanwadu ar gost cyflawni archwilio.

Rydym yn ymwybodol o wahanol fentrau - gan y Cyngor Adrodd Ariannol a gosodwyr safonau rhyngwladol - sy'n archwilio sut y gellir gwneud archwilio yn fwy cymesur. Rydym yn monitro ac yn ymgysylltu â'r datblygiadau hyn.

Gobeithio y bydd yr ymateb hwn yn helpu i egluro'r gwahanol faterion a godwyd yn ystod yr ymgynghoriad â ffioedd. Os oes gennych unrhyw gwestiynau pellach, mae croeso i chi gysylltu â fi neu Ann-Marie Harkin, Cyfarwyddwr Gweithredol Cyflenwi Archwilio.

Yn gywir

ADRIAN CROMPTON
Archwilydd Cyffredinol Cymru

Atodiad 1: cymharu ffioedd

Tabl 1: Cyfraddau ffioedd arfaethedig Archwilio Cymru 2026-27

Gradd	Cyfradd (£ yr awr) 2026-27	Cyfradd (£ yr awr) 2025-26
Cyfarwyddwr Archwilio	189	183
Rheolwr Archwilio	146	141
Arweinydd Archwilio	120	115
Uwch-archwilydd	96	91
Archwilydd	66	66
Hyfforddai graddedig	63	59
Prentis	50	47

Ffynhonnell: Ymgynghoriad ar Raddfeydd Ffioedd 2026-27

Tabl 2: Cerdyn cyfradd PSAA ar gyfer archwiliadau 2024-25

Grade of Staff	Hourly Rate
Partner/Director	£428
Senior Manager/Manager	£236
Senior Auditor	£153
Other Staff	£117

Ffynhonnell: Cerdyn ardrethi - PSAA

Noder

Mae Public Sector Audit Appointments Ltd (PSAA) yn gwmni annibynnol, nid-er-elw a sefydlwyd gan y Gymdeithas Llywodraeth Leol (LGA) yn Lloegr. Un o'i brif rolau yw gosod ffioedd archwilio ar gyfer cyrff llywodraeth leol yn Lloegr. Adroddodd PSAA fod tua 98% o gyrff llywodraeth leol cymwys wedi optio i mewn i'w gynllun ffioedd.

4

11:10, 0 Mins

4 - NWSSP – Audit and Assurance Services - Internal Audit

4.1

11:10, 10 Mins

4.1 - Internal Audit Plan Progress Report

James Johns (NWSSP - Internal Audit)

For assurance

Attachments

4.1 SBAR IA Plan Progress Report December 2025.pdf

4.1 IA Plan Progress Report December 2025.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	09 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Audit & Assurance Services Progress Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Head of Internal Audit
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Internal Audit

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

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 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.
The Audit & Risk Assurance Committee is asked to approve the updates to the plan.

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

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Internal Audit Plan & Charter. Individual Internal Audit reports. Evidence gathered from the Health Board as part of the delivery of audit assignments. Health Board Risks.
Rhestr Termau: Glossary of Terms:	Contained within the reports.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Director of Corporate Governance Executive Directors and Senior Managers relevant to the individual audits.

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

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

Hywel Dda University Health Board

Audit & Risk Assurance Committee

December 2025

Audit & Assurance Services
Internal Audit Progress Report

CONTENTS

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
Medical Devices	 Substantial

3. Planning and Delivery Update

3.1 The assignment status schedule for the 2025/26 plan is set out at Appendix A. The schedule includes at this stage an initial timeline for audit assignments as we look to use a flexible approach with our delivery through the year in order to ensure effective management of the available resources.

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

Audit	Current status	Current Position/ comments	ARAC
Vaccinations and Immunisations	Initial draft	Issues with engagement during the audit and the subsequent provision of further information following the initial feedback of findings, which has resulted in significant additional audit work being required.	Feb
Operational Governance	WIP	A knock-on effect of the additional work required on the above review together with the delays in being provided with all required documentation.	Feb

Level 3 & 4 Directorates	Initial draft	Some delays in receipt of required documentation, together with the audit field work taking longer than planned.	Feb
Managed Practices	Fieldwork complete	Audit field work taking longer than planned.	Feb
Cyber	Fieldwork complete	A delay in the start of audit fieldwork was requested by the UHB.	Feb

3.3 As a result of ongoing planning discussions with the Health Board, including with the Director of Corporate Governance and ARAC Chair, it has been requested that the audits of Health & Safety and Complaints are deferred.

It has also been requested that follow up audits covering sickness management (from both previous audits), Human Tissue Act and ED data validation are added to the current year plan.

The Committee is asked to approve the amendments to the plan.

3.4 Further discussions are ongoing in relation to some additional audits that may be required to be undertaking in the current year. Further details will be brough to the committee once the requirements are finalised. In addition, the planned capital project audit work is being reviewed due to position with the progression of relevant business cases

3.5 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 have been observed, along with attendance at Healthcare Regulators Summit. Ongoing liaison with Audit Wales and Health Inspectorate Wales has 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				
Operational Governance Arrangements	Q2/3	Dec	Chief Operating Officer	WIP			
Level Three / Four Directorates	Q2/3	Dec	Chief Operating Officer	WIP			
Nursing Management	Q1/2	Aug	Nursing, Quality Safety & Experience	FINAL	Limited	1	2
Estates/Facilities - Cleaning Standards	Q3/4	May	Allied Health Professionals & Health Science	planning			
Medical Workforce Stabilisation	Q3/4	April	Medical				
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	planning			
Decision making for high cost drugs	Q2/3	Feb	Finance	planning			

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	Initial draft			
Patient Experience	Q3/4	Dec	Nursing, Quality Safety & Experience	Initial draft			
Infection Prevention & Control	Q3/4	Apr/may	Nursing, Quality Safety & Experience	planning			
Complaints	Q3	Apr	Nursing, Quality Safety & Experience	HDUHB request to defer			
Health & Safety	Q3/4	Feb	Allied Health Professionals & Health Science	HDUHB request to defer			
Theatre Stock System Implementation	Q3	Feb	Chief Operating Officer				
Human Tissue Authority	Q2	Oct	Allied Health Professionals & Health Science	FINAL	Limited	2	4
IRMER	Q3/4	Apr/may	Allied Health Professionals & Health Science	planning			
Medical Devices Regulations	**Q2/3**	**Dec**	**Chief Operating Officer**	**Final**	**Substantial**		**1**

Escalation Governance	Q3/4	Feb	Corporate Governance /CEO	planning			
Managed Practices	Q1/2	Dec	Chief Operating Officer	Fieldwork complete			
Follow up and agreed Action Implementation Tracking -			Corporate Governance	wip			
Cyber Security	Q2/3	Dec	Finance	wip			
Departmental / Local IT systems management	Q3	Feb	Finance				
Estates Assurance - Space Utilisation	Q2/3	Feb	Strategy & Planning				
Major Infrastructure Investment Plan (MIIP)	Q3/4	April	Strategy & Planning				
Control of Contractors	Q1/2	Oct	Chief Operating Officer	Final	Advisory	-	-
Capital Governance	Q1	Oct		Final	Advisory	-	-
Integrated Audit & Assurance Plans (SSU)– Withybush General Hospital Fire – Phase 2; and Glangwili General Hospital Fire – Phase 2	IAAPs		Strategy & Planning				

Office details: Audit & Assurance Services West Team

Contact details: james.johns@wales.nhs.uk
Webpage: Audit & Assurance Services - NHS Wales Shared Services Partnership

4.2

11:20, 10 Mins

4.2 - Medical Devices Regulations (Substantial Assurance)

James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Gareth Rees (Hywel Dda UHB - Operations Directorate), Jan Bojanowski (Hywel Dda UHB - Head of Clinical Engineering)

For assurance

Attachments

4.2 Medical Devices Regulations Final IA Report.pdf

Medical Devices Regulations

Final Internal Audit Report

2025/26

Hywel Dda University Health Board

Substantial Assurance

Contents

Review Reference	HDU-2526-23
Fieldwork	September – November 2025
Executive Sign Off	01/12/25
Audit Committee	December 2025
Executive Lead	Andrew Carruthers, Chief Operating Officer
Audit Team	James Johns, Head of Internal Audit
	Sophie Corbett, Deputy Head of Internal Audit

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

The objective of this audit is to provide assurance that effective governance, operational controls, and monitoring arrangements are in place to ensure compliance with the UK Medical Devices Regulations 2002 and the MHRA[1] Managing Medical Devices guidance in relation to the management of reusable medical devices.

Overview

The Health Board has in place appropriate governance arrangements for medical devices that is underpinned by policies and procedures, a centralised asset management system for the recording and monitoring of devices, distribution and communication channels for safety notices and alerts, appropriately trained staff and the monitoring and the scrutiny of incidents reported on the Datix system.

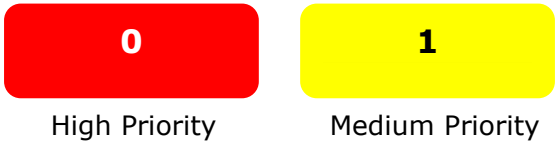
One matter requiring management attention surrounded the expired training of employees for one manufacturer for devices that have not changed since the received training to ensure the Health Board is not impacted from a legal and patient safety aspect by this situation.

We have concluded **Substantial** assurance on this area. Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives[2]		Related Findings	Assurance
1	Appropriate governance arrangements are in place for the management of medical devices.	-	**Substantial**
2	A comprehensive inventory listing of medical devices is maintained. Devices are properly maintained, kept in an appropriate state of repair and decontaminated.	-	**Substantial**
3	Training programmes ensure that staff are trained and competent in the use of medical devices.	1	**Reasonable**
4	Device faults, alerts or warning notices issued by appropriate agencies are promptly addressed and reported. Incidents relating to medical devices are reported via Datix and escalated where appropriate.	-	**Substantial**

Management Actions



Themes

Risk Types

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

1 Medicines and Healthcare Products Regulatory Agency

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

Findings & Agreed Action Plan

Objective 1: Appropriate governance arrangements are in place for the management of medical devices	**Substantial**

Overview / Summary of Observations

The Health Board's Scheme of Delegation formally outlines the strategic and operational governance responsibilities for medical devices to the Director of Allied Health Professions & Health Science and Chief Operating Officer respectively.

A Medical Devices Group has been established with a terms of reference (ToR) in place outlining key elements including duties, operational responsibilities, membership, frequency of meetings and reporting arrangements. The Head of Clinical Engineering and Deputy Director of Health Care Sciences are the Chair and Vice Chair respectively.

The reporting arrangements in the ToR was recently updated and submitted to the Medical Devices Group in October 2025 following the changes made to the operational governance arrangements within Hywel Dda, with the updated ToR to be submitted for ratification and approval at the next Quality Safety Intelligence Group (QSIG) meeting.

A *Medical Devices Management Policy* is in place, and available to staff on the organisation's intranet site, that sets out the Health Board's approach and commitment to achieving a safe and assured system for medical devices management. A review of the *Medical Devices Management Policy* confirmed its alignment and completeness against the MHRA *Managing Medical Devices Guidance* document and other NHS Wales organisation policies. In addition, a 'Strategic Medical Devices Replacement' paper outlining current status, recent investments and future planning for medical devices across the Hywel Dda University Health Board was submitted to the Capital Sub-Committee in July 2025

A review of the governance reporting arrangements during 2025 confirmed the Medical Devices Group reports through to the Health Board via QSIG. Prior to the changes in the governance reporting structure, we can also confirm that the Medical Devices Group reported through to the Quality, Safety & Experience Sub-Committee (QSESC) and Committee (QSEC).

Objective 2: A comprehensive inventory listing of medical devices is maintained. Devices are properly maintained, kept in an appropriate state of repair and decontaminated	**Substantial**

Overview / Summary of Observations

The Clinical Engineering Department has a centralised asset management system (e-Quip) in place that maintains an inventory record of medical devices received into the organisation. A review of the e-Quip system confirmed that content of the system aligned with the requirements of the MHRA.

A sample of 20 medical devices categorised as 'in use' was reviewed on the e-Quip system and confirmed that required risk assessments (known as Acceptance Testing) had been completed before first use, whilst other key documentation such as delivery notes and service history was also evident.

In September 2025, the British Standards Institute (BSI) undertook an audit to determine the effectiveness of implementation of the of the Clinical Engineering Department management system including a review of decontamination compliance. The observed compliance and consistency in the booking-in, checking and completion of paperwork for medical devices requiring decontamination.

Objective 3: Training programmes ensure that staff are trained and competent in the use of medical devices	**Reasonable**

Overview / Summary of Observations

The Health Board has a *Medical Devices Training, Safe Use & Operation Procedure* in place that was approved by the Medical Devices Group in February 2025 and aligns with MHRA guidance. The procedure is available to employees on the organisation's intranet site.

The BSI audit undertaken in September 2025 also reviewed training record compliance. The report confirmed training records and certificates were compliant and up to date.

A sample of employees training records tested during this internal audit review corroborated the findings in the BSI report. Employees are issued a certificate from the manufacturers per medical device following training, in addition to online secure portables on the manufacturers website that contains testing procedures and updates or safety notices on the medical devices.

We noted that for one medical device manufacturer an expiry date is included on their training certificates. Of the sampled certificates reviewed, two employees had certificates that expired in 2023 with no subsequent refresher training having taken place. This finding was raised with the Head of Clinical Engineering who explained that this represented a low risk as the individual employees would have received the appropriate training with notices of any changes or defects to the medical device received via the manufacturers secure online portal. The Health Board should risk assess this finding to ensure that this does not impact the organisation.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Expired Training** Of the sampled certificates reviewed, two employees had certificates that expired in 2023 with no subsequent refresher training having taken place. This finding was raised with the Head of Clinical Engineering who explained that this represented a low risk as the individual employees would have received the appropriate training with notices of any changes or defects to the medical device received via the manufacturers secure online portal. The Health Board should risk assess this finding to ensure that this does not impact the organisation.	The Health Board is exposed to legal and patient safety risks due to expired training of medical devices of staff	**Agreed Action:** The Staff Training Policy (GQP 005) will be updated to reflect the validity of external medical device training certificates, following an expiration date, currently outlined in the training matrix. The only company that provide certificates with an expiry date is Dreager, they have confirmed that refresher training is only advised but this is at the discretion of the Health Board. Their online portal only allows access to the latest documents, and so any changes will be evident from the outset and technicians will be aware and can seek support if needed. Using the online portal will be written into the policy for these devices and mitigates the risk. **Expected Evidence of Implementation:** 1) Updated Staff Training Policy 2) Evidence to show access to the portal is available to all trained technicians
		Medium Priority	**Officer:** Jan Bojanowski, Head of Clinical Engineering **Target Implementation Date:** 28 November 2025
	Theme: Training & Development	Control Operation	

Objective 4: Device faults, alerts or warning notices issued by appropriate agencies are promptly addressed and reported. Incidents relating to medical devices are reported via Datix and escalated where appropriate	**Substantial**

Overview / Summary of Observations

The Health Board has in place an *Incident, Near Miss and Hazard Reporting Management Procedure* to ensure that all staff can identify incidents, take appropriate actions and reduce risks to service users and employees. The procedure document also outlines the Head of Clinical Engineering as the Health Board's Medical Devices Safety Officer (MDSO) in line with MHRA requirements.

Arrangements to distribute medical devices safety information to appropriate Clinical Engineering individuals was evident through direct manufacturer notifications, MHRA alerts and safety notices communicated via the ECRI[3] system. We also noted that medical devices regulation updates and changes were submitted and discussed at the Medical Devices Group meeting during 2025.

Incidents and never events involving medical devices for the period January to October 2025 identified only five entries. Of the two incidents that were closed, a review of the Datix confirm their entries as complete, whilst three were currently under 'management review'. MHRA guidance states that any incident deemed serious must be reported, with defined criteria outlined for what constitutes a 'serious incident'. A review of the five incidents confirmed that none were reported to the MHRA, as they were correctly assessed as not meeting the criteria for seriousness threshold.

A review of the Medical Devices Group for the period January to October 2025 also confirmed that medical devices incidents are regularly reported for discussion.

[3] Emergency Care Research Institute

Appendix A

Assurance Opinion

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

Prioritisation of Findings

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

Disclaimer

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

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

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

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.

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

4.3

11:30, 0 Mins

4.3 - Vaccination and Immunisation

James Johns (NWSSP - Internal Audit), Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health)

DEFERRED to 10 February 2026 meeting

For assurance

4.4 **11:30, 0 Mins**

4.4 - Operational Governance Arrangements

James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

DEFERRED to 10 February 2026 meeting

For assurance

4.5

11:30, 0 Mins

4.5 - Managed Practices

James Johns (NWSSP - Internal Audit), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

DEFERRED to 10 February 2026 meeting

For assurance

4.6

11:30, 0 Mins

4.6 - Level 3 and 4 Directorates

James Johns (NWSSP - Internal Audit), Huw Thomas (Hywel Dda UHB - Director of Finance)

DEFERRED to 10 February 2026 meeting

For assurance

5

11:30, 0 Mins

5 - Financial Focus

5.1

11:30, 10 Mins

5.1 - Financial Assurance Report

Huw Thomas (Hywel Dda UHB - Director of Finance)

For assurance

Attachments

5.1 SBAR Financial Assurance Report ARAC December 2025.pdf

5.1 Financial Assurance Report ARAC December 2025.pdf

5.1 Appendices 1-3 - Financial Assurance Report ARAC December 2025.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	09 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Financial Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Tim John, Head of Accounting and Statutory Reporting

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

The Standing Orders require that ARAC provides assurance to the Board that the University Health Board's assurance processes are operating effectively. Critical to this is Financial Assurance, which cannot be measured only by the UHB's main finance report and requires further information in order to assess the control environment in place; the risk assessment and management process; and the control activities.

Asesiad / Assessment

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

Alert: No issues to report

Advise:

a) The Committee is advised of the breaches of Standing Financial Instructions (SFIs), in respect of retrospective purchase orders, which are reported in Appendix 1b. Where these breaches occur, they are reviewed by local NWSSP Procurement for appropriate re-education and the relevant director is informed.

b) While the level of staff overpayments increased, the average recovery period has decreased from 6 to 5 months. The target is to have no overpayments; however, the total overpaid during September and October 2025 represents 0.23% of the average monthly net pay costs (July and August 2025 – 0.24%).

c) There were two individual losses exceeding £5,000 in September and October 2025; one in respect of a bad debt write off (£27k) and another in respect of drugs wastage (£8k). In addition, there were losses and write offs less than £5,000 in the period totalling £41,452, a small decrease on the previous two month period.

d) Compliance with Reporting requirements – Non-material accounting issue. Investigation of the Health Board's pharmacy system, WellSky, identified that costs totalling £6.134m, associated with the Aseptics module, had been overstated during the period January 2023 to March 2025. Audit Wales are aware of the issue, corrective measures have been processed, a root and branch review is being undertaken and it is proposed that Internal Audit is requested to independently assess our work and emerging proposals.

Assure:

a) Purchase To Pay (P2P)

i. No PO, No Pay. The Health Board actively enforces the No PO, No Pay policy and whilst there have been zero invoices paid without a purchase order, preventative control checks are in place to ensure that proactive management minimises the potential for non-compliance in the future and any delays for vendor payment. This preventative control is called invoices on hold (IOH).

ii. Public Sector Payment Policy (PSPP) compliance remains on target for delivery for the year – the target is to pay 95% of all non-NHS invoices within 30 days. Budget holders are continually pursued to authorise invoices promptly, as e-mail requests from NWSSP Accounts Payable are often ignored.

Currently, training is provided to areas where there are frequently high numbers of failures. This is in addition to contacting suppliers with invoices on hold without a PO and/or contacting the service users to raise a PO if required. To further improve compliance across all aspects of the P2P process, a Task and Finish group is being established between the Core Accounting Team, the local Procurement team and NWSSP Accounts Payable to review and triangulate a cohesive approach.

b) Single Tender Actions (STAs) and contracts awarded are carefully controlled. No STAs have been made since March 2024.

c) Compliance with employment taxes – internal discussions ongoing to ensure compliance with National Minimum Wage (NMW) regulations.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is asked to**:**

- **SCRUTINISE** the award of contracts listed in Appendix 1a
- **DISCUSS** the breaches of Standing Financial Instructions (SFIs) as detailed in Appendix 1b
- **DISCUSS** the staff overpayments as detailed in Appendix 2 and seek assurance that actions to control them are sufficiently embedded
- **DISCUSS** losses as detailed in Appendix 3 and **APPROVE** losses in excess of £5,000
- **DISCUSS** the WellSky accounting issue and **TAKE ASSURANCE** that the implemented corrective actions will eliminate the risk of recurrence
- **TAKE ASSURANCE** from the actions taken to:
  a) Improve Purchase To Pay (P2P) compliance
  b) Manage Single Tender Actions (STAs)
  c) Ensure National Minimum Wage (NMW) compliance

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.4 The Committee's principal duties encompass the following: 2.4.2 Seek assurance that the systems for financial reporting to Board, including those of budgetary control, are effective, and that financial systems processes and controls are operating. 3.10 The Committee will be responsible for reviewing the UHB's Standing Orders and Standing Financial Instructions and Scheme of Delegation annually, (including associated framework documents as appropriate), monitoring compliance, and reporting any proposed changes to the Board for consideration and approval. 3.13 Approve the writing-off of losses or the making of special payments within delegated limits. 3.15 Receive a report on all Single Tender Actions and extensions of contracts.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	BAF SO9-PR20 BAF SO10-PR33
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	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:	Monitoring returns to Welsh Government based on the Health Board's financial reporting system. Activity recorded in the AR and AP modules of the Oracle business system and activity recorded in the procurement Bravo system.

Rhestr Termau: Glossary of Terms:	AP - Accounts Payable AR – Accounts Receivable BGH – Bronglais General Hospital CAT – Core Accounting Team CF – Counter Fraud COS – Contracted Out Service VAT EOY – End of Year ERs NI – Employers National Insurance GGH – Glangwili General Hospital HMRC – His Majesty's Revenue and Customs IFRS – International Financial Reporting Standards NWSSP – NHS Wales Shared Services Partnership PID – Patient Identifiable Data PO – Purchase Order POL – Probability of Loss PPH – Prince Philip Hospital PSPP – Public Sector Payment Policy SFI – Standing Financial Instructions SLA – Service Level Agreement STA – Single Tender Action VAT – Value Added Tax WGH – Withybush General Hospital WRP – Welsh Risk Pool
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	UHB's Finance Team UHB's Management Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Financial implications are inherent within the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	Risk to our financial position affects our ability to discharge timely and effective care to patients.
Gweithlu: Workforce:	Overpayments are reported within this report.
Risg: Risk:	Financial risks are detailed in the report.
Cyfreithiol: Legal:	The UHB has a legal duty to deliver a breakeven financial position over a rolling three-year basis and an administrative requirement to operate within its budget within any given financial year.
Enw Da: Reputational:	Adverse variance against the UHB's financial plan will affect our reputation with Welsh Government, Audit Wales and with external stakeholders.
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

5.1 Financial Assurance Report for the period 1 September to 31 October 2025 Audit and Risk Assurance Committee

9 December 2025

Compliance requirements for ARAC - Overview

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

2a. Compliance with Purchase to Pay requirements

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

IOH

September and October 2025
No. 243; Value £977k

July and August 2025
No. 150; Value £654k

Cumulative to end October 2025
No. 127; Value £282k

Cumulative to end of August 2025
No. 99; Value £498k

PSPP

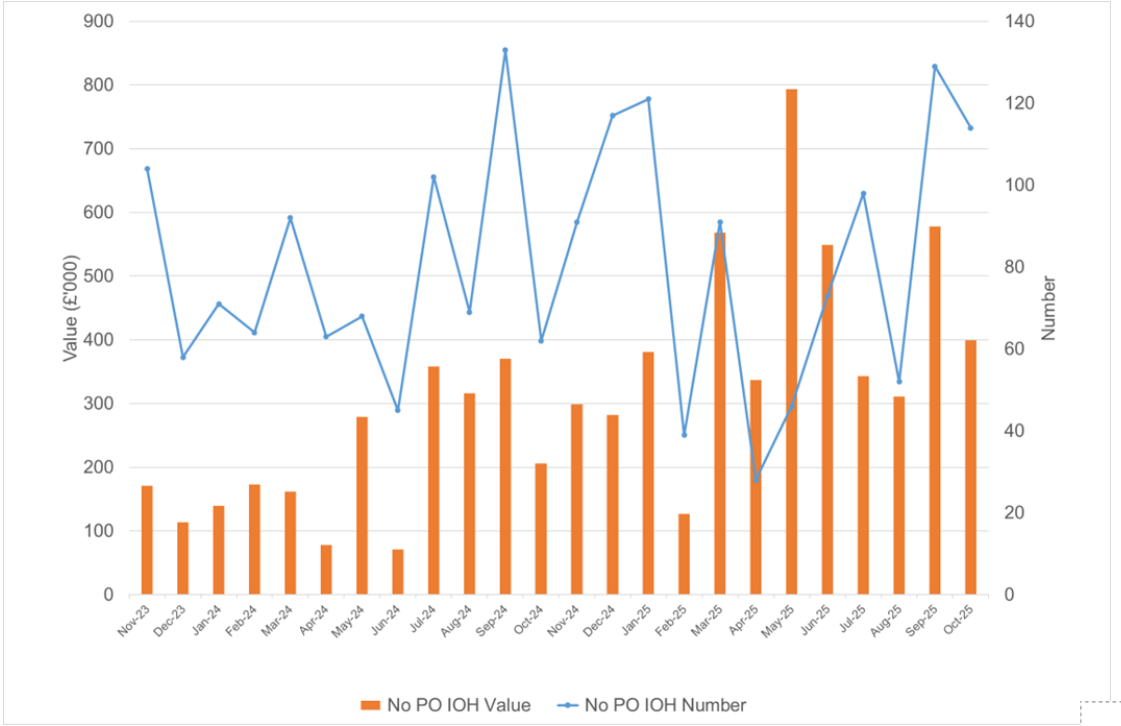
Non – NHS (statutory target > 95%)
September 2025 – 95.4%
October 2025 – 96.1%

Cumulative to 31 Oct 2025
96.4%

NHS (no statutory target)
September 2025 – 80.5%
October 2025 – 93.3%

Cumulative to 31 Oct 2025
86.1%

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



Reducing invoices on hold

Supplier and Health Board Non-Compliance exceeding £50,000	No. of invoices	Value £
Suppliers		
Ceredigion County Council	11	207,565
Royal Mail Group PLC	12	64,096
Clinical Care Groups/Executive function		
Community and Integrated Medicine	25	200,416
Capital Expenditure	3	177,961
MH & LD	19	97,616
Operational Allied Health and Health Services	12	76,130
Chief Operating Officer Management	7	65,497
Planned and Specialist Care	21	52,500

Improvements

A joint improvement plan with immediate effect between Finance, Local Procurement and Accounts Payable to decisively reduce non-compliance with P2P

2b. Compliance with Purchase to Pay requirements

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

STA

September and October 2025
No. 0; Value £0

July and August 2025
No. 0; Value £0

Tenders Awarded (>£25k)

September and October 2025
No. 29; Value £9,784,834

July and August 2025
No. 8; Value £1,349,630

Consultancy

September and October 2025
No. 0; Value £0

July and August 2025
Number = 0; Value = £0

Top 5 Tenders Awarded (>£25k)

Supplier	Description	Value £	Department
TR Jones Limited	Fire Upgrade Works at WGH	2,717,804	Estates
Circle Healthcare Group (BMI Werndale Hospital)	Outsourcing of T&O Procedures	797,262	Planned Care
Multitone Electronics Plc	Critical Paging System Replacement	580,882	Digital
Mind	Individual Placement Support	500,000	MH & LD
New Medical Systems Limited (trading as Newmedica)	Outsourcing VR & Ocular Plastics	485,861	Planned Care
Total		**5,081,809**	

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

Contracts Awarded*	Number	Value £	Details
Post competitive tender	24	9,099,218	**Appendix 1a**
Direct awards via Framework agreement	4	506,846	**Appendix 1a**
VEAT	1	178,770	**Appendix 1a**
Total*	**29**	**9,784,834**	
Consultancy Contracts	**-**	**-**	**-**
Breaches of SFIs	**3**	**40,097**	**Appendix 1b**
Contract Awards reported retrospectively	**2**	**604,640**	**Appendix 1a**

*** Includes contract awards reported retrospectively**

3. Compliance with Income to Cash

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Salary Overpayments

September and October 2025 No. 43; Value £75,974 (Appendix 2)

July and August 2025 No. 36; Value £100,039

Debt balance at 31 October 2025: £316k; average recovery period of 5 months

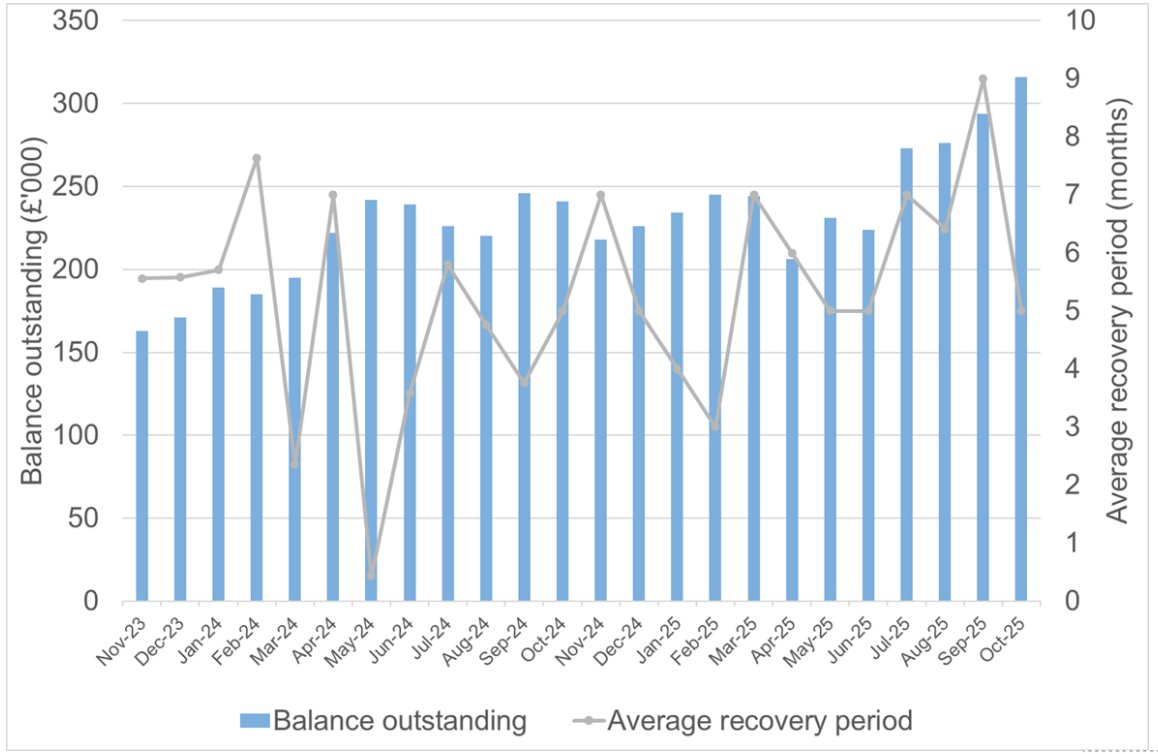
31 August: £276k; average recovery period of 6 months

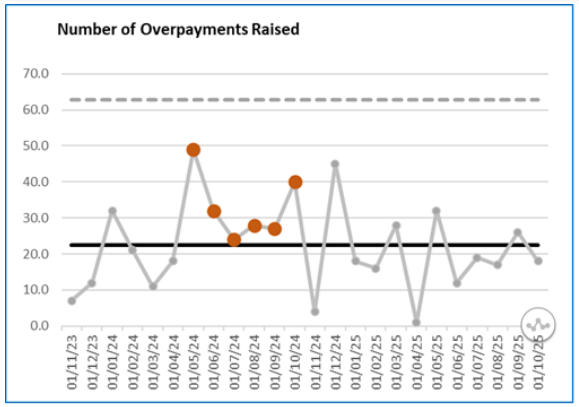
	October	August
Avge no of invoices raised	**22**	22
Avge value	**£33k**	£32k
Avge no paid	**18**	18
Avge value	**£30k**	£29k

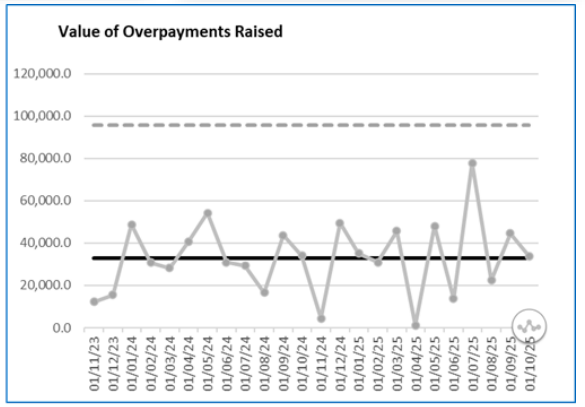
Underpayments September and October 2025 - £12,546

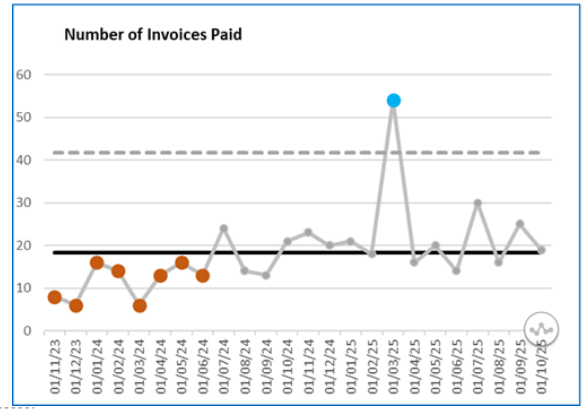
July and August 2025 - £24,467

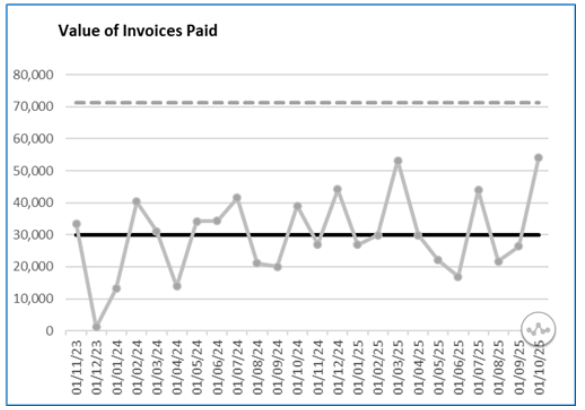
Trend of aged overpayments and recoveries











4. Losses and Special Payments

Losses £5k and over requiring ARAC Approval	**September and October 2025 £35,480** *July and August 2025 £Nil*	**Losses under £5k approved by DoF and CEO**	**September and October 2025 £41,452 (Appendix 3)** *July and August 2025 £46,131*

Losses – Requiring Approval from ARAC	**£**
1. Nurokor Limited – write off Tritech R&D income following company liquidation (previously provided for as bad debt)	27,272
2. Pharmacy wastage – drugs (cold chain failure)	8,208
All Other Losses	
Ex gratia	350
Overpayments of salaries, salary sacrifice, accommodation, Wagestream, private patient income etc	2,440
4b Other causes* - expired stock, wastage, breakages	38,662
Total Losses	**76,932**

*** 4b Other causes**

In accordance with the Health Board's Losses and Special Payments Procedure (Procedure number: 066) category 4b is defined as:
4) Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to:
a. culpable causes e.g. theft, fraud, arson or sabotage whether proved or suspected, neglect of duty or gross carelessness
b. other causes

5. Other Areas

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Compliance with Capital Requirements

Project Bank Account (PBA)

The business case for the Withybush Fire Upgrade Phase 2 project has now been approved by WG and the construction contract for this project meets the criteria mandating use of a PBA. The contractor for the scheme is aware of the requirement and nominated a preferred banking provider, which was confirmed by WG as a compliant banking provider. Construction is due to start in January 2026, and the finance team is monitoring progress in setting up the bank account.

Compliance with Tax Requirements

Compliance with VAT Requirements

No updates or issues to report

Compliance with Employment Tax Requirements

Internal discussions between Finance and Workforce colleagues are ongoing in respect of NMW compliance and further updates will be provided as appropriate.

Compliance with Reporting requirements: Non-material accounting issue - WellSky

Investigation of the Health Board's pharmacy system, WellSky, identified that some transactions associated with the Aseptics module within WellSky had not been accounted for correctly. This has led to a total non-material overstatement of costs (£6.134m) in the Health Board's position from the introduction of the Aseptics module in January 2023 to 31 March 2025. The appropriate accounting amendments were made in Month 7 to rectify the £6.134m overstatement of historic costs and Audit Wales have been made aware of the issue. A Task and Finish Group has been established with members of the Finance and Pharmacy teams to undertake a root and branch review of the WellSky system and it is proposed that Internal Audit is requested to independently assess our work and emerging proposals. Further updates will be provided in due course.

5.1 Financial Assurance Report for the period 1 September to 31 October 2025
Audit and Risk Assurance Committee

9 December 2025

Appendices

Appendix 1a: Contracts awarded

Contracts Awarded Post Competitive Tender:

P Reference & Title	P0248 – Major Capital Construction Scheme for Fire Upgrade Works at WGH
Supplier	TR Jones Limited
Contract Period	17/11/2025 to 16/11/2027
Value	£2,717,804.17
Department	Estates
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	July 2025
Compliant	Y
Comment	Following a competitive tender, TR Jones Limited were awarded a 24 month contract for a Major Capital Construction Scheme for Fire Upgrade Works at WGH. This contract award does not allow for an extension.

P Reference & Title	P0308 – Outsourcing of T&O Procedures
Supplier	Circle Healthcare Group (BMI Werndale Hospital)
Contract Period	01/10/2025 to 31/03/2027
Value	£797,262.50
Department	Planned Care
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Following a competitive tender, Circle Healthcare Group (BMI Werndale Hospital) were awarded an 18 month contract for Outsourcing of T&O Procedures. This contract award does not allow for an extension.

P Reference & Title	P0110 – Critical Paging System Replacement
Supplier	Multitone Electronics Plc
Contract Period	01/12/2025 to 30/11/2028
Value	£580,882.00
Department	Digital
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Following a competitive tender, Multitone Electronics Plc were awarded a 36 month contract for a Critical Paging System Replacement. An option to extend the contract for a further 24 months is included in the award.

P Reference & Title	P0391 – Outsourcing VR & Oclar Plastics
Supplier	New Medical Systems Limited (trading as Newmedica)
Contract Period	01/10/2025 to 31/03/2027
Value	£485,861.62
Department	Planned Care
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Following a competitive tender, New Medical Systems Limited (trading as Newmedica) were awarded an 18 month contract for Outsourcing VR & Oclar Plastics. This contract award does not allow for an extension.

P Reference & Title	P0013 – Day Opportunities Services
Suppliers	Adferiad, Arts Care Gofal Celf, Clynfyw CIC, HUTS, Mind & POBL
Contract Period	01/07/2026 to 30/06/2027
Value	£476,273.62
Department	Mental Health and Learning Disabilities (MHLD)
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Extensions to a competitive tender have been awarded to Adferiad, Arts Care Gofal Celf, Clynfyw CIC, HUTS, Mind & POBL for 12 months. The contracts are for Day Opportunities Services. The contract awards do not allow for further extension periods.

P Reference & Title	P0012 – Community Wellbeing Service
Suppliers	Adferiad, Get the Boys a Lift, Men2Men, Mind & VC Gallery
Contract Period	01/07/2026 to 30/06/2027
Value	£406,676.46
Department	MHLD
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Extensions to a competitive tender have been awarded to Adferiad, Get the Boys a Lift, Men2Men, Mind & VC Gallery for 12 months. The contracts are for Community Wellbeing Service. The contract awards do not allow for further extension periods.

P Reference & Title	P0011 – Sanctuary Services
Supplier	Adferiad & Mind
Contract Period	01/07/2026 to 30/06/2027
Value	£374,972.86
Department	MHLD
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Extensions to a competitive tender have been awarded to Adferiad & Mind for 12 months. The contracts are for Sanctuary Services. The contract awards do not allow for further extension periods.

P Reference & Title	P0055A – Insourcing of Obstetric & Non-Obstetric Ultrasound Examinations
Supplier	Globe Locums Limited
Contract Period	01/12/2025 to 31/03/2026
Value	£360,898.10
Department	Radiology
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Following a competitive tender, Globe Locums Limited were awarded a 4 month contract for Insourcing of Obstetric & Non-Obstetric Ultrasound Examinations. An option to extend the contract for a further 12 months is included in the award.

P Reference & Title	P0097A – Office Furniture Renewal
Supplier	H Jenkinson & Company Limited
Contract Period	01/10/2025 to 30/09/2028
Value	£344,038.62
Department	Estates
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Following a competitive tender, H Jenkinson & Company Limited were awarded a 36 month contract for an Office Furniture Renewal. An option to extend the contract for a further 12 months is included in the award.

P Reference & Title	P0007 – Community Advocacy
Supplier	Advocacy West Wales
Contract Period	01/07/2026 to 30/06/2027
Value	£247,761.98
Department	MHLD
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	An extension to a competitive tender has been awarded to Advocacy West Wales for 12 months. The contract is for Community Advocacy. This contract award does not allow for a further extension period.

P Reference & Title	P0008 – Social Inclusion Service
Supplier	Adferiad, Age Cymru & Mind
Contract Period	01/07/2026 to 30/06/2027
Value	£246,305.87
Department	MHLD
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Extensions to a competitive tender have been awarded to Adferiad, Age Cymru & Mind for 12 months. The contracts are for Social Inclusion Services. The contract awards do not allow for further extension periods.

P Reference & Title	P0009 – Wellbeing Support Services
Supplier	West Wales Action for Mental Health
Contract Period	01/07/2026 to 30/06/2027
Value	£189,770.52
Department	MHLD
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	An extension to a competitive tender has been awarded to West Wales Action for Mental Health for 12 months. The contract is for Wellbeing Support Services. This contract award does not allow for a further extension period.

P Reference & Title	P0242A – Rubrik Licences Renewal Extension
Supplier	Insight Direct (UK) Ltd
Contract Period	01/10/2025 to 30/09/2026
Value	£180,585.30
Department	Digital
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	An extension to a competitive tender has been awarded to Insight Direct (UK) Ltd for 12 months. The contract is for a Rubrik Licences Renewal Extension. This contract award does not allow for a further extension period.

P Reference & Title	P0384 – Telehealth Monitoring of COPD/Asthma
Supplier	NuvoAir
Contract Period	01/11/2025 to 31/10/2027
Value	£165,000.00
Department	Community
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Following a competitive tender, NuvoAir were awarded a 24 month contract for Telehealth Monitoring of COPD/Asthma. An option to extend the contract for a further 12 months is included in the award.

P Reference & Title	P0010 – Core Counselling Services
Supplier	Carmarthenshire Counselling Service & Pembrokeshire Counselling Service
Contract Period	01/07/2026 to 30/06/2027
Value	£163,661.62
Department	MHLD
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Extensions to a competitive tender have been awarded to Carmarthenshire Counselling Service & Pembrokeshire Counselling Service for 12 months. The contracts are for Core Counselling Services. The contract awards do not allow for further extension periods.

P Reference & Title	P0005 – EMP & Training Support
Supplier	Links Mind
Contract Period	01/07/2026 to 30/06/2027
Value	£163,575.65
Department	MHLD
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	An extension to a competitive tender has been awarded to Mind Links for 12 months. The contract is for EMP & Training Support. This contract award does not allow for a further extension period.

P Reference & Title	P0006 – Learnings Disability Support Services (Early Intervention in Psychosis Service)
Supplier	Carmarthenshire People First & Pembrokeshire People First
Contract Period	01/07/2026 to 30/06/2027
Value	£159,128.14
Department	MHLD
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Extensions to a competitive tender have been awarded to Carmarthenshire People First & Pembrokeshire People First for 12 months. The contracts are for Learnings Disability Support Services (Early Intervention in Psychosis Service). The contract awards do not allow for further extension periods.

P Reference & Title	P0370 – Outsourcing MRI Scans (Prostate Pathway)
Supplier	Siarad Medical Services Limited & Circle Healthcare Group (BMI Werndale Hospital)
Contract Period	01/10/2025 to 31/03/2027
Value	£153,485.22
Department	Planned Care
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Following a competitive tender, Siarad Medical Services Limited & Circle Healthcare Group (BMI Werndale Hospital) were awarded an 18 month contract for Outsourcing MRI Scans (Prostate Pathway). Both contract awards do not allow for an extension.

P Reference & Title	P0004 – Perinatal Mental Health Support Services
Supplier	Mind
Contract Period	01/07/2026 to 30/06/2027
Value	£88,282.96
Department	MHLD
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	An extension to a competitive tender has been awarded to Mind for 12 months. The contract is for Perinatal Mental Health Support Services. This contract award does not allow for a further extension period.

P Reference & Title	P0345 – Medical Assessments Dols
Supplier	Liquid Personnel
Contract Period	01/12/2025 to 30/11/2027
Value	£67,500.00
Department	Primary Care
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Following a competitive tender, Liquid Personnel were awarded a 24 month contract for Medical Assessments Dols. An option to extend the contract for a further 12 months is included in the award.

P Reference & Title	P0062 – Advanced Care Planning (2T's) Cluster
Supplier	Marie Curie
Contract Period	01/10/2025 to 30/09/2026
Value	£64,500.00
Department	Primary Care
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	An extension to a competitive tender has been awarded to Marie Curie for 12 months. The contract is for Advanced Care Planning (2T's) Cluster. This contract award does not allow for a further extension period.

P Reference & Title	CAP25-02 – Pathology Autoclave
Supplier	BMM Weston
Contract Period	01/10/2025 to 31/03/2026
Value	£60,360.00
Department	Pathology
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	Following a competitive tender, BMM Weston were awarded a 6 month contract for a Pathology Autoclave. This contract award does not allow for an extension.

Direct awards via Framework Agreements:

P Reference & Title	P0373 – Lease Car Management
Supplier	Knowles Associates Total Fleet Management Limited
Framework Utilised	Crown Commercial Services (CCS) Vehicle Lease, Fleet Management and Salary Sacrifice Car Schemes Framework Agreement (RM6268)
Contract Period	01/10/2025 to 30/09/2027
Value	£248,342.68
Department	Finance / Transport
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	No
Compliant	Y
Comment	A direct award via CCS Vehicle Lease, Fleet Management and Salary Sacrifice Car Schemes Framework Agreement (RM6268) has been awarded to Knowles Associates Total Fleet Management Limited for Lease Car Management for 24 months. An option to extend the contract for a further 12 months is included in the award.

P Reference & Title	P0281A – Intouch System Renewal
Supplier	VitalHub UK Limited
Framework Utilised	NHS Shared Business Services (SBS) Audio Visual Solutions and Integrated Operating Theatres 2 Framework Agreement (SBS10245)
Contract Period	21/10/2025 to 21/10/2027
Value	£115,622.00
Department	Digital
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	No
Compliant	Y
Comment	A direct award via NHS SBS Audio Visual Solutions and Integrated Operating Theatres 2 Framework Agreement (SBS10245) has been awarded to VitalHub UK Limited for an Intouch System Renewal for 24 months. An option to extend the contract for a further 24 months is included in the award.

P Reference & Title	P0403 – Monitors and Peripherals (Picton Terrace)
Supplier	Dell Corporation Limited
Framework Utilised	NHS SBS Tech Devices – Link 4 Framework Agreement (SBS10515)
Contract Period	01/11/2025 to 31/10/2026
Value	£75,670.00
Department	Digital
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	No
Compliant	Y
Comment	A direct award via NHS SBS Tech Devices – Link 4 Framework Agreement (SBS10515) has been awarded to Dell Corporation Limited for Monitors and Peripherals (Picton Terrace) for 12 months. This contract award does not allow for an extension.

P Reference & Title	P0346 – Mobile Phones - Vodafone Sims
Supplier	Vodafone Limited
Framework Utilised	CCS Mobile Voice and Data Framework Agreement (RM6261)
Contract Period	01/08/2025 to 31/07/2028
Value	£67,212.00
Department	Digital
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	No
Compliant	Y
Comment	A direct award via CCS Mobile Voice and Data Framework Agreement (RM6261) has been awarded to Vodafone Limited for Mobile Phones - Vodafone Sims for 36 months. This contract award does not allow for an extension.

Direct awards via VEAT/Transparency Process:

P Reference & Title	P0323 – Finance Close System
Supplier	Blackline Systems Inc
Contract Period	15/10/2025 to 14/10/2028
Value	£178,770.00
Department	Finance
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	No
Compliant	Y
Comment	A Transparency Notice was issued to confirm that Blackline Systems Inc were awarded a 36 month contract for a Finance Close System. The contract award does not allow for an extension.

Awards reported retrospectively:

P Reference & Title	P0081A – Individual Placement Support
Supplier	**Mind**
Contract Period	01/04/2025 to 31/03/2026
Value	£500,000.00
Department	Mental Health and Learning Disabilities (MHLD)
Procurement Process	Transparency Notice
Professional Services (Yes/No)	No
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	In the month of May 2025, a contract was awarded to Mind for a term of 12 months, for Individual Placement Support. This contract does not allow for an extension. The procurement process utilised was a Transparency Notice.

P Reference & Title	P0423 – VAT Re-Review Services
Supplier	KPMG LLP
Contract Period	14/07/2025 to 31/12/2025
Value	£104,640.27
Department	Finance
Procurement Process	Direct Award via the CCS Provision of Tax Advisory Services Framework Agreement (RM6187)
Professional Services (Yes/No)	Yes
Date of Board Approval (If Applicable)	N/A
Compliant	Y
Comment	In the month of July 2025, a contract was awarded to KPMG LLP for a term of 6 months, for VAT Re-Review Services. This contract does not allow for an extension. The procurement process utilised was a Direct Award via the CCS Provision of Tax Advisory Services Framework Agreement (RM6187).

Appendix 1b: Breaches of SFIs

Title	Annual QB Test Licence and Test Fee - 01/07/2025 to 30/06/2026
Supplier	QB Tech Limited
Month/Year	September 2025
Value	£25,022.40
Department	Planned and Specialist Care
Comment	In the month of September 2025, a retrospective purchase order was raised to QB Tech Limited for the Annual QB Test Licence and Test Fee - 01/07/2025 to 30/06/2026. The total value of the purchase order was £25,022.40. This breach of Standing Financial Instructions sits within the Planned and Specialist Care Directorate.
Action Taken	Breach Added to Procurement Workplan

Title	Picton Terrace - Ground & First Floor - 2 Door Storage Wall Modules with Fixed Height Plinth Including Site Survey, Delivery & Installation
Supplier	BOF Group Limited TA BOF
Month/Year	October 2025
Value	£9,768.00
Department	Capital Expenditure
Comment	In the month of October 2025, a retrospective purchase order was raised to BOF Group Limited TA BOF for Picton Terrace - Ground & First Floor - 2 Door Storagewall Modules with Fixed Height Plinth Including Site Survey, Delivery & Installation. The total value of the purchase order was £9,768.00. This breach of Standing Financial Instructions sits within the Capital Expenditure Directorate.
Action Taken	Escalated for Re-Education, and Relevant Director Informed for Awareness and Action

Title	Supply and Install Additional Smoke Detectors & Replace Light Fittings at PPH
Supplier	IWEC International
Month/Year	October 2025
Value	£5,306.85
Department	Estates and Facilities
Comment	In the month of October 2025, a retrospective purchase order was raised to IWEC International for the Supply and Install Additional Smoke Detectors & Replace Light Fittings at PPH. The total value of the purchase order was £5,306.85. This breach of Standing Financial Instructions sits within the Estates and Facilities Directorate.
Action Taken	Escalated for Re-Education, and Relevant Director Informed for Awareness and Action

Appendix 2: Overpayment of Salaries

	Period covered by this report: 1 September 25 – 31 October 25		
Ref	**Reason for Overpayment**	**Value (£)**	**Number of invoices**
1	Processing Error	2,441.86	2
2	Late Notification of Changes	20,257.92	10
3	Late Notification of Termination	33,051.32	17
4	Late Notification of Absence	14,553.12	12
5	Incorrect Information Supplied to Payroll	5,669.69	2
		75,973.91	**43**

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

2025/26	WRITE OFF LIST		
	Period covered by this report:	1st September to 31 October 2025	
	Losses and Special Payments Category	**Value (£)**	**Explanation**
	OVERPAYMENT OF SALARY	1,393.98	CCI COLLECTION RECOMMEND WRITE OFF - INDIVIDUAL HAS DECLARED BANKRUPCY
	Total Write Off	**1,393.98**	
	4b Other	1,062.00	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1,446.91	P06-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	1,575.50	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1,582.80	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	1,584.00	P07-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	2,087.73	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	2,116.80	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	2,363.42	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	3,649.82	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	Total Other/Ex Gratia	**17,468.98**	
	Total	**18,862.96**	

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

2025/2	WRITE OFF LIST		
	Period covered by this report:	1st September to 31 October 2025	
	Losses and Special Payments Category	**Value (£)**	**Explanation**
	OVERPAYMENT OF SALARY	0.02	UNDERPAID OF INVOICE
	ACCOMMODATION	0.06	UNDERPAID OF INVOICE
	ACCOMMODATION	0.06	UNDERPAID OF INVOICE
	ACCOMMODATION	0.06	UNDERPAID OF INVOICE
	OVERPAYMENT OF SALARY	0.10	UNDERPAID OF INVOICE
	WAGESTREAM	11.87	COLLECTION EFFORTS EXHAUSED - NOT VIABLE FOR CCI
	WAGESTREAM	24.38	COLLECTION EFFORTS EXHAUSED - NOT VIABLE FOR CCI
	OVERSEAS PATIENT	35.00	COLLECTION EFFORTS EXHAUSED - NOT VIABLE FOR CCI
	SALARY SACRIFICE	204.47	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
	PRIVATE PATIENT	345.89	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
	PRIVATE PATIENT	424.44	CCI COLLECTION EFFORTS EXHAUSED - RECOMMEND WRITE OFF
	Total Write Off	**1,046.35**	
	4b Other	0.01	P06-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.01	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	0.02	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	0.12	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.13	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	0.15	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.16	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.19	P07-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	0.26	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.28	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.33	P06-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.33	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.35	P07-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	0.37	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.37	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.39	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.40	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.42	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.42	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.43	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.45	P07-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.48	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.53	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	0.67	P07-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	0.71	P06-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	0.71	P06-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	0.71	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.82	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.83	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	0.89	P07-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	0.98	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.00	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.01	P07-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	1.06	P06-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	1.10	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.16	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	1.32	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.34	P07-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	1.41	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	1.73	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.74	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	1.78	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.91	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	1.93	P07-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	1.94	P06-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	1.98	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH

	4b Other	2.10	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.13	P07-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	2.16	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.26	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.29	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.35	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.44	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.50	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.50	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.56	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	2.59	P06-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	2.66	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	2.67	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.75	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.88	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.88	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	2.94	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	2.95	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	2.99	P07-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	3.00	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	3.01	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	3.07	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	3.12	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	3.18	P07-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	3.22	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	3.39	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	3.45	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	11 EX-GRATIA	3.50	Travel costs for cancelled appointment - JL
	4b Other	3.53	P06-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	3.59	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	3.60	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	3.67	P06-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	3.75	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	3.96	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	4.07	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	4.32	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	4.56	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	4.66	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	4.96	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	5.13	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	5.20	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	5.44	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	5.59	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	5.76	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	5.77	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	5.82	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	5.88	P06-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	5.94	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	5.98	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	6.00	P06-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	6.14	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	6.36	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	6.42	P06-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	6.46	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	6.48	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	6.90	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	7.02	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	7.06	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	7.20	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	7.40	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	7.40	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	7.56	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	7.85	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	8.20	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	8.69	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	8.92	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	8.95	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	9.09	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	9.33	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	9.37	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH

	4b Other	9.54	P06-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	9.58	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	9.72	P06-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	9.84	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	9.84	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	11 EX-GRATIA	10.00	Travel costs for cancelled appointment - AGW
	4b Other	10.06	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	10.10	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	10.27	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	10.38	P06-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	10.62	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	10.90	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	11.02	P06-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	11.22	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	11.22	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	11.88	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	12.12	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	12.22	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	12.35	P06-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	12.35	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	12.45	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	12.47	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	12.52	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	12.73	P06-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	12.86	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	12.89	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	13.16	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	13.28	P07-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	13.45	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	13.90	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	13.92	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	14.01	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	14.40	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	14.44	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	14.74	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	14.80	Float for H.Serv Shop Trolley
	4b Other	15.67	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	11 EX-GRATIA	17.00	Travel costs for cancelled appointment - KJT
	4b Other	17.05	P06-26 WDA - HDUHB~~E EXPIRED STOCK WDA
	4b Other	18.00	P07-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	18.00	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	18.43	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	18.53	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	18.67	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	18.70	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	11 EX-GRATIA	19.00	Travel costs for cancelled appointment - CME
	4b Other	19.05	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	19.49	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	19.52	P07-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	20.16	P06-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	11 EX-GRATIA	20.16	Travel costs for cancelled appointment - GM
	4b Other	20.30	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	20.36	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	20.38	P06-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	20.49	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	20.65	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	20.98	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	21.00	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	22.00	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	22.90	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	23.27	P07-26 Bronglais Hospital~~B WASTAGE / BREAKAGES BGH
	4b Other	23.95	P06-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	23.99	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	23.99	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	24.00	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	24.98	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	25.16	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	25.20	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	25.20	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	11 EX-GRATIA	26.00	Travel costs for cancelled appointment - DMB
	4b Other	26.21	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	11 EX-GRATIA	26.50	Travel costs for cancelled appointment - NRR
	4b Other	26.64	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	26.85	P06-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	11 EX-GRATIA	27.50	Travel costs for cancelled appointment - AD
	4b Other	27.60	P06-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	29.68	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	30.00	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	30.48	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	30.78	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH

	4b Other	31.26	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	31.32	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	32.16	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	32.76	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	33.86	P07-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	34.02	P06-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	34.66	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	34.74	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	36.00	P06-26 Aseptics - HDUHB~~W EXPIRED STOCK WGH
	4b Other	36.00	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	37.92	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	38.02	P07-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	38.60	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	40.26	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	40.62	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	42.00	P06-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	43.12	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	43.37	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	43.71	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	45.00	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	46.80	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	48.00	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	50.30	P06-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	53.40	P06-26 Prince Philip Hospital~~P EXPIRED STOCK PPH
	4b Other	53.69	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	59.76	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	60.00	P06-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	60.00	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	61.56	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	64.80	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	67.64	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	67.96	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	68.87	P06-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	68.87	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	69.60	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	72.83	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	74.09	P07-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	75.00	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	76.69	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	79.20	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	81.50	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	82.08	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	87.32	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	87.90	P06-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	88.66	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	89.03	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	90.00	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	90.00	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	90.00	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	97.02	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	97.92	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	97.96	P06-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	98.35	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	98.40	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	98.74	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	99.72	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	11 EX-GRATIA	100.00	Ex-Gratia - lost property - EG12824
	11 EX-GRATIA	100.00	Ex-Gratia - lost property - EG12825
	4b Other	100.59	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	100.80	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	101.54	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	101.55	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	101.64	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	102.00	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	105.68	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	109.08	P07-26 Prince Philip Hospital~~P WASTAGE / BREAKAGES PPH
	4b Other	111.18	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	115.05	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	115.20	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	119.44	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH

	4b Other	120.34	P06-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	125.74	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	132.74	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	141.60	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	144.72	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	145.44	P06-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	150.70	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	152.04	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	153.38	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	156.75	P06-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	162.62	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	164.89	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	169.20	P06-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	176.26	P06-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	179.89	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	184.37	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	186.59	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	192.00	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	192.24	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	192.60	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	201.18	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	204.00	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	209.70	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	211.49	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	218.93	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	229.20	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	238.88	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	243.47	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	248.04	P06-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	294.00	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	295.20	P06-26 Withybush Hospital~~W WASTAGE / BREAKAGES WGH
	4b Other	302.40	P07-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	312.73	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	312.73	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	324.00	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	324.00	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	324.10	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	378.94	P07-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	381.24	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	390.00	P06-26 Bronglais Hospital~~B EXPIRED STOCK BGH
	4b Other	588.00	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	617.04	P07-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	658.50	P07-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	677.90	P06-26 Glangwili Hospital~~G WASTAGE / BREAKAGES GGH
	4b Other	720.00	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	825.76	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	4b Other	857.89	P06-26 Withybush Hospital~~W EXPIRED STOCK WGH
	4b Other	944.78	P06-26 Glangwili Hospital~~G EXPIRED STOCK GGH
	Sub total	**21,543.59**	
	Total	**22,589.94**	

5.2

11:40, 10 Mins

5.2 - Counter Fraud Update

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

For information

Attachments

5.2 SBAR Counter Fraud Update ARAC December 2025.pdf

5.2 Counter Fraud Update ARAC December 2025.pdf

5.2 Appendix A - Case Analysis.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	09 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Counter Fraud Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Ben Rees, Head of Counter Fraud

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

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

Cefndir / Background

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

Asesiad / Assessment

Main Report:
The Health Board is compliant with the Welsh Government Directives.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is invited to receive for information the Counter Fraud Update Report and appended items.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.2 In particular, the Committee will review the adequacy of: 3.2.4 the policies and procedures for all work related to fraud and corruption as set out in National Assembly for Wales Directions and as required by the Counter Fraud and Security Management Service.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	3. Effective 4. Efficient
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Striving teams
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Counter Fraud Workplan 2025/26
Rhestr Termau: Glossary of Terms:	LCFS – Local Counter Fraud Specialist/s CF – Counter Fraud CFS Wales – Counter Fraud Services Wales NHS CFA – NHS Counter Fraud Authority NWSSP – NHS Wales Shared Services Partnership LPE – Local Proactive Exercise FRA – Fraud Risk Assessment
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Not applicable.

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

HYWEL DDA UNIVERSITY HEALTH BOARD

COUNTER FRAUD UPDATE

For Presentation 09 December 2025

The NHS Protect Standards are set in four generic areas:

- **Strategic Governance**
- **Inform and Involve**
- **Prevent and Deter**
- **Hold to Account**

AREA OF ACTIVITY	2025/26 Resource (days)	Resource Used as at 30/11/2025	Resource Used (%) as at 30/11/2025)
STRATEGIC GOVERNANCE	40	21	53
INFORM AND INVOLVE	85	57	67
PREVENT AND DETER	130	84	64
HOLD TO ACCOUNT	185	110	60
TOTAL	**440**	**272**	**62**

Work Area	*Summary of work areas completed*
Inform and involve	• All new inductees are required to complete the Health Board's induction programme and the Counter Fraud mandatory training e-learning package. • Counter Fraud content was delivered to Nurses by way of presentations on the Medicines Management programme. In addition, this last quarter has seen presentations delivered to optometrists covering the North Ceredigion and South Pembrokeshire areas, engaging with all Clusters, raising awareness of fraud in the NHS and the need for greater collaborative working to reduce instances to an absolute minimum. • International Fraud Awareness Week (IFAW) took place between Sunday 16 and Friday 21 November 2025. Counter Fraud participated in the event by way of holding two online Webinars and in person engagement events with both Hospital Staff and Service users by holding in person meet and greet events at Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital and Withybush General Hospital. In addition, various online material was shared via Viva Engage and the Counter Fraud intranet site. Evidence of said activity can be seen via the two links: **1 -** Bore da pawb As part of International Fraud Awareness week, the Counter Fraud team visited BGH yesterday, where we spent some time engaging with membe... Posted in HDD Tîm Hywel Dda Team on Nov 18, 2025 **2 -** International Fraud Awareness Week (IFAW) 2025 As part of the event, Counter Fraud also visited Primary Care partners, which included GP Providers and Pharmacies. • Counter Fraud, in collaboration with the Home Office hosted two 90-minute training sessions to over 100 attendees covering ID document fraud and how it affects the NHS. The session included Home Office training on how to spot forged documents and what to do should an adverse incident occur.

	The training was aimed at mitigating risks associated with a previously reported alert involving the impersonation of medical professionals. Attendees included HDdUHB Recruitment, Nurse Bank and Rostering, Appointing Managers and Ward Supervisors. • Counter Fraud currently sit on the quarterly HDdUHB Local Intelligence Network (LIN), at which advice is provided on current fraud trends associated with Controlled Drugs. Where applicable, relevant advice, including raising awareness of Fraud in the NHS, is provided.
Prevent and deter	• In response to the National Fraud Initiative, a local proactive exercise was undertaken linked to Declarations of interests submitted by employees who were matched as being linked to known suppliers / contractors of HDdUHB or who had secondary employment with participating organisations. A report outlining the exercise and its findings has been completed and appended to the In-Committee report for the committee's attention. • In August 2025, Counter Fraud highlighted the reporting of a risk linked to the impersonation of Agency employed Registered Nurses and Healthcare Support Workers. In response, a local proactive exercise was undertaken, which confirmed that existing processes to mitigate the risk were in operation and were effective and reducing the likelihood of an adverse incident. To this end, Counter Fraud, in partnership with the Home Office, undertook a training session to help HDdUHB employees to identify fake or forged documents, addressing an action highlighted in an October 2025 In-Committee session risk report. • To better understand fraud risks, trends and potential areas of further monitoring, Counter Fraud have undertaken an analysis of all referrals, both crime and non-crime recorded and closed across various directorates and departments between 01 November 2024 and 21 November 2025. Analysis includes monthly trends, top offence types, county-level breakdowns, subtype analysis, and a heatmap of Directorate vs Subtype for targeted risk management. Forecasts for the next three months are also provided, along with a predictive risk matrix for Q1 2026.

The report also includes details of all cases received during the reporting period; however, not all resulted in criminal activity being substantiated. Key insights include:

Overall Trends

Fraud Volume:

- Average of ~4.6 cases per month, with a slight upward trend forecasted for Q1 2026 (expected 5.7 → 6.0 cases per month).

Dominant Fraud Type:

- NHS Staff Fraud – Employee fraud is the most prevalent across all counties and directorates.

Seasonality:

- Increased activity observed toward year-end, with an increase in working whilst sick and service user fraud noted, this is likely to continue into early 2026.

Top Offence Types:

1. NHS Staff Fraud – Employee fraud
2. NHS Patient Fraud
3. NHS Staff Fraud – Pharmaceutical
4. Third Party (External) Fraud
5. NHS Supplier Fraud

County-Level Insights:

- Carmarthenshire: Highest risk, with a recent spike noted in November 2025 (5 cases).
- Pembrokeshire: Stable but persistent staff fraud cases.
- Ceredigion: Emerging risk with recent increase in fraud cases.

Subtype Patterns:

- Working Whilst Sick and Timesheet Fraud dominate under 'Fraud by false representation'.

- Patient fraud linked to Supply of Controlled Drugs and Forged Prescriptions remains a concern.

Directorate Risk:

- Nursing and Midwifery: Highest concentration of staff-related fraud.
- Service User: High risk for controlled drug supply and prescription fraud.
- Contractor: Vulnerable to mandate fraud and false representation.

Predictive Risk for Q1 2026 - Top 5 High-Risk Areas:

1. Nursing & Midwifery | Fraud by false representation (Risk Score: 21)
2. Service User | Supply of controlled drugs (Risk Score: 9)
3. Contractor | Fraud by false representation (Risk Score: 9)
4. Hotel Facilities | Fraud by false representation (Risk Score: 6)
5. Service User | Fraud by false representation (Risk Score: 6)

Mitigation Recommendations:

- Strengthen monitoring in Nursing & Midwifery (Working Whilst Sick, Timesheet Fraud).
- Enhance prescription controls for Service User fraud linked to prescriptions (currently underway via the rollout of digital prescriptions).
- Conduct targeted local proactive exercises in Hotel Facilities.
- Increase staff fraud awareness training across high-risk areas.

A detailed visual breakdown report of allegations by directorate, department and location is included to support future targeted risk mitigation, and has been appended to this report, Appendix A refers.

- The Public Sector Fraud Authority (PSFA) – part of the UK Government's Cabinet Office and HM Treasury – oversees the National Fraud Initiative (NFI) across the UK. Audit Wales leads the exercise in Wales under the Auditor General's powers in the Public Audit (Wales) Act 2004. The Auditor General's Code of Data Matching

Practice summarises the key legislation, and controls, governing the exercise in Wales. The Auditor General has mandated that unitary local authorities, NHS bodies, police forces, and fire and rescue authorities participate in the NFI. NFI helps prevent and detect fraud by sharing and matching sets of data electronically. Further information on the initiative can be found here, National Fraud Initiative | Audit Wales.

Final data sets were released in January 2025. Work on the initiative is now nearing completion, with only two matches remaining open, due to ongoing enquiries.

To date, the exercise has assisted in the recovery of approximately £33,000. Enquiries associated with the work are nearing completion, with only one report remaining open, a breakdown of each exercise and a summary of activity undertaken has been provided below:

Match Type	Purpose of the match	Total Matches	Opened	Reviewed and closed	Remaining	Remarks
Payroll to Payroll	To identify individuals who may be committing employment fraud by failing to work their contracted hours because they are employed elsewhere or are taking long-term sickness absence from one employer and working for another employer at the same time. The criteria for a match are a person having one full-time post plus at least one other post elsewhere.	86	86	85	1	1 enquiry remains open. This matter is linked to an ongoing investigation into an offence of Fraud by False Representation. NWSSP is leading on the case as the subject concerned is a substantive employee of theirs.
Payroll to Pension	To identify cases where employees who have gone back into employment after drawing a pension that could result in an abatement of pension.	110	110	110	0	Enquiries undertaken include working with NWSSP Pensions to ensure each entry is valid and compliant. No issues have been identified, and all matches are now closed.

	Payroll to Creditors	The match identifies instances where an employee and creditor are linked by the same bank account or the same address to identify employees with interests in companies with which your organisation is trading. This may indicate potential undeclared interests and possible procurement corruption or where a member of staff has set up a creditor with their own bank details in order to receive payments they are not entitled to.	24	24	24	0	All matches are now complete, resulting in no concerns being identified.
	Payroll to companies' house	To identify potential undeclared interests that have given a pecuniary advantage. To do this NFI have matched payroll data to companies' house information and then to your creditors data. The reports are split between those highlighting employees who appear to be registered directors of companies that the employing body has traded with and those where the employees address appears to have links to the company directors or the company.	49	49	49	0	All matches are now complete, resulting in no concerns being identified.
Hold to Account	• New referrals have been received into the department over the last two months, with significant work being undertaken. A detailed report of all new, existing, and closed investigations has been provided to the Committee via an In-Committee report.						
Strategic Governance	• Quarterly statistics have been submitted to Counter Fraud Service (CFS) Wales and in compliance with WG directions.						

Report Provided by:
Ben Rees - Lead Local Counter Fraud Specialist
For presentation; 09 December 2025.

Report agreed by:
Huw Thomas
Director of Finance

Fraud Case Analysis Report

Executive Summary

This report provides an overview of fraud cases investigated across various directorates and departments between 01 November 2024 and 21 November 2025. It includes monthly trends, top offence types, county-level breakdowns, subtype analysis, and a heatmap of Directorate vs Subtype for targeted risk management. Forecasts for the next three months are also provided, along with a predictive risk matrix for Q1 2026.

The report includes details of all cases received during the reporting period; however, not all resulted in criminal activity being substantiated. Key insights include:

Overall Trends

- Fraud Volume: Average of ~4.6 cases per month, with a slight upward trend forecasted for Q1 2026 (expected 5.7 → 6.0 cases per month).
- Dominant Fraud Type: NHS Staff Fraud – Employee fraud is the most prevalent across all counties and directorates.
- Seasonality: Increased activity observed toward year-end, with an increase in working whilst sick and service user fraud noted, this is likely to continue into early 2026.

Top Offence Types

1. NHS Staff Fraud – Employee fraud
2. NHS Patient Fraud
3. NHS Staff Fraud – Pharmaceutical
4. Third Party (External) Fraud
5. NHS Supplier Fraud

County-Level Insights

- Carmarthenshire: Highest risk, with a recent spike noted in November 2025 (5 cases).
- Pembrokeshire: Stable but persistent staff fraud cases.
- Ceredigion: Emerging risk with recent increase in fraud cases.

Subtype Patterns

- Working Whilst Sick and Timesheet Fraud dominate under ‘Fraud by false representation’.
- Patient fraud linked to Supply of Controlled Drugs and Forged Prescriptions remains a concern.

Directorate Risk

- Nursing and Midwifery: Highest concentration of staff-related fraud.
- Service User: High risk for controlled drug supply and prescription fraud.
- Contractor: Vulnerable to mandate fraud and false representation.

Predictive Risk for Q1 2026

Top 5 High-Risk Areas:

1. Nursing & Midwifery | Fraud by false representation (Risk Score: 21)
2. Service User | Supply of controlled drugs (Risk Score: 9)
3. Contractor | Fraud by false representation (Risk Score: 9)
4. Hotel Facilities | Fraud by false representation (Risk Score: 6)
5. Service User | Fraud by false representation (Risk Score: 6)

Mitigation Recommendations

- Strengthen monitoring in Nursing & Midwifery (Working Whilst Sick, Timesheet Fraud).
- Enhance prescription controls for Service User fraud linked to prescriptions (currently underway via the rollout of digital prescriptions).
- Conduct targeted local proactive exercises in Hotel Facilities.
- Increase staff fraud awareness training across high-risk areas.

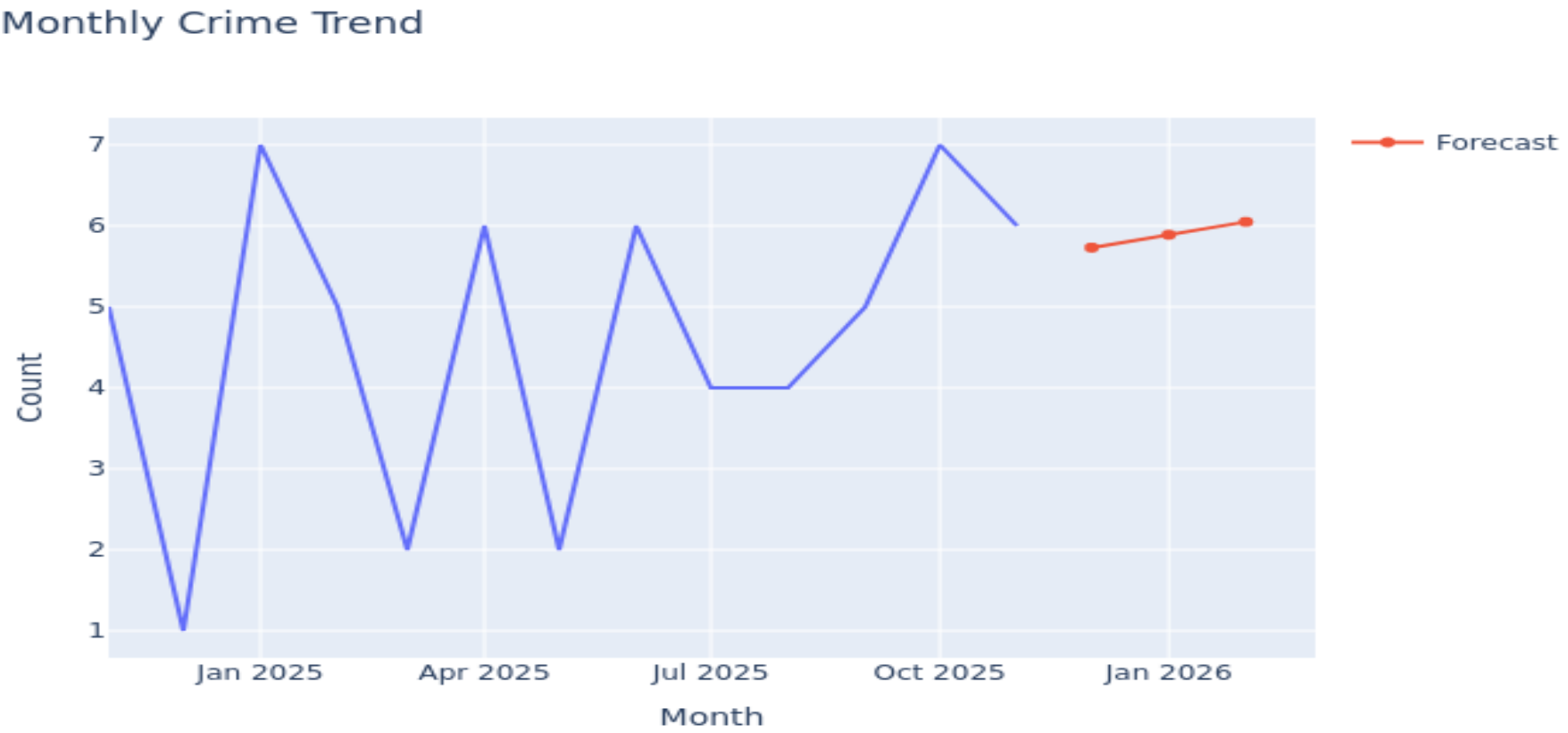


Figure 1: Monthly crime trend with forecast (including predicted increase in Q1 2026).

Top Offence Types

This chart highlights the five most frequent offence types observed in the dataset.

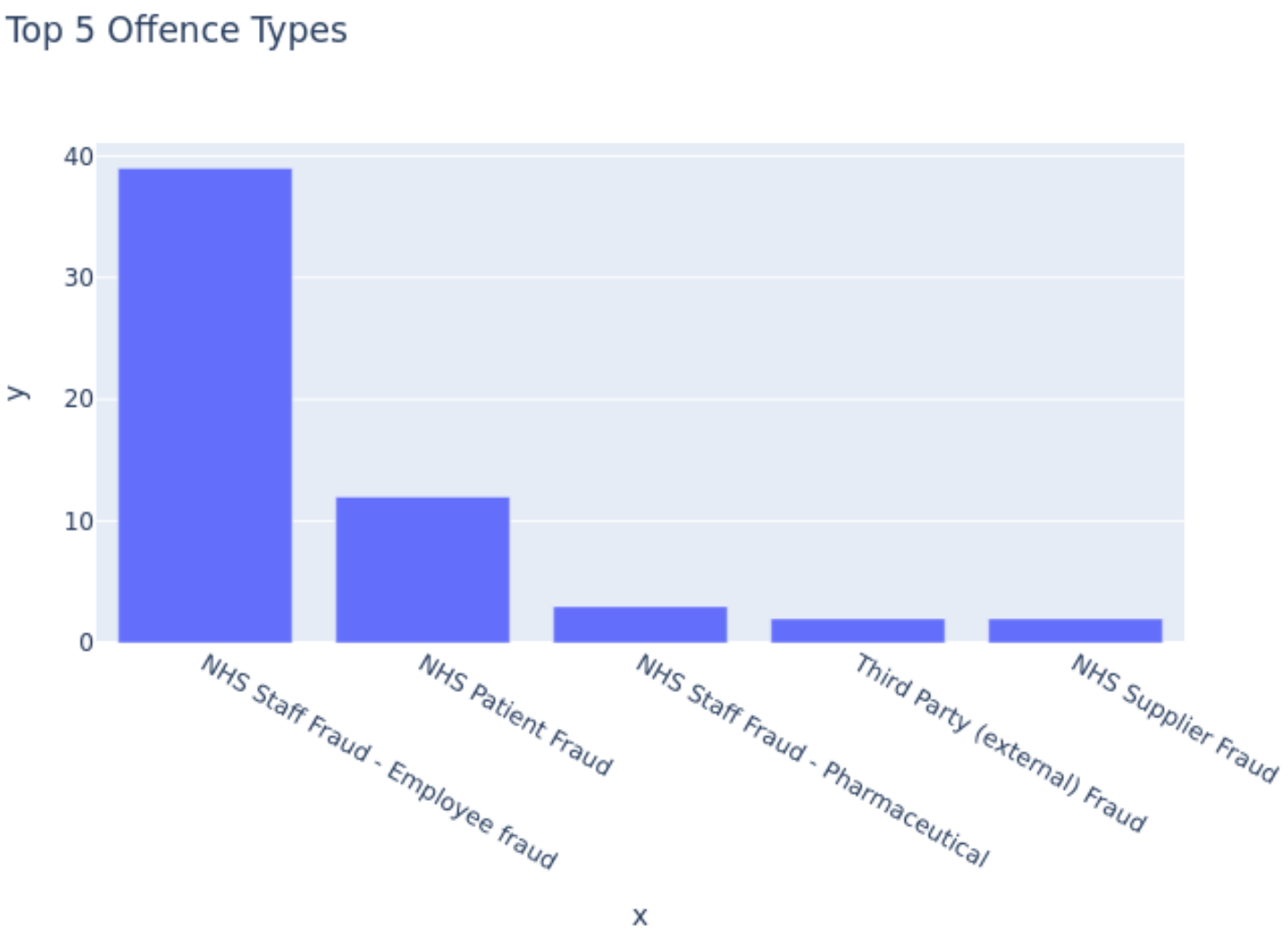


Figure 2: Top 5 offence types across all counties.

County-Level Trends

The following chart compares monthly crime trends across Carmarthenshire, Pembrokeshire, and Ceredigion.

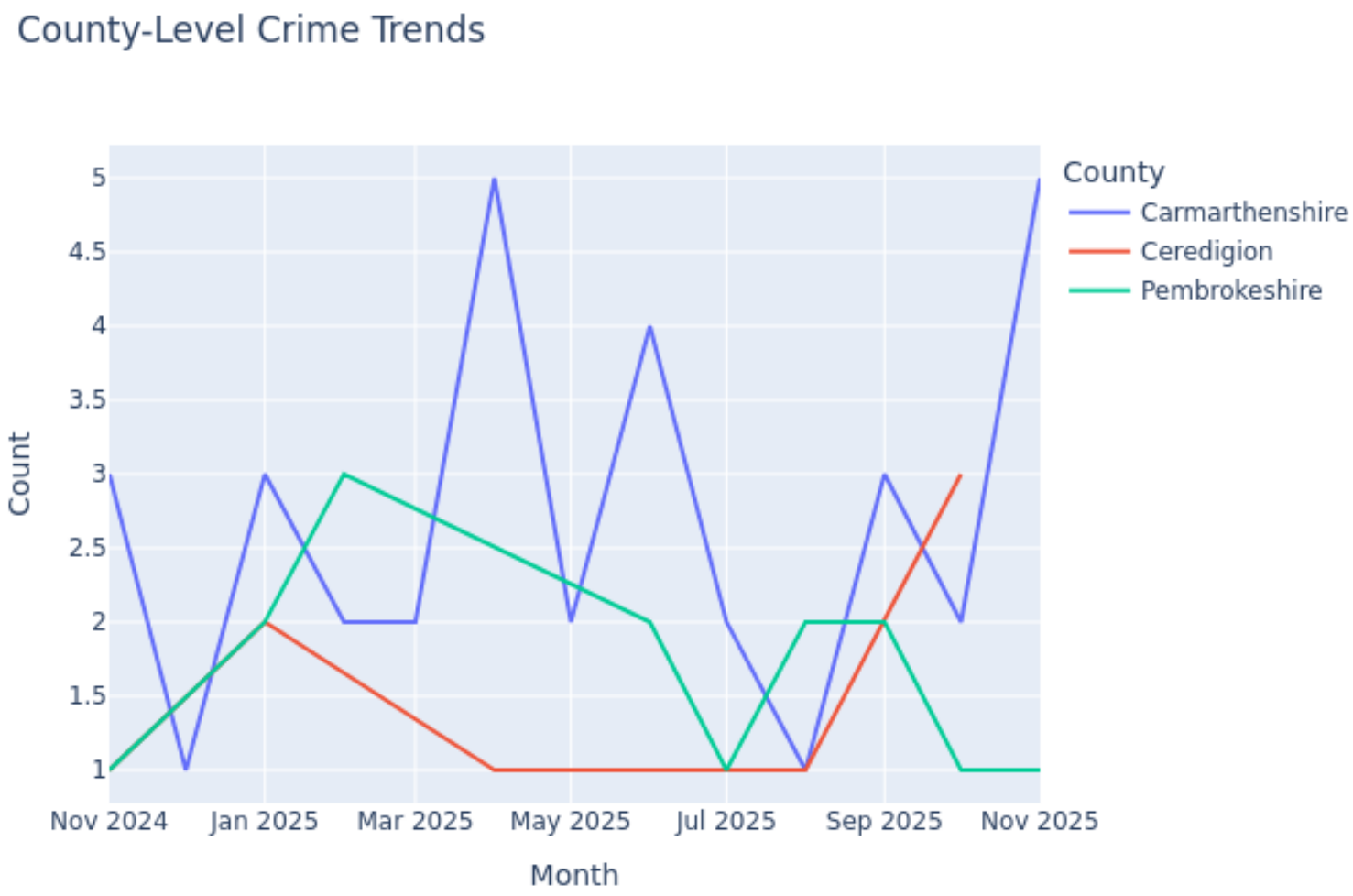


Figure 3: County-level monthly crime trends.

County Offence Breakdown

This chart shows the distribution of offence types per county.

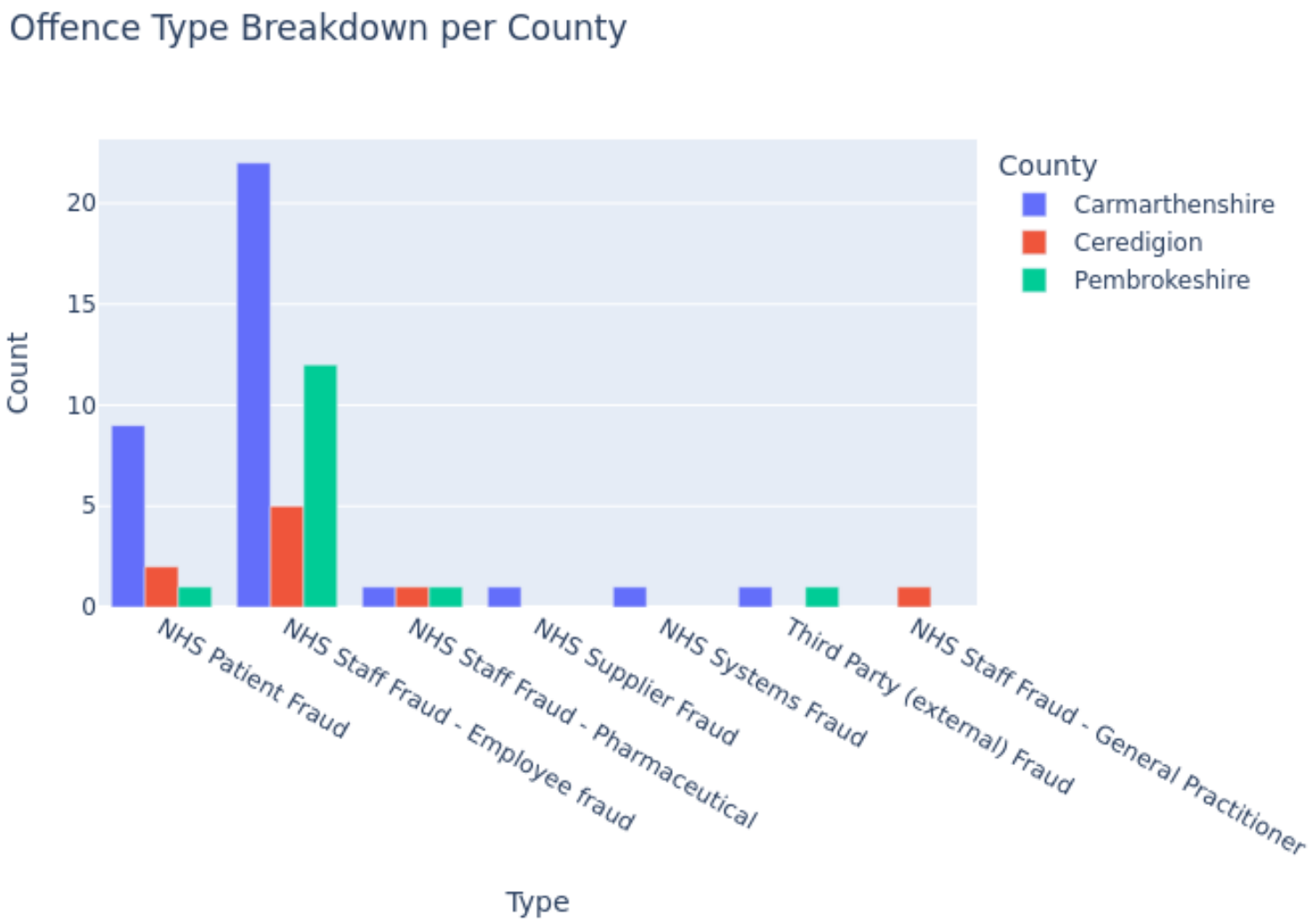


Figure 4: Offence type breakdown by county.

Subtype Breakdown per County

The chart below illustrates the most common subtypes (e.g., Working Whilst Sick, Timesheet Fraud) per county.

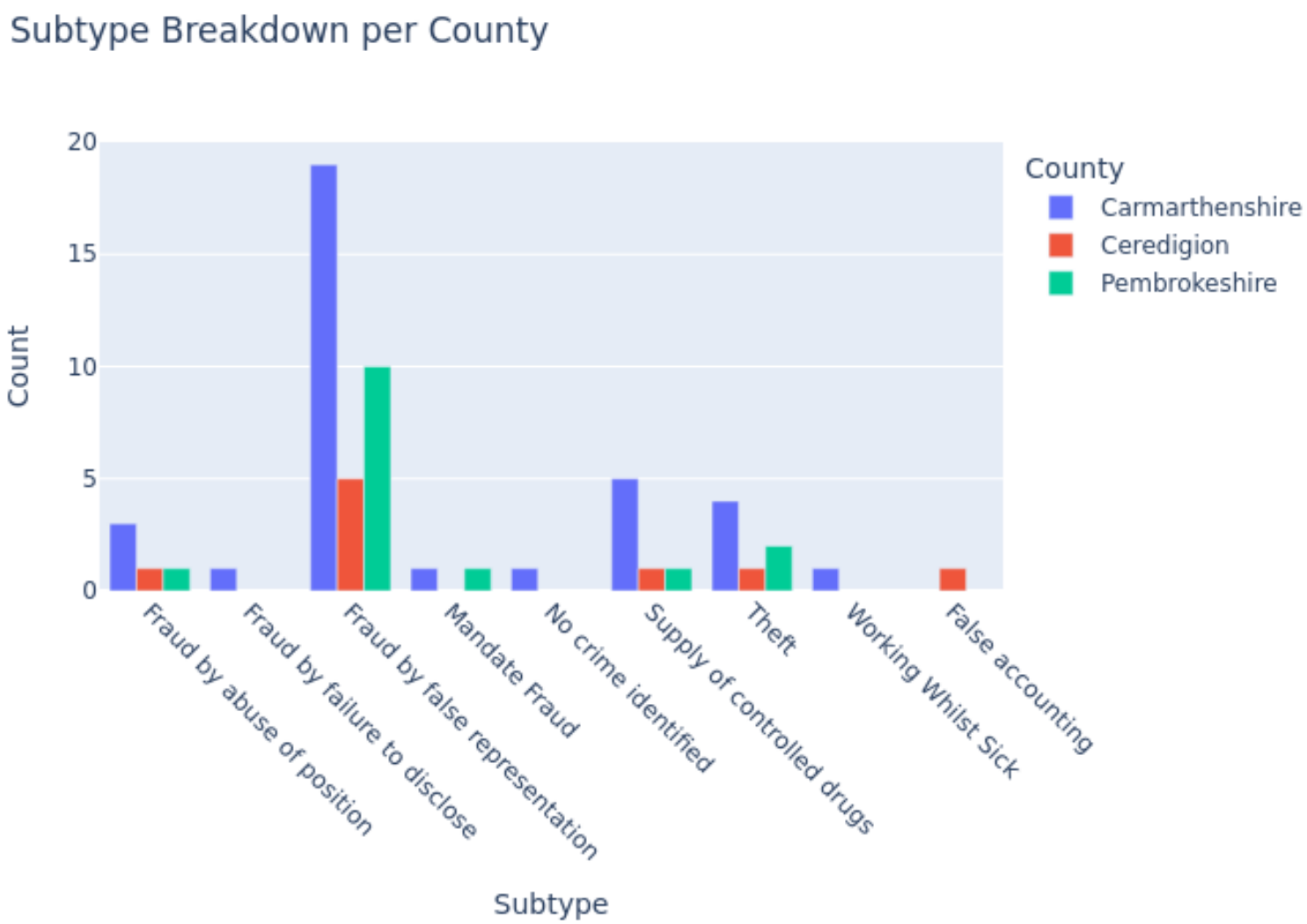


Figure 5: Subtype distribution across counties.

Predictive Risk Matrix for Q1 2026

This section provides a predictive risk assessment for Q1 2026 based on historical patterns and weighted recent activity. Higher scores indicate greater likelihood of fraud occurrence in the upcoming quarter.

Top 5 Predicted High-Risk Areas:

1. Nursing and Midwifery | Fraud by false representation → Risk Score: 21

2. Service User | Supply of controlled drugs → Risk Score: 9

3. Contractor | Fraud by false representation → Risk Score: 9

4. Hotel Facilities | Fraud by false representation → Risk Score: 6

5. Service User | Fraud by false representation → Risk Score: 6

Risk methodology

- Data Selection - All cases were grouped by Directorate and Subtype. Only valid entries with both fields populated were included.
- Weighting Recent Activity - Cases from the last 3 months (Sept–Nov 2025) were given a weight of 3. Older cases were given a weight of 1, ensuring recent spikes influence the risk score more heavily, reflecting emerging threats.
- Risk Score Calculation - For each Directorate–Subtype combination, the weighted counts were summed:

  "Risk Score"= ("Older Cases"×1) +("Recent Cases"×3)

  Example: Nursing & Midwifery | Fraud by false representation:

  4 older cases + 5 recent cases - (4×1) + (5×3) = 4 + 15 = 19 (rounded to 21 after including additional recent entries).

- Ranking - The top 5 combinations with the highest risk scores were selected for Q1 2026 predictions.

6

11:50, 0 Mins

6 - Assurance and Risk

6.1

11:50, 10 Mins

6.1 - Risk Assurance Report

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

For assurance

Attachments

6.1 Risk Assurance Report December 2025.pdf

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Audit and Risk Assurance Committee

Risk Assurance Report

9th December 2025

Situation and Background

The report aims to provide assurance to the Audit and Risk Assurance Committee (ARAC) on the effectiveness of the Risk Management Framework, and the implementation of the Risk Management Strategy. This is in line with the requirements as noted in the Committee's Terms of Reference which state:

2.4.1. Review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical.

The report aims to provide assurance by outlining the risk management activity that has taken place since the previous report presented to ARAC in August 2025 on the effectiveness of the Risk Management Framework, and the implementation of the Risk Management Strategy. The revised Risk Management Framework and Risk Management Strategy were approved by the Board in September 2025.

The Risk Management Framework sets out the components that provide the foundation and organisational arrangements for supporting risk management processes in Hywel Dda UHB (the Health Board).

The Risk Management Strategy provides a supportive framework that ensures the integration of risk management into policy making, planning and decision-making processes.

This report also provides ARAC with a high-level summary of each Clinical Care Group and Executive Function's internal escalation status in relation to their risk management processes.

Progress since the previous report to ARAC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

A summary is provided below of the progress made against the next steps which were identified in the previous tracker report provided to ARAC in August 2025:

Next Steps	Progress Made
To identify a suitable risk management system and commence work on its implementation and roll-out ahead of 30 November 2027	The requirement to identify a suitable risk management system is one of three objectives within the refreshed Risk Management Strategy, approved by Board at its meeting in September 2025. The Assistant Director of Assurance and Risk, and Head of Assurance and Risk are continuing with discussions at an All-Wales level to identify a suitable supplier, and whether a joint approach with other NHS Wales organisations is feasible. Concerns around the timeframe to implement a new risk management system and resource availability have been articulated on the Governance operational risk register.
Complete the review of risk themes.	Work continues with leads across the organisation to ensure appropriateness of current risk themes, and their alignment to new Committee and sub-committee reporting structures. Progress made to date is detailed on the Thematic Analysis slide later in this paper, with work to have completed by March 2026.

Risk Management Framework

Risk Management Framework (the Framework)
Risk Management is the process which aims to help organisations management understand, evaluate and take action on all their risks with a view to increasing the probability of success and reducing the likelihood of failure (Institute of Risk Management). It forms part of the overall governance framework of the organisation.

The Health Board's Framework is made up of the **risk architecture**, **strategy** and **protocols** (RASP), sets out the roles and responsibilities of individuals and committees, and wraps around the Health Board's risk management process. The Framework provides the mandate for embedding risk reporting in the Health Board, and includes the process for the escalation of risk, and acceptance of risks which exceed the Health Board's risk appetite.

The Framework was refreshed during Q2 of 2025/26, endorsed by ARAC in August 2025 ahead of approval by Board at its meeting in September 2025, and details the process for the escalation of risks and their acceptance when they exceed the Health Board's risk appetite.

Risk Management Strategy

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Management Strategy (the Strategy)

The Health Board's Strategy provides a supportive framework that ensures the integration of risk management into policy-making, planning and decision-making processes, and specifically:

- To improve the quality of service and protect patients, carers, staff and others who come in to contact with the Health Board;
- To create awareness through the Health Board about the importance of recognising and managing risk in a timely manner and providing staff with the appropriate knowledge, skills and support;
- To promote positive risk taking in the context of clinical care and in controlled circumstances;
- To provide a robust basis for strategic and operational planning through structured consideration of key risk elements;
- To enhance partnership working with stakeholders in the delivery of services;
- To improve compliance with relevant legislation and national best practice standards; and
- To enhance openness and transparency in decision-making and management.

The Risk Management Strategy (the Strategy), approved by Board in September 2025, sets out the Health Board's risk management policy statement and objectives in respect of strengthening risk management for the period up to September 2026.

The Strategy aims to support a dynamic and systematic approach to risk management, and to ensure prompt and comprehensive identification, assessment and management of risks that threaten the delivery of its strategic objectives and day-to-day operations.

The following slides detail:

- the status of the objectives from the previous Strategy 2024/25; and
- The underpinning plans to achieve the three objectives per the ref[illegible]egy over the next 12 months.

Status of objectives from Strategy 2024/25

Objective 1- Implement and embed the UHB's refreshed risk appetite statements Appetite and Tolerance Statement	How we achieved the objective
Developing an implementation strategy to embed revised risk appetite statement across the UHB;	**Complete** The revised approach to risk tolerance was approved by Board at its meeting in March 2025, providing guidance links proposed actions to their anticipated impact on risk score, and shows the risk score trajectory over time. The revised approach utilises the Target Risk Score (TRS) to demonstrate the lowest level of risk exposure the Health Board is willing to tolerate following completion of all planned actions. Should the risk remain, this then triggers discussion on the acceptance of the risk in line with the Health Board risk appetite. This approach is now being embedded across the Health Board.
Reviewing our approach to risk tolerance and how it aligns to the refreshed risk appetite statements (approved by Board in January 2025);	
Providing practical support to services in the utilisation of refreshed risk appetite statement; and	**Complete** The Assurance and Risk Team continue to provide support via the provision of technical risk management training to operational managers and risk leads across the Health Board. Guidance is included within papers submitted to Clinical Care Group and Executive Function meetings via the submission of Assurance and Risk papers, with further resources available to staff across the Health Board via the Assurance and Risk Sharepoint site.
Reviewing the risk appetite statement after 6 months with the Executive Risk Group (ERG) to ensure it remains fit for purpose and support effective decision making.	**Complete** The risk appetite statements were reviewed and refreshed by the Executive Team in December 2024 as part of the required annual review, and subsequently approved by Board at its meeting in January 2025, with minimal changes made

Status of objectives from Strategy 2024/25

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Objective 2- Support the strengthening of operational risk management arrangements	How we achieved the objective
Ensuring risk management arrangements and systems are realigned to the new Operations Directorate structure (when approved), and systems used to capture this process are appropriately updated;	**Complete** The Organisational Change Process (OCP) within the remit of the Chief Operating Officer were introduced in April 2025. Hierarchies within the Datix risk register system were updated in line with the revised arrangements and went "live" in April 2025, with support from colleagues across other corporate functions. System changes have allowed for the timely and accurate reporting of risks to the appropriate Clinical Care Group and Clinical Service Group meetings, which commenced in April and May 2025.
Supporting corporate and operational directorates via quality and business meetings and Directorate Improving Together sessions to identify, assess and manage risks and improve outcomes;	**Complete** The Assurance and Risk team adopts a business-partnering approach to support operational and corporate teams to meet their risk management obligations. Each Function is assigned a dedicated Assurance and Risk Officer (ARO), who prepare risk reports and attend relevant service governance meetings, in addition to meeting risk leads to facilitate and support discussions on risk management.
Reviewing current partnership risk management arrangements with key partners and to utilise learning to develop a plan for all partnerships to strengthen these arrangements which will support the UHB to achieve its objectives;	**Included in Strategy for 2025/26** There are currently no defined approaches and processes for addressing risk with all our key partners, however key people are aware of areas of potential risk with partnerships. Partnership arrangements is included in objective 3 of the refreshed Risk Management Strategy 2025/26 approved by the Board in September 2025.
Reviewing the training needs analysis and provision of risk management training to implement the operationalisation of revised risk appetite statements across the UHB;	**Complete** The Assurance and Risk Team have updated the training needs analysis which was included in the revised Risk Management Framework approved by the Board in September 2025. The training materials and Sharepoint site have all been updated.
Implement the new Once for Wales Concerns Management system when it has been developed and is ready to be rolled out; and	**Included in Strategy for 2025/26** Meetings continue to be held with colleagues from other NHS Wales bodies, and alternative risk management system providers to identify a suitable system to be used from December 2027.
Providing practical support to services with operational risk management arrangements via business partnering arrangements to ensure risk management outcomes inform and prioritise organisational decision making.	**Complete** Each Function is assigned a dedicated ARO, who provide training and advice, prepare risk reports and attend relevant service governance meetings, in addition to meeting risk leads to facilitate and support discussions on risk management as part of the team's business as usual. The planning process for the Annual Plan 2026/27 is being informed by the organisational risk register.

Status of objectives from Strategy 2024/25

Objective 3- Understand how established risk management processes currently contribute to the overall health of the UHB (i.e. achievement of objectives, delivery of plans and performance), and how this can be strengthened.	How achieved the objective
Engaging with relevant teams across the UHB to establish how risk information is currently utilised within their areas to support the achievement of the delivery of our objectives and performance targets to inform our risk maturity assessment, and how this could be strengthened;	**Complete** A risk maturity self-assessment was undertaken during quarter 3 of 2024/25, in accordance with the Orange Book (a recognised risk management standard for the public sector), the outcomes of which were presented to ARAC in April 2025 and underpinned the refreshed objectives included within the revised Strategy for 2025/26. Risk leads and thematic subject matter experts across the Health Board were given the opportunity to provide feedback via an online questionnaire to further inform the completion of the risk maturity self-assessment this year, with high response rate from colleagues in areas including Mental Health, Primary Care, and Nursing Quality and Patient Experience. Outcomes from the questionnaire highlighted the need to support the embedding of risk management arrangements at a local level, and these have been reflected in the three new objectives as outlined in the Risk Management Strategy (detailed on the next three slides)
Engaging with service leads across the UHB to assess the risk culture within the organisation to identify areas of improvement to support individuals in undertaking risks in an informed manner to support the achievement of our objectives and performance targets.	**Complete** The outcomes and identified next steps of the assessment have been used to inform the revised Strategy, with the Head of Assurance and Risk developing an implementation plan to ensure the delivery of the refreshed objectives. Feedback will continue to be requested from services, including communication via Viva Engage, on a regular basis to inform ongoing improvement.

Planned actions to implement objectives per the refreshed Risk Management Strategy 2025/26

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Objective 1 - Support operational risk management arrangements to ensure consistent approach to the ownership and oversight of risks	Our plan to achieve the objective
Supporting Functions via local quality and performance governance meetings and Executive Improving Together sessions to identify, assess and manage risks and improve outcomes;	AROs will continue to regularly attend governance meeting including submission / presentation of governance papers, provide training and support, and undertake monthly analysis of key risk metrics as part of Executive Improving Together sessions. **Throughout the year.**
Providing practical support to services with operational risk management arrangements via partnering arrangements to ensure risk management outcomes inform and prioritise organisational decision making;	Monthly analysis of key risk metrics as part of Executive Improving Together sessions will identify areas who may require additional support. Escalation of key risks via governance arrangements. **Throughout the year.**
Develop a checklist to support operational management to improve local induction processes relating to risk management, highlighting local and organisational objectives, processes in place to report a risk, and priorities and support the identification of any training needs for new starters within their team;	Training Needs Analysis form has been included within the recently revised Risk Management Framework , and added to the Assurance and Risk Sharepoint site. In addition, the Assurance and Risk Tea, have developed a Risk Management Managers Training Package for delivery as part of the HB wide managers training programme. **Training is due to commence in February 2026.**
Further develop risk management training materials to ensure alignment with the UHB's objectives following the Strategy Refresh;	Incorporate strategy refresh in governance papers to meetings, alerting the need to align risks appropriately. Development and delivery of risk training. Strategy Refresh due to be presented to Board in January 2026, with **training materials to reflect developments by March 2026.**
Developing a communications plan in order to further promote awareness of risk management arrangements; and	The Assurance and Risk Sharepoint site will be further developed as and when required to promote awareness of risk management arrangements, with improved utilisation of Viva Engage to communicate key messages as part of the development of a communications plan. A progress update on this will be provided in the next Risk Assurance report. **Throughout the year.**
Developing a detailed scope and procure a new risk register system.	Finalised project specification document for a risk management system leading to the identification and implementation of a suitable risk management system. **Specification ment to be finalised by December 2025.**

Planned actions to implement objectives per the refreshed Risk Management Strategy 2025/26

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Objective 2 - Support the strengthening of operational risk management arrangements	Our plan to achieve the objective
Continue to implement the current risk appetite across the UHB, ensuring that risks are aligned with the UHB's risk appetite;	The Assurance and Risk team will continue to deliver and develop risk training including communication, as outlined in objective 1, as well as supporting functions to ensure escalation of risks which exceed risk appetite as per guidance in the Risk Management Framework. **Throughout the year**
Reviewing the risk appetite following the Strategy Refresh; and	A focus session with the Executive Team and Independent Members will be undertaken to review the risk appetites following the Strategy Refresh, scheduled to be presented to Board in January 2026. **To be completed by May 2026**.
Reviewing and updating strategic risks and Board Assurance Framework as part of Strategy Refresh.	The principal risks and Board Assurance Framework will be refreshed following the Strategy Refresh, and presented to Board in May 2026. Regular reporting of principal risks to the Board and its Committees will continue, including progress on their development. **To be completed by May 2026.**

Planned actions to implement objectives per the refreshed Risk Management Strategy 2025/26

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Objective 3 - Improving the risk maturity of the UHB	Our plan to achieve the objective
Continued engagement with relevant teams across the UHB to establish how risk information is currently utilised within their areas to support the achievement of the delivery of our objectives and performance targets to inform our annual risk maturity assessment;	Assurance and Risk team will continue to encourage staff to complete the Risk Maturity Assessment feedback during 2025/26, in accordance with the Orange Book (a recognised risk management standard for the public sector). Risk Maturity Assessment responses will be collated and reviewed on a quarterly basis, with reports being provided to future ARAC meetings. **Throughout the year**
Further development of risk management training material, with more focus on the identification of opportunities;	The Assurance and Risk team will continue to deliver and develop risk training including communication, as outlined in objective 1. **Throughout the year**
Engaging with service leads across the UHB to assess the risk culture and the interdependencies of risks within the organisation to identify areas of improvement to support individuals in undertaking risks in an informed manner to support the achievement of our objectives and performance targets;	The Assurance and Risk team will continue to encourage staff to complete the Risk Maturity Assessment feedback. The Assurance and Risk team will continue to present risk management and performance information to governance meetings, including information on linked risks and their interdependencies. Undertake focussed sessions with service leads to assess risk culture within their areas. **Throughout the year**
Develop guidance for appropriate risk management arrangements with key partners of the UHB to support its ability to achieve organisational objectives;	Assurance and Risk Team to develop written guidance on partnership risk management, and include in relevant training and Sharepoint material. **To be completed by March 2026.**

Risk Management Process

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Risk Management Process

The Health Board's risk management process is recorded via the Datix Risk Register Module (Datix), with risk register reports provided to both assurance and operational management meetings. Datix enables risks to be recorded at one of three risk levels, ensuring that risks are reported to and scrutinised at the most suitable forums:

- **Principal** – Risks that affect the organisation's ability to achieve its strategic objectives in the long-term
- **Corporate** – Significant risks that affect the organisation's ability to achieve its planning objectives and to deliver healthcare services in the 'here and now'
- **Operational** – Risks that affect the objectives of a Function.

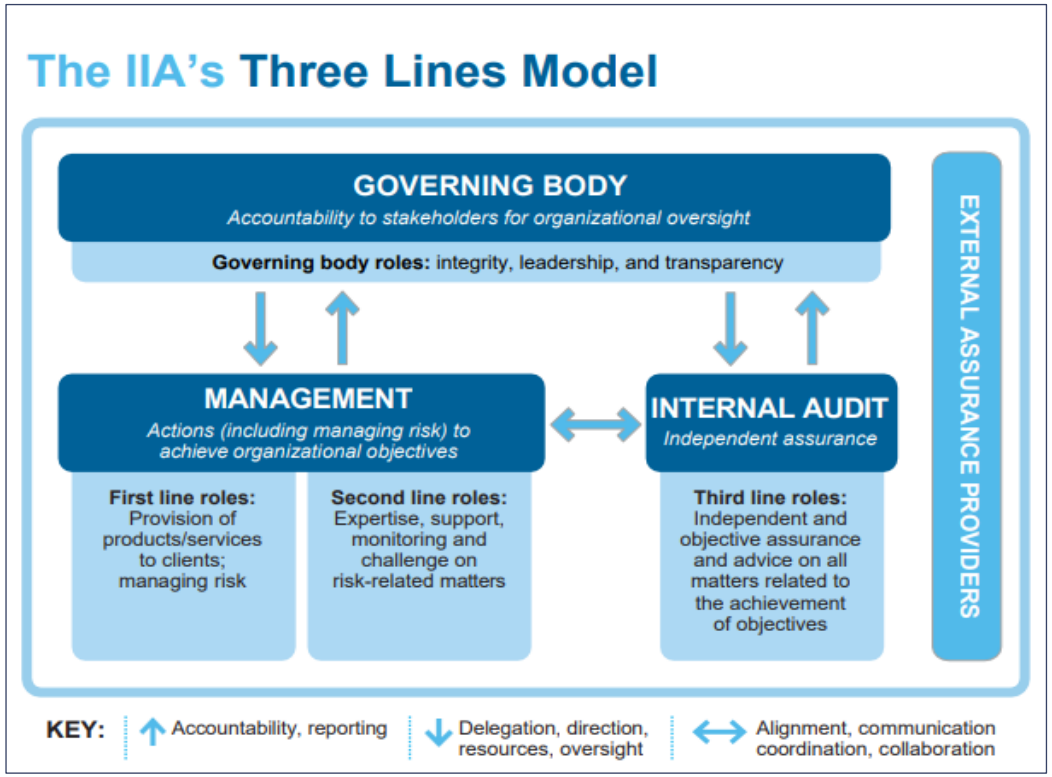
Risk management processes have been reviewed and updated to ensure ownership by appropriate service leads in line with revised management hierarchies, and support the effective oversight and escalation through updated operational and executive governance arrangements within Functions.

Risk Architecture

Risk architecture is the organisational arrangements for risk management which details the roles, responsibilities and the lines of communication for reporting on risk management and have recently been updated in light of the change to the Clinical Care Group operational structure to reflect revised management hierarchies and governance arrangements. These are detailed in the Risk Management Framework which was approved by Board in September 2025.

Three Lines of Defence

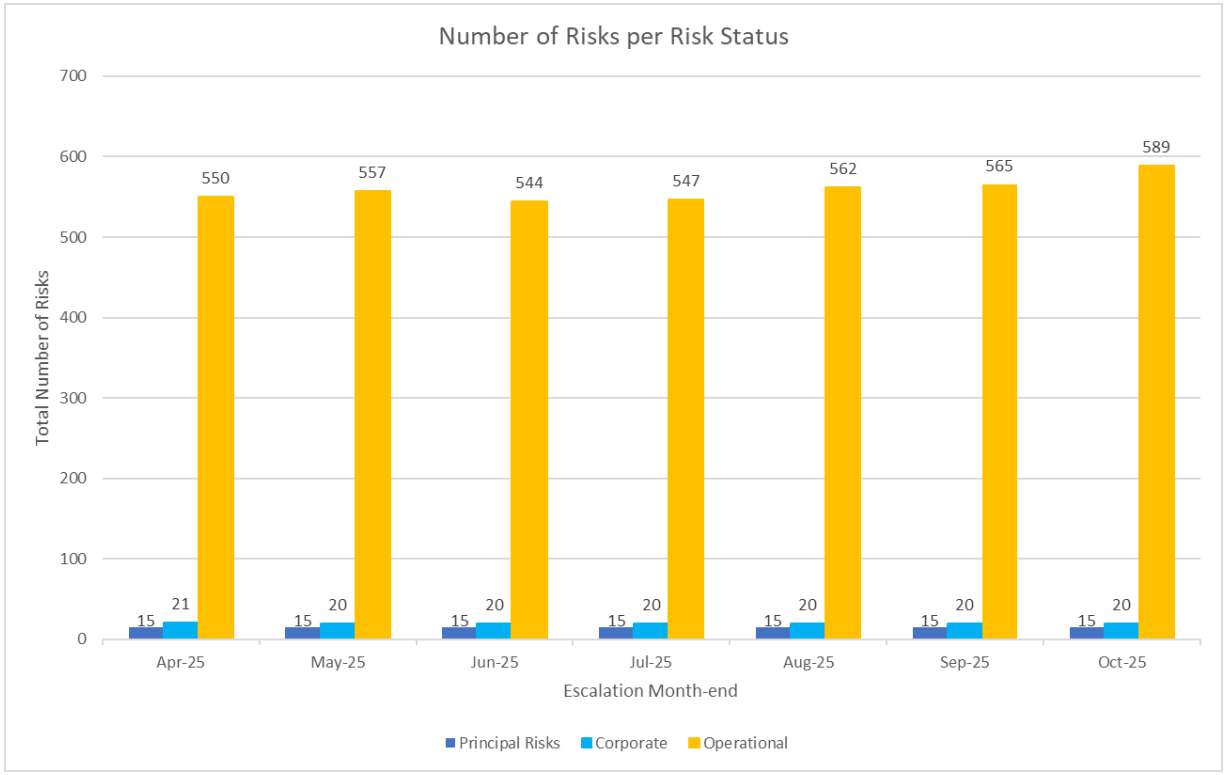
The Health Board operates within the widely accepted "Three Lines of Defence Model" which provides a simple and effective way to delegate and coordinate risk management roles and responsibilities within an organisation, to ensure the appropriate responsibility is allocated for the management, reporting and escalation of risk.



Context

The Health Board has 624 open risks on the Datix Risk Module as of 31 October 2025 (June 2025: 579) split across Principal*, Corporate and Operational risk levels.

*As Principal Risks are reviewed and updated by the Executive Team in line with the Board Assurance Framework, the focus of this report and the Improving Together metrics are on Corporate and Operational Risks.



Risks by Function– October 2025

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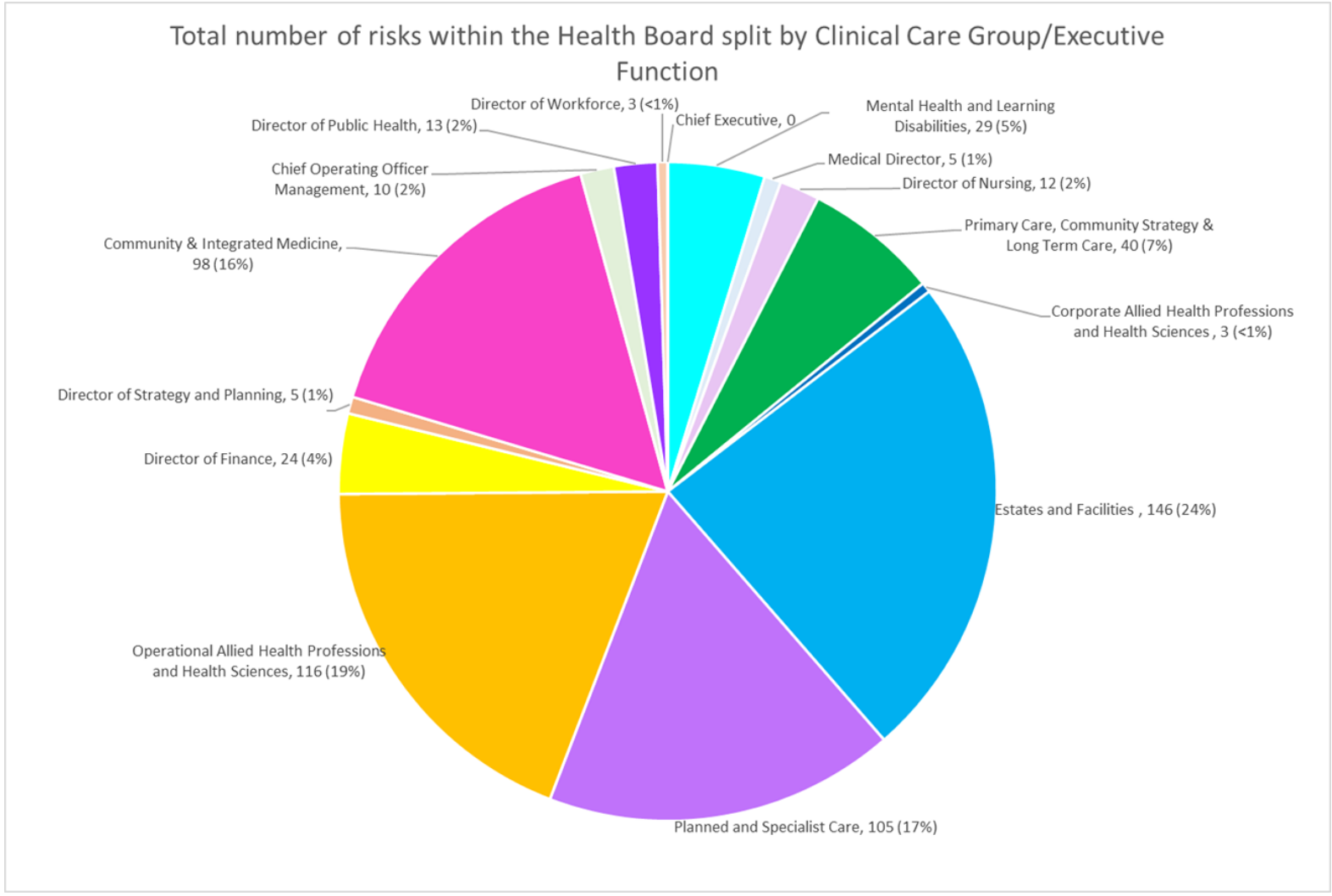
Estates and Facilities hold the largest number of risks at 146 (June 2025: 130), primarily relating to the condition of the Health Board's ageing estate and equipment (including fire safety devices and equipment), and the financial climate, with at least 55% of the risks reliant on capital funding to resolve. This is reflected in corporate risk 1745: *Risk of not being able to safely deliver services due to ageing estate and infrastructure across the Health Board* (current risk score of 15 as at November 2025).

Operational Allied Health Professions and Health Sciences have had the largest increase in the number of risks since the previous report presented to ARAC and hold the largest number of extreme risks (59), with financial risks and service fragility cited as main drivers.

Planned and Specialist Care hold 105 risks (June 2025: 110), and Community and Integrated Medicine 98 (June 2025: 93) hold a similar number of risks as reported in June 2025, reflecting the continuing challenges faced by the CCGs including lack of funding, workforce shortages, fragile services, and Planned and Specialist Care holding long waiting lists due to demand exceeding capacity and reliance on ageing or insufficient equipment.



1st Line of Defence:
Risk Management - Overdue risk and actions

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Since the introduction of the internal escalation framework, there has been fluctuations in the number of overdue risks throughout the year which may reflect the impact of operational demands across the Health Board. **12% of risks were overdue for review as at 31 October 2025** (June 2025: 11%).

Of those risks noted as overdue at October 2025, **64 have recently lapsed and are not overdue by more than one month** (June 2025: 54) and are therefore considered to be within an acceptable timeframe for review. 11 risks were overdue by more than one month, with 5 of these overdue by more than 2 months.

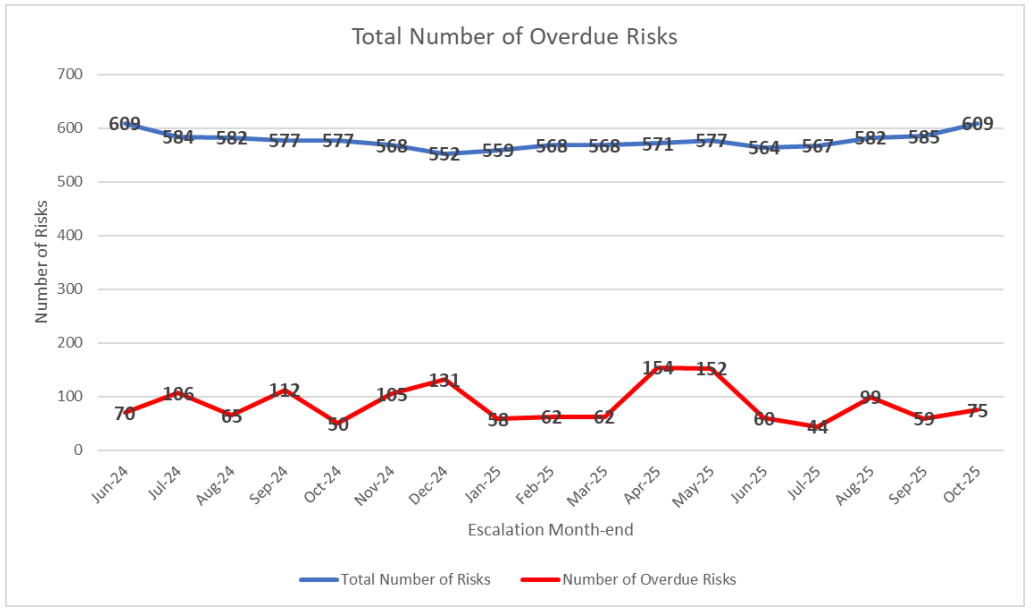
There has been a **notable reduction in the number of overdue risk actions since the implementation of the internal escalation framework,** however further progress is required to ensure that actions are clear, deliverable, reviewed and updated in a timely manner, and implemented within noted timeframes. **16% of risk actions are overdue as at October 2025** (Jun 2025: 18%), and may be a result of:

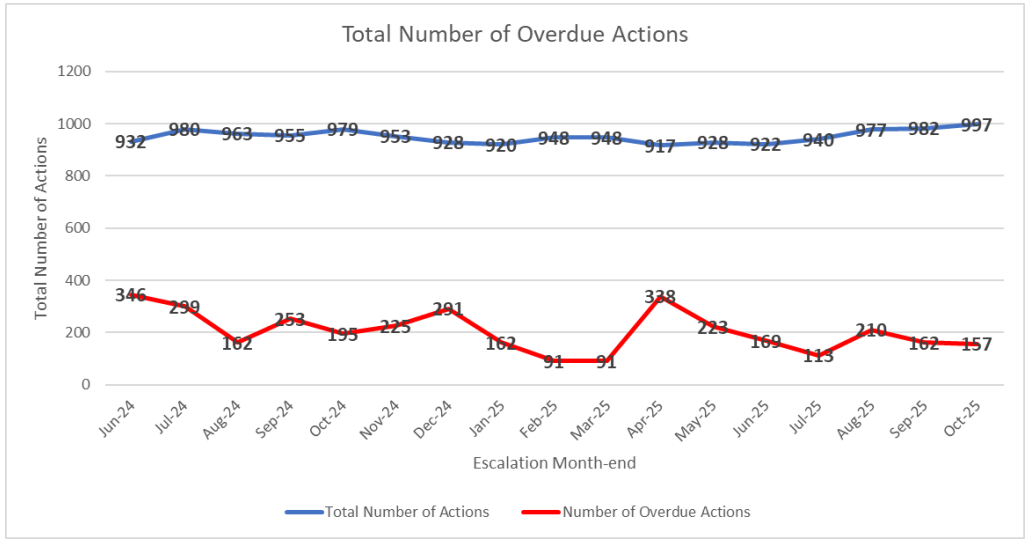
- being assigned unrealistic or unachievable timescales; or
- are not being updated fully during risk reviews.

There are currently 11 risks without risk actions plans, due to a combination of risks where leads have omitted to add actions to new risks, and risks that are being considered for “acceptance” in line with guidance from the recently approved Risk Management Framework. The Assurance and Risk business partners pick these up with risk leads at review meetings and via governance reports issued to Clinical Care Group and Executive Function leads.

Limiting factors which provide a barrier to the completion of risk action plans should be reflected in the rationale for Target Risk Scores (TRS) in line with the revised approach to risk tolerance, outlined in the Health Board’s Risk Management Framework.

Risk leads are advised to provide realistic revised action dates where original dates have lapsed, with sufficient narrative noting the reasons behind any delays and justification for the new date expected to achieve the TRS.





1st Line of Defence:
Risk Management - Overdue risks and risk actions

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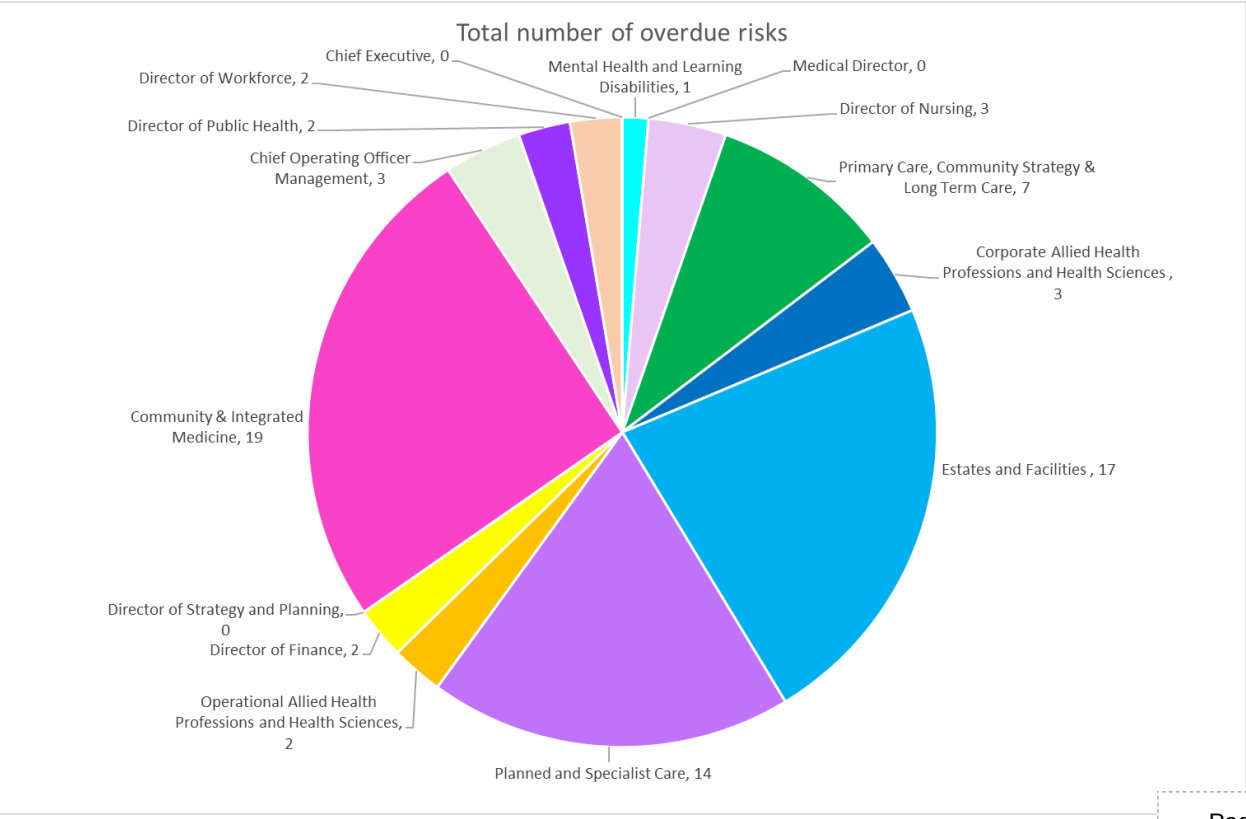
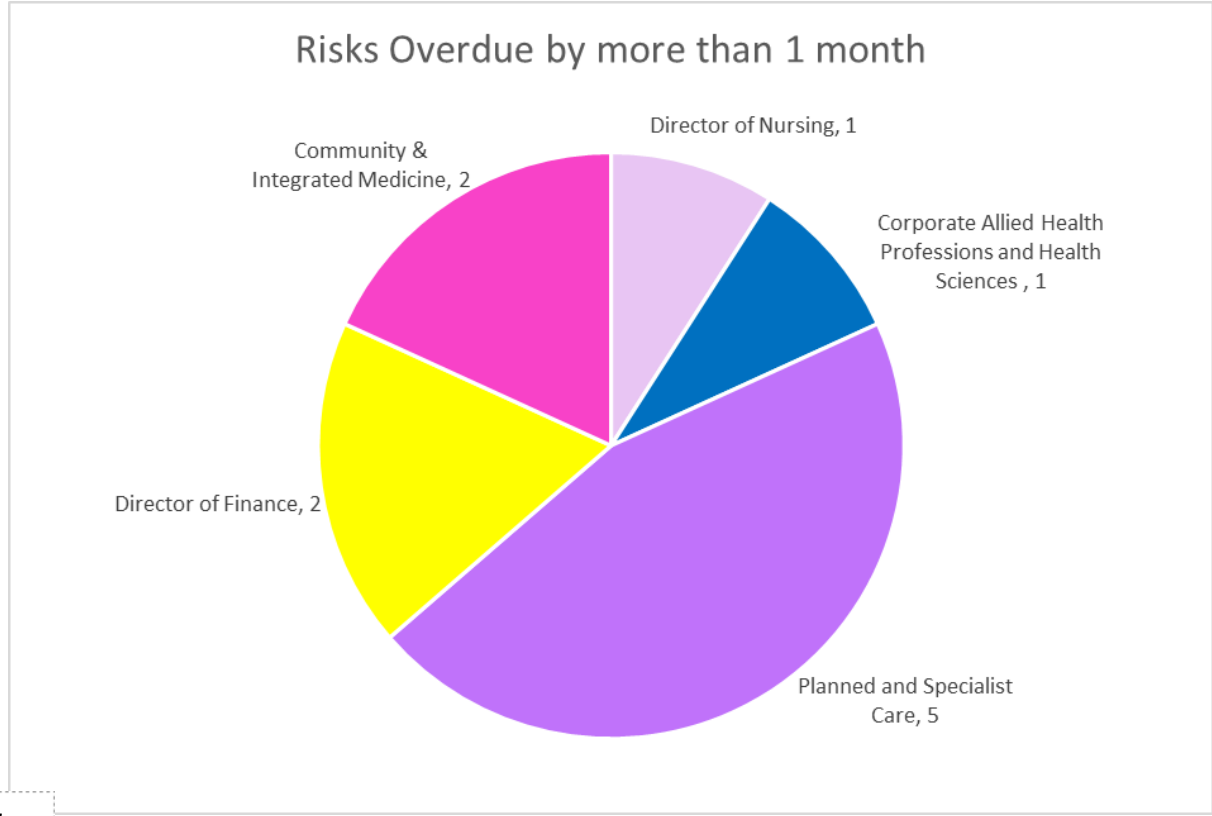
The **75 overdue risks** as at October 2025 are shown below split by function. **Community & Integrated Medicine have the largest number of overdue risks** (19 out of 98 on their risk register, 19%) (June 2025: 6), and the **largest number of overdue risk actions** (48 out of 167, 28%) (June 2025: 25), reflecting their current Level 3 escalation criteria for risk management under the Governance domain.

Estates and Facilities also had a high number of overdue risks (17 of 146 risks on their risk register, (11%)), though none of these were overdue by more than 1 month and therefore not currently of concern. Despite having only 2 overdue risks, **Operational Allied Health Professions and Health Sciences had a high number of overdue risk actions** (31 of 220 actions, 14%) suggesting that these were not updated on risk review. Assurance and Risk Officers continue to provide support to risk leads to ensure the appropriate and timely update of risks.





Risk Management (1st Line): Risk Treatment

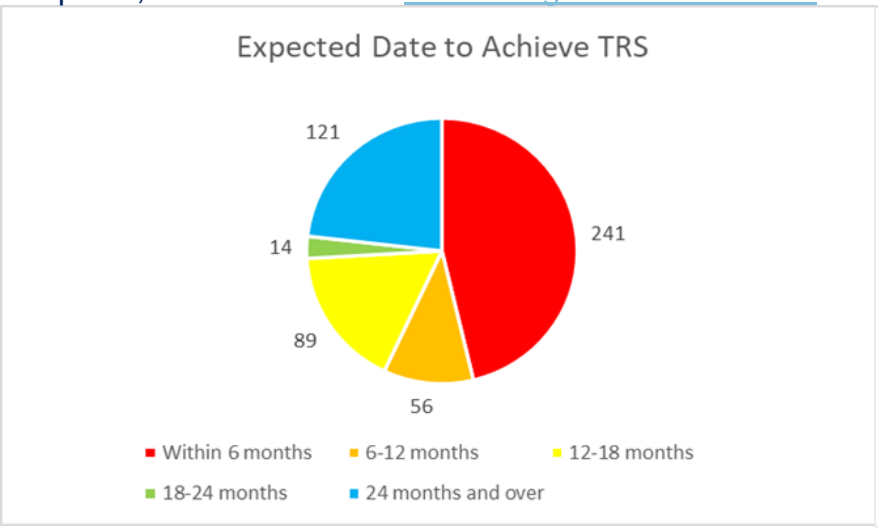
30 risks do not currently have an 'Expected Date to Achieve Target Risk Score (TRS)':

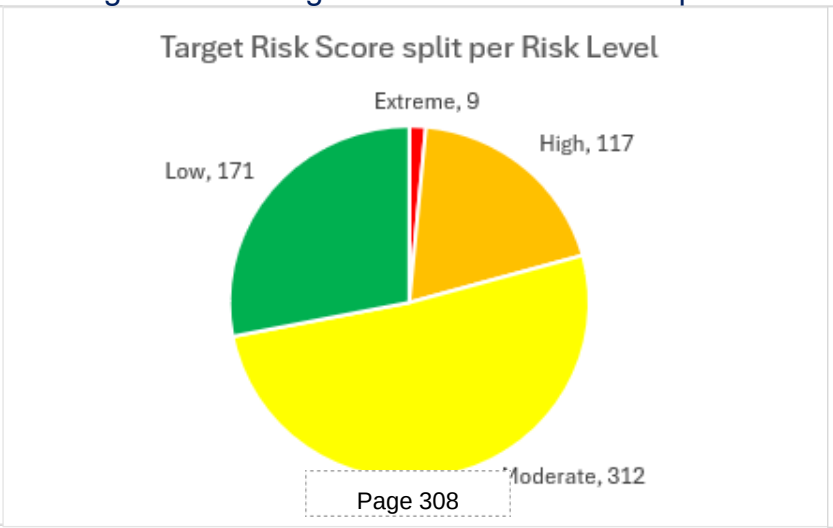
- 11 of these have not yet passed their review date since the field become mandatory on Datix due to the risks having a low or moderate current risk scores, and should therefore be updated at the next risk review;
- 3 high-scoring risks are overdue for review; and
- 16 risks have been reviewed but the 'Expected Date to Achieve TRS' section has not been updated and have a generic date in the data field.

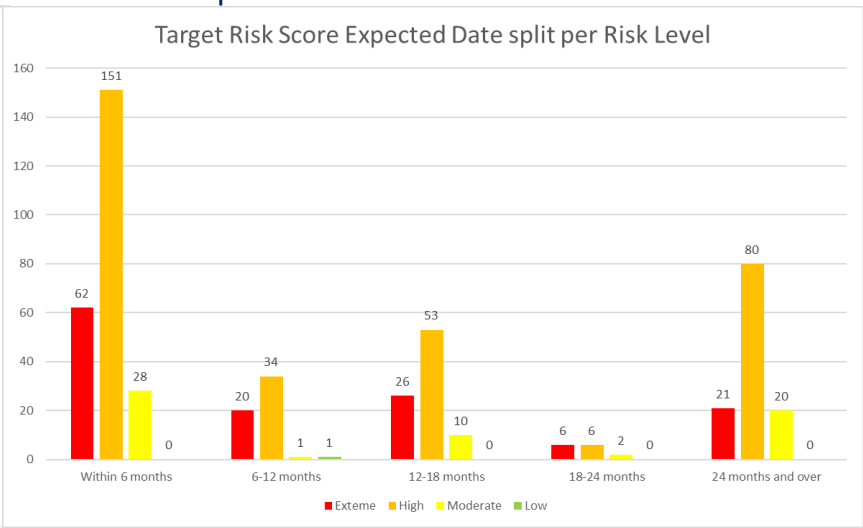
38 risks have an 'Expected Date to achieve TRS' that has passed, of which 17 have a current risk score that meets the TRS score. Of the remaining 21, 15 have been reviewed but the 'Expected Date to achieve TRS' has not been updated, suggesting that risk leads may not be fully updating risks on review. Risks with no assigned TRS date and lapsed TRS dates are flagged to risk leads by the Assurance and Risk business partners via the relevant governance meetings and addressed in risk review meetings.

Of the 9 risks with an Extreme TRS, these are held with Operational Allied Health Professions & Health Sciences (4), Mental Health and Learning Disabilities (3) and Community & Integrated Medicine (2). 1 Mental Health and Learning Disabilities risk sits at Corporate level and will be reviewed as part of the Executive Team "deep-dive" sessions. The remaining 8 operational risks with an extreme TRS have open risk actions, suggesting that the risks can be further managed and mitigated, and that the TRS score may need revision.

It is recognised that this is a new approach to risk acceptance which is still being embedded across the organisation. The Assurance and Risk Team continue to support Functions by highlight these risks within governance reports and the expectations around their update, reiterating the escalation via management structures to support decision-making if required, as outlined in the risk management framework. Risk management training material has also been updated to reflect these requirements.







Risk Management (1st Line): Risk Treatment

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As of October 2025, the average age of a risk is 3 years and 3 months (June 2025: 3 years and 5 months), with 119 (20%) risks having been identified as a risk pre-Covid (June 2025: 120 (21%)).

58% of these risks are aligned to the Estates & Facilities function, and primarily relate to the condition of the Health Board's ageing estate, plant and equipment (e.g. air handling units, heating, water and electrical systems). It is unlikely that the remaining aged risks will be fully mitigated until capital funding has been agreed and obtained. This is reflected in Corporate Risk 1745.

There has been an improvement in risk management for the Estates and Facilities function, with more realistic timescales provided for risks, and following their EITS session in September 2025, the Senior Leadership Team have confirmed that all long-standing risks have been reviewed.

Of the risks with a TRS expected date of 24 months and over, the majority (74) sit with the Estates & Facilities Function, which reflect the reasons stated above.

Risk Ref	Title	Date Risk Identified	Current Risk Score	Risk Level (Current)	Target Risk Score	RR - Target Risk Score Expected Date
1309	Risk to meeting demands for diagnostic reporting due to shortfall in Consultant Cellular Pathologist workforce	01/03/2011	20	Extreme	10	31/08/2028
1119	Risk of harm to service users due to inadequate water flow through pipes to prevent bacterial growth/water borne diseases	02/07/2012	6	Moderate	3	30/01/2032
430	Risk of Boiler House Engineering Plant and equipment failure due to having reached the end of its engineering life expectancy	01/08/2012	9	High	3	31/01/2030
1068	Risk of electrical shock from defective systems due to lack of periodic inspections, BGH	01/08/2012	8	High	4	31/03/2029
1069	Risk of patient harm and business interruption due to Medical Gas Plant and equipment failure (BGH)	01/08/2012	8	High	4	31/03/2026
1094	Risk of patient harm due to inability to maintain failing and ageing Nurse Call System, PPH & AVH	01/08/2012	6	Moderate	3	31/01/2030

Oversight of Risk (2nd Line): Internal Escalation

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Internal Escalation

The Health Board has an internal escalation process, as part of the Executive Improving Together (EIT) Framework, whereby CCG /Executive Functions are assessed on a monthly basis against seven domains, including 'Governance' (with specific focus on four key areas noted below), to drive improvement in performance, and awarded one of four levels based on their performance:

- Risk management, with relevant risks articulated with appropriate actions in place, evidenced that these are being delivered;
- Implementation of recommendations raised in audits / inspections and regulatory activity;
- Implementation of Welsh Health Circulars and Ministerial Directions; and
- Governance arrangements are in place.

Level 1: Reasonable assurance that the function can meet prescribed targets in a given domain within the year

Level 2: Limited assurance that the function can meet prescribed targets in a given domain within the year

Level 3: No assurance that the function can meet prescribed targets in a given domain within the year OR insufficient engagement with Targeted Intervention objectives

Level 4: No assurance that the function can meet prescribed targets in a given domain within the year, with insufficient actions or engagement in place to secure recovery

Measures to assess against the Governance Domain - Risks

Level	Criteria
Level 4 – no assurance and insufficient actions / engagement	No plan in place and no engagement, (eg no risk action plans, no expected date to achieve Target Risk Score). No evidence that risks are escalated via CCG management structures where necessary, no engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 3 – no assurance	Lack of evidence that risks are being managed and mitigated within expected timescales. Evidence where known risks are not articulated on the function's risk register. **Less than 80% compliance** of risks and risk actions being updated within required timescales Limited evidence that risks are escalated via CCG management structures where necessary, therefore not demonstrating good engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 2 – Limited assurance	Relevant risks articulated on risk registers with action plans in place, but lack of evidence that risks are being managed and mitigated within expected timescales. *(eg risk action plans not being implemented within original action dates, limited evidence of reduction in current risk score).* **Between 80% - 89% compliance** of risks and risk actions being updated within required timescales Some evidence that risks are escalated via CCG management structures where necessary, demonstrating engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 1 – Reasonable assurance	Relevant risks articulated on risk registers with action plans in place, and evidence that the function is delivering against these (eg specific and measurable risk action plans, current risk score and target risk score clearly articulated, achieving expected target risk dates) **Over 90% compliance** of risks and risk actions being updated within required timescales isks are escalated via CCG management structures where necessary, demonstrating good engagement and the ability for ake informed decisions on prioritisation of resources

2nd Line of Defence: Internal Escalation Framework Governance Domain

Service	April 2025	May 2025	June 2025	July 2025	August 2025	September 2025	October 2025
Chief Operating Management	2	2	1	1	1	1	2
Community & Integrated Medicine	2	2	2	2	3	3	3
Estates & Facilities	3	3	2	2	2	1	1
Executive Director of Allied Health Professions and Health Sciences	1	2	1	1	1	1	1
Executive Director of Finance	2	2	2	1	1	1	1
Executive Director of Nursing, Quality and Patient Experience	2	2	2	2	2	2	2*
Executive Director of Public Health	2	1	1	1	1	1	1
Executive Director of Strategy and Planning	2	2	2	1	1	1	1
Executive Director of Workforce and Organisational Development	1	1	2	1	1	1	1
Executive Medical Director	2	2	1	1	1	1	1
Governance and Communication	1	1	1	1	1	1	1
Mental Health and Learning Disabilities	3	3	2	2	2	2	2
Operational Allied Health Professions and Health Sciences	2	2	2	2	2	1	1
Planned and Specialist Care	3	3	3	3	3	3	2
Primary Care, Community Strategy & Long Term Care	2	2	2	2	2	2	2*

As at 31 October 2025, Community & Integrated Medicine met the Level 3 escalation criteria for risk management under the Governance domain, with a detailed analysis provided on the next slide. An additional three Functions met the Level 2 escalation for risk management.

The Assurance and Risk Team provide focussed support for those Functions at levels 3 and 4 to aid their de-escalation/recovery, and to prevent those awarded level 2 status being escalated. Detail is provided within each report provided and presented at Function governance meetings the reasons behind their escalation status, and suggested actions in order to de-escalate (where appropriate).

*Whilst five Functions met the Level 2 escalation criteria under the Governance Domain, the escalation status of two Functions was not attributable to risk management, as it was predominantly based on the management of their audit and inspection recommendations and/or other factors such as implementation of Welsh Health Circulars / Ministerial Directions and general governance arrangements.

2nd Line of Defence: Internal Escalation – Governance Domain : Level 3 - No Assurance

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Community & Integrated Medicine

As at 31 October 2025, the Clinical Care Group (CCG) had **19 of 98 risks overdue** (19%), meeting the Level 2 criteria within the escalation criteria (between 80-90% compliance).

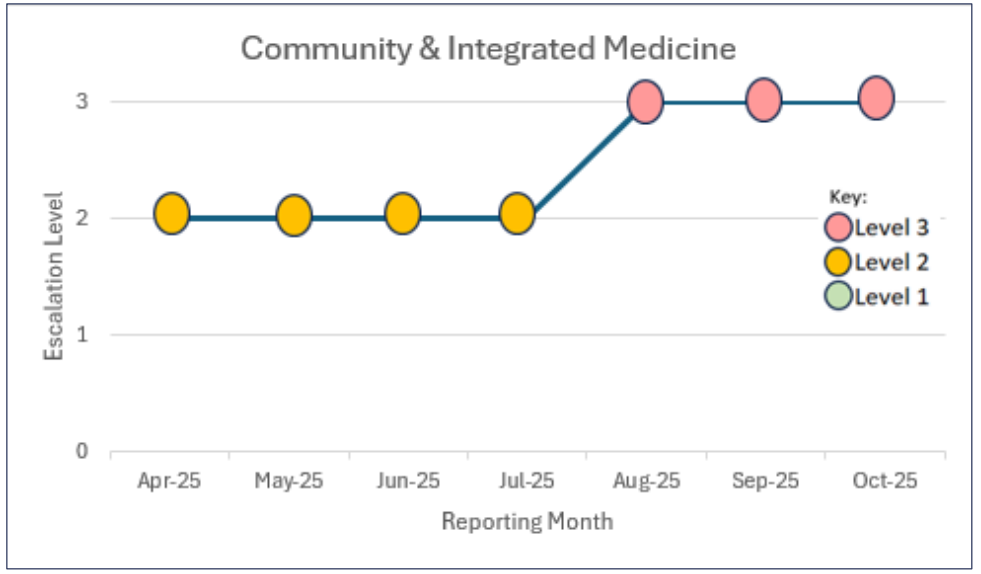
The CCG however had 167 open risk actions, of which **48 were overdue (29%).** Whilst a slight improvement on the September 2025 position (32%), the CCG meets Level 3 criteria (less than 80% compliance of risk actions being updated within required timescales).

Additionally, **4 risks did not have any open actions**.

5 of the 98 risks (5%) did not have an 'Expected Date to achieve TRS', and a further **12 risks do not have a 'Rationale for Target Risk Score (TRS)'** noted on Datix. 3 risks had been reviewed which had an 'Expected Date to achieve TRS' which had passed and the date not been revised accordingly, suggesting that risks are not fully updated during review.

The **pace at which emerging risks are added to Datix** within some Clinical Service Groups **remains slow**. Risks which have been recently discussed but have yet to be added include those relating to Medical/Clinical staffing, grant funded posts, Health Care Support Worker posts, and manual handling training.

The Assurance and Risk Officer continues to offer support to the CCG by meeting when required with risk leads, and highlights this information at the relevant governance meetings.



2nd Line of Defence: Internal Escalation – Governance Domain : Level 2 – Limited Assurance

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The following 3 services were awarded a Level 2 attributable risk management performance within the Governance domain as at 31 October 2025:

Clinical Care Group / Executive Function	Reason for award of L2	De-escalation Criteria
Chief Operating Officer	Deteriorating position with **3 (30%) risks overdue** and **6 (46%) risk actions overdue**. 50% TRS dates have passed *Noting that risks have been updated accordingly ahead of the Executive Improving Together session held in November 2025.*	To achieve Level 1, 90% of risks and risk actions are reviewed within timeframes and compliance achieving TRS dates
Mental Health and Learning Disabilities	Whilst an improved position was noted compared to September 2025, with only 3% of risks and 4% of risk actions overdue, **known risks are not entered on Datix promptly.**	To achieve Level 1, 90% of risks and risk actions are reviewed within timeframes, risk registers are relevant and updated in a timely manner, and evidence of compliance in achieving TRS dates
Planned and Specialist Care	Slightly deteriorating position with **13% risks overdue** and **29 (16%) risk actions overdue**	To achieve Level 1, 90% of risks and risk actions are reviewed within timeframes and evidence of compliance in achieving TRS dates

2nd Line of Defence: Thematic Analysis

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk owners can assign multiple ‘themes’ to their risks on Datix, which allows the Health Board to share risk information on specific areas, with the relevant subject matter experts within the Health Board. They in turn can offer specific support and guidance to risk owners in the management of risk and identify trends and areas of concern.

Each theme is aligned to a designated committee to provide assurance that processes are in place to deliver a holistic approach to risk management, further enabling the Health Board to better identify and define its risk appetite, risk capacity and total risk exposure in relation to each risk. It also provides the opportunity to group similar risks or generic type of risk. Thematic risk registers also support the identification of trends, clusters, and potential gaps within the Health Board’s control framework. They may be used to determine whether further action is needed to prevent risks from materialising.

Each risk theme has assigned owners based on their subject matter expertise and are provided with the relevant thematic risk register on a bi-monthly basis. Upon receipt, theme owners are expected to:

- Confirm that risks are appropriately assigned to the theme
- Review the risk, associated controls, and planned actions from an expert perspective
- Offer oversight and guidance to the relevant manager on any additional controls required to manage the risk to an acceptable level

To strengthen the effectiveness of this framework, the Assurance and Risk Team have been conducting a review of existing risk themes. The review identified duplication across several themes, leading to a decision to streamline and consolidate them into a more manageable and meaningful data set. The progress of the work undertaken to date are noted on the following slides. Further work is being undertaken by the team to review certain risk themes, such as ‘Patient Safety and Quality’ and ‘Finance’, to ensure these are as effective and meaningful as possible.

2nd Line of Defence: Thematic Analysis

The following slides details those risk themes where work is ongoing:

Risk theme	Committee theme reported to	Review undertaken
Consent and Mental Capacity	Quality, Safety and Experience Committee	The risk theme expert has confirmed that the themed risk register is reviewed on a regular basis.
Finance	Finance and Performance Committee	Further work is being undertaken with Finance colleagues to determine whether this theme can be refined to allow more meaningful information to be captured from the data, and to provide better insight.
Fragile Services	Quality, Safety and Experience Committee	These themes are currently being reviewed as a result of the new reporting structures under QSEC to ensure their appropriate oversight at the appropriate sub-group of QSIG. This work is being supported by the Interim Assistant Director of Nursing. Progress of this work is due to be presented to QSEC in February 2026 via the Assurance and Risk Report. The 'risk theme' expert has confirmed that the themed risk register is reviewed on a regular basis.
Infection Control	Quality, Safety and Experience Committee	
Medication	Quality, Safety and Experience Committee	
NICE/National Guidance	Quality, Safety and Experience Committee	
Patient Safety	Quality, Safety and Experience Committee	
Quality	Quality, Safety and Experience Committee	
Safeguarding	Quality, Safety and Experience Committee	

2nd Line of Defence: Thematic Analysis

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The following risk themes have received confirmation from the relevant risk theme lead that the thematic risk register as sent bi-monthly by the Assurance and Risk Team is regularly reviewed and analysed, and therefore considered relevant.

Risk theme	Committee theme reported to	Review undertaken
Accommodation/Property	Health and Safety Committee	The risk theme expert has confirmed that the themed risk register is reviewed on a regular basis.
Business Continuity/Service Disruption	Quality, Safety and Experience Committee	The risk theme was previously reconciled with the Business Continuity Plan register but recent review has been constrained by limited capacity. Work will re-commence when capacity in the team improves. The risk theme expert has requested the themed risk register is still sent and confirmed this work is planned to recommence in the near future.
Capital - Digital	Capital Sub Committee	The risk theme expert has confirmed that the themed risk register is reviewed on a regular basis with the capital themed risks also being shared with the operational teams who are involved in the Capital Planning process for 2026/27.
Capital - Equipment	Capital Sub Committee	The risk theme expert has confirmed that the themed risk register is reviewed on a regular basis.
Capital - Estates	Capital Sub Committee	The risk theme expert has confirmed that the themed risk register is reviewed on a regular basis.
Cyber Security	Information Governance Sub Committee	The risk theme expert has confirmed that the themed risk register is reviewed on a regular basis.
Deprivation of Liberty Safeguards (DoLS)	Quality, Safety and Experience Committee	The risk theme expert has confirmed that the themed risk register is reviewed on a regular basis.
Digital Transformation	Digital, Data and Innovation Committee	The risk theme expert has confirmed that the themed risk register is reviewed on a regular basis.
Estates	Health and Safety Committee	The risk theme expert has confirmed that the themed risk register is reviewed on a regular basis
Fire	Health and Safety Committee	The risk theme expert has confirmed that the themed risk register is reviewed on a regular basis with a 'Key Actions Report for Fire Themed Risks Overview' report presented for information to the Fire Safet

2nd Line of Defence: Thematic Analysis

Risk theme	Committee	Current/proposed work
ICT (Information and Communications Technology)	Information Governance Sub Committee	The 'risk theme' expert has confirmed that the themed risk register is reviewed on a regular basis.
Information & Data Capture	Information Governance Sub Committee	The 'risk theme' expert has confirmed that the themed risk register is reviewed on a regular basis.
Information Governance	Information Governance Sub Committee	The 'risk theme' expert has confirmed that the themed risk register is reviewed on a regular basis.
Medical Devices	Quality, Safety and Experience Committee	New 'risk theme' expert has confirmed that the themed risk register is reviewed on a regular basis.
Natural Environment	Health and Safety Committee	The 'risk theme' expert has confirmed that the themed risk register is reviewed on a regular basis.
Reputation	*Managed outside of Committee as agreed with the Director of Communications*	*Managed outside of Committee as agreed with the Director of Communications*
Safeguarding	Quality, Safety and Experience Committee	The 'risk theme' expert has confirmed that the themed risk register is reviewed on a regular basis.
Security	Health and Safety Committee	The 'risk theme' expert has confirmed that the themed risk register is reviewed on a regular basis.
Workforce	People, Organisational Development and Culture Committee	The Assurance and Risk Team are currently working with Workforce & Organisational Development to review the existing risk theme to better align to the W&OD Directorate Pillars enabling more meaningful information to be captured from the data, to provide better insight. It is anticipated that the risk themes will be agreed and operational risks aligned to these on Datix during Q3 of 2025/26.

3rd Line of Defence: Independent Assurance

Independent Assurance (3rd line)

The third line of defence relates to those who provide independent assurance over the management arrangements in place and, where appropriate, can advise on control strategies.

On 11 March 2025, Welsh Government considered the Health Board's escalation status and in recognition of governance improvements, related to improved Board stability and an increased degree of confidence in the organisation's governance, the Health Board was de-escalated for Governance from level 4 (targeted intervention) to level 3 (enhanced monitoring). Risk management is one of the criteria considered in the governance domain and therefore reflects confidence across the Health Board's governance framework, including its risk management framework. Further evidence was submitted in October 2025 to demonstrate continued improvements within the Governance domain and working towards a further de-escalated position of Level 2.

Audit Wales are undertaking fieldwork for the Structured Assessment 2025 which will include focusing on Corporate systems of assurance, including the effectiveness of risk management arrangements, with the final report being presented to ARAC at its meeting in December 2025.

Committee and Reporting Structures

Effective risk management requires a reporting and review structure to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place. The Health Board's risk reporting structure is outlined in Appendix 2 of the Risk Management Strategy.

1. The Board

The Board is responsible for oversight of the Health Board's **principal risks**, which are those that affect its ability to achieve its strategic objectives.

Principal risks are reported to the Board 3 times a year, with the last report provided in November 2025 as part of the BAF Dashboard. The Health Board will be looking to update the planning objectives, principal risks and outcome measures which support the four strategic objectives following the completion of the Strategy Refresh which will be presented to Board in January 2026.

The Board is also responsible for oversight of the Health Board's **corporate risks**, which are defined as significant risks which affect the Health Board's ability to deliver the healthcare services in the 'here and now'.

Corporate risks are reported to the Board 3 times a year, with the last report provided in September 2025. In November 2025, the Executive Team agreed to add 3 new corporate risks, with a total of 23 risks on the Corporate Risk Register as at November 2025.

The Formal Executive Team reviews the corporate risk register on a monthly basis, and the principal risk register on a quarterly basis, ahead of Board reporting. The Executive Team is able to:

- Approve or escalate new risks for addition to corporate/principal risk registers; and
- Approve the closure of, or de-escalation of corporate/principal risks to operational level.

At Formal Executive Team in October 2025, a "deep-dive" approach on corporate level risks commenced to seek formal agreement on TRS scores, provide steer around further risk treatment, and to consider the acceptance of these risks. A schedule has been put forward based on the current risks on the Corporate Risk Register to ensure all are appropriately

Committee and Reporting Structures - CRR

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The table below summarises the changes to the Corporate Risk Register (CRR) since the previous report presented to ARAC in August 2025. All changes are included in risk reports presented to Board and Committees.

Risk Ref and Title	Clinical Care Group/Executive Function	Lead Committee	Current Risk Score Oct-25	Nature of Change	Date of change on CRR
1552 - Risk of inadequate body storage capacity across Health Board mortuaries	Operational Allied Health Professions & Health Sciences	Quality, Safety and Experience Committee	20	Risk escalated to Corporate level	05/11/2025
2190 - Risk of delay in CHC direct payments due to short timescale, limited resources & lack of WG policy guidance	Primary Care, Community Strategy & Long Term Care	Quality, Safety and Experience Committee	16	New risk added	05/11/2025
2212 - There is a risk that the Health Board will not have an approvable Integrated Medium-Term Plan (IMTP) by March 2028.	Director of Strategy and Planning	Strategy and Planning Committee	12	New risk added	05/11/2025
1978 - Risk of insufficiently skilled workforce to deliver services due to limited labour market	Workforce & Organisational Development	People, Organisational Development and Culture Committee	16	Increase in Current Risk Score from 12 to 16	04/07/2025
1821 - Risk to the welfare of Health Board staff due to current demands	Workforce & Organisational Development	People, Organisational Development and Culture Committee	12	Increase in Current Risk Score from 9 to 12	31/07/2025
1032 - Risk of timely ASD diagnostic assessment for CYP due to increasing demand	Mental Health and Learning Disabilities	Quality, Safety and Experience Committee	20	Decrease in Target Risk Score from 20 to 16	15/09/2025

Risks that have been Escalated or De-Escalated:

Risk Ref and Title	Clinical Care Group/Executive Function	Lead Committee	Risk Score Oct-25	Risks that have Escalated or De-escalated	Date of change on CRR
1708 - Risk of increasing fragility in primary care contractor services due to external factors	Primary Care, Community Strategy & Long Term Care	Quality, Safety and Experience Committee	16	Risk de-escalated to Operational level	06/08/2025

Committee and Reporting Structures

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

2. Board Committees and Sub-Committees

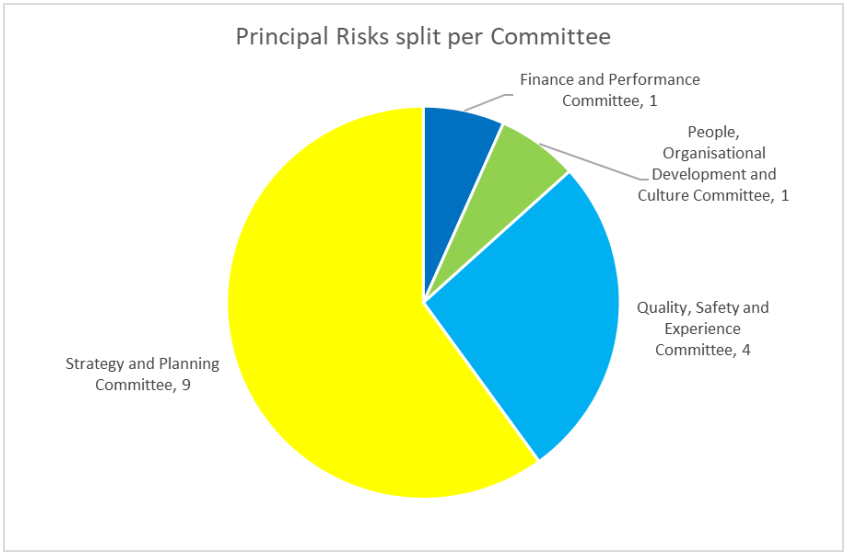
Terms of References (TORs) are in place for each committee in the Health Board, outlining their responsibility to review and seek assurance that risks aligned to Committees are being effectively managed across the Health Board, and report any areas of significant concern. Following the change in reporting arrangements, all risks (Principal, Corporate and Operational) are now reported to each Committee meeting via the "Assurance and Risk Report". Principal, Corporate and Operational risks are reported on an alternate basis to the bi-monthly Committees, with the exception of Digital, Data and Innovation Committee (DDIC) and People, Organisational Development and Culture Committee (PODCC) where all risks are reported to each quarterly meeting. The new format slides have been positively received, generating focussed discussion on risks.

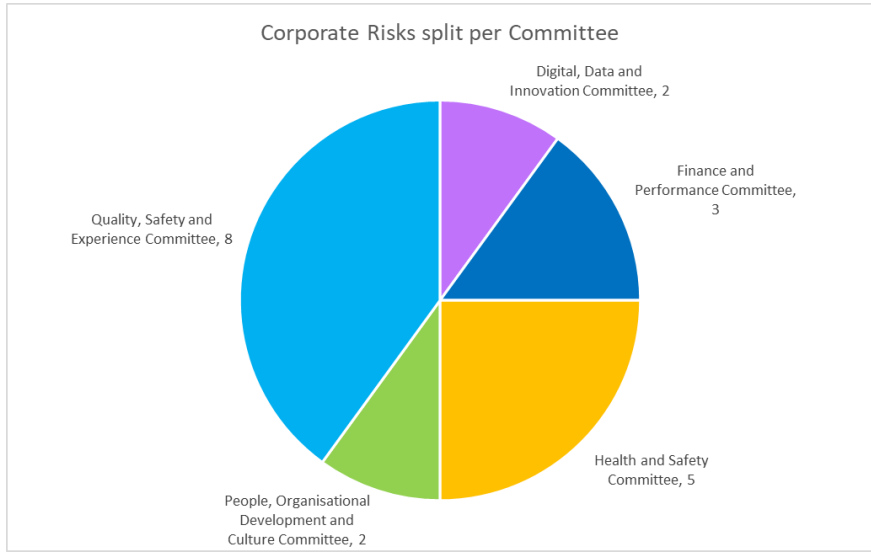
Risks are also reported to sub-committees, each of whom have delegate authorities from the parent committee who receive update reports at each meeting.

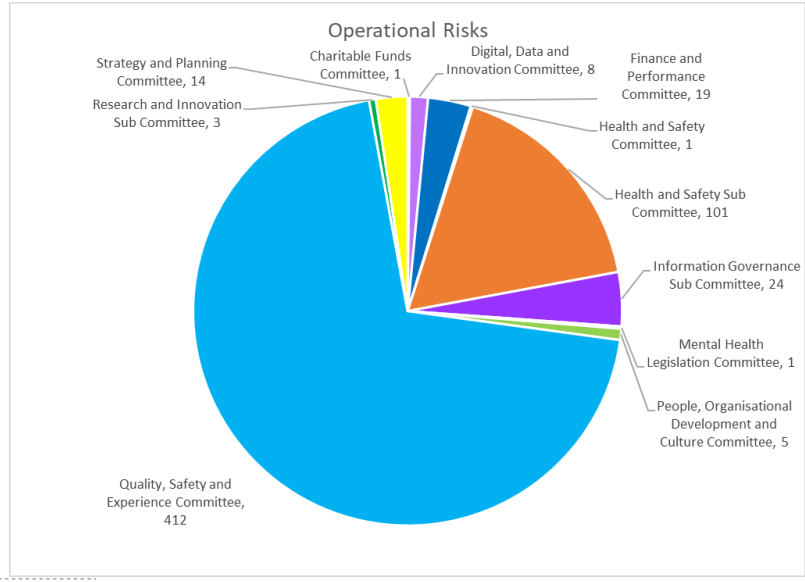
Operational risks are reported to committees based on the following criteria:

- Current Risk Score is "extreme" or "high"; and
- Current Risk Score is either equal to or exceeds the "Target Risk Score"

Tables of Actions (TOAs) are generated from meetings reflecting any next steps in relation to risk management which require to be undertaken, reflecting committee discussions







3. Clinical Care Group and Executive Function Level Monitoring Arrangements

Clinical Care Groups

Risks are discussed at the CCG Integrated Governance Group meetings which occur fortnightly, alternating the agendas of Quality, Health & Safety, and Business, Planning, Performance & People. The CCG's remit is to evidence to the Integrated Quality, Finance and Performance Delivery Group (IQFPDG) that these risks are being managed and monitored effectively in line with the Health Board's Risk Management Framework. The requirements of the CCG are stipulated within the Operational Scheme of Delegation as has been in place since the introduction of the CCG structures as part of the operational Organisational Change Process (OCP).

The Assurance and Risk team prepare risk reports for CCG and Executive Function meetings, presenting at meetings where requested and sharing the slides at meetings where not in attendance.

Executive Functions

Executive Functions have local governance arrangements for risk, most notable Senior Leadership Team meetings, with their frequency varying dependant on the Function.

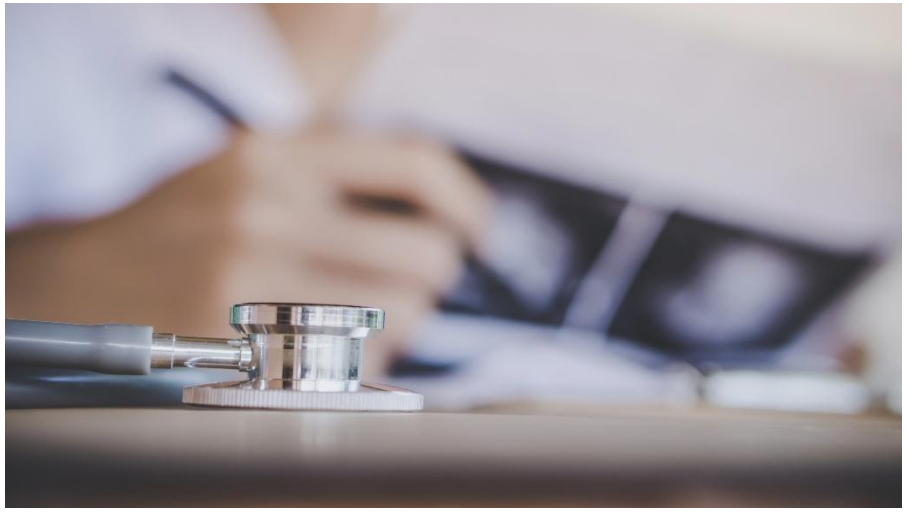
Continuing local governance arrangements, including frequency of stood down meetings, are considered when awarding the escalation status for Governance.

Next Steps and Recommendations

Next Steps

This report has identified a number of areas that could be strengthened, with updates to be provided in the next Risk Assurance report to ARAC on these:

- To finalise the review of existing risk themes, to ensure these are a manageable and meaningful set.
- To work towards achieve our new objectives over the next 12 months following the approval of the Risk Management Strategy (the Strategy), approved by Board in September 2025, including identifying a suitable risk management system ahead of 30 November 2027.



Recommendations

The Audit and Risk Assurance Committee is asked to **TAKE ASSURANCE** on risk management arrangements and processes in order to report progress to the Committee, including the revised performance management arrangements.

7

12:00, 0 Mins

7 - For Information

7.1

12:00, 0 Mins

7.1 - ARAC Workplan 2025/26

For information

Attachments

7.1 Audit Work Programme 2025-26.pdf

HYWEL DDA UNIVERSITY HEALTH BOARD – AUDIT & RISK ASSURANCE COMMITTEE DRAFT ANNUAL WORK PLAN 2025/26

The proposed work programme is aligned to the requirements of the 2012 Revised NHS Wales Audit Committee Handbook, Draft Terms of Reference and example agenda and timetable.

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
INTRODUCTIONS									
Apologies	**Chair**	✓	✓	✓	✓	✓	✓	✓	✓
Declaration of Interests	**All**	✓	✓	✓	✓	✓	✓	✓	✓
GOVERNANCE									
Minutes from previous meeting	**Chair**	✓		✓	✓	✓	✓	✓	✓
Matters Arising & Table of Actions	**Chair**	✓		✓	✓	✓	✓	✓	✓
Matters Arising not on agenda	**Chair**	✓		✓	✓	✓	✓	✓	✓
Self-Assessment of Committee's effectiveness	**Chair**			D	✓		✓		
Escalation Status Update	**PK/LD/SA**	✓		✓	✓	✓	✓	✓	✓
Review and report upon the adequacy of arrangements for declaring, registering and handling interests	**JW**		✓						✓
Receive full report of all offers of gifts and hospitality	**JW**		✓						✓
Compliance with Ministerial Directions	**JW**		✓						
Compliance with Welsh Health Circulars (WHCs)	**JW**		✓						
Review ARAC Annual Report	**Chair**		✓						
Review Board Effectiveness Report	**JW**		✓						
Review Accountability Report, incl Annual Governance Statement	**JW**		✓ (Draft)	✓ (Final)					
Review Annual Head of Internal Audit Report and Opinion (incl Capital/PFI)	**JJ**		✓ (Draft)	✓ (Final)					
Internal Audit: Annual Governance Statement Review	**JJ**		✓	✓					
Review, agree and recommend to the Board the audited accounts & financial statements	**HT**		✓ (Draft)	✓ (Final)					

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
Audit Enquiries to those charged with Governance and Management	**HT**		✓						
Audit Wales ISA 260 incl Letter of Representation	**Audit Wales**			✓					
Review the Health Board's Annual Report (Overview & Perf Section)	**HT**		✓ (Draft)	✓ (Final)					
Review changes to Standing Orders & Standing Financial Instructions*	**JW**	✓ (SOs)		✓ (SFIs)					
Annual Review of Standing Orders and Standing Financial Instructions	**JW**	✓ (SOs)		✓ (SFIs)					✓
Scheme of Delegation	**JW**	✓							
Annual Review of Terms of Reference	**Chair/JW**			✓					
All Wales NHS Audit Committee Chairs' Meeting Update	**Chair**				D	✓	✓	✓	✓
NWSSP's Construction Frameworks for Swansea Bay & Hywel Dda UHBs	**LD**				✓				
Review of any other sources of external assurance to ensure approp planning & coordination and that the Board is informed accordingly of any issues relating to compliance, risks of non-compliance & recommendations	**All**	✓	✓	✓	✓	✓	✓	✓	✓
Provide assurances where a significant activity is shared with another organisation (eg NWSSP/JCC)	**HT/SM**	✓	✓	✓	✓	✓	✓	✓	✓
Receive assurances from internal audit performed at these organisations that risks in the services provided to them are adequately managed and mitigated with appropriate controls	**JJ**	✓	✓	✓	✓	✓	✓	✓	✓
Review of Capital & PFI Audit Reports including results & the adequacy of executive & management responses to any issues identified and ensuring that they are acted upon	**EJ**	✓	✓	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
AUDIT WALES									
Review External Audit Plan via update reports	**Audit Wales**	✓		✓	✓	✓	✓	✓	✓
Approve External Audit Strategy & Annual Audit Plan (designed to implement the strategy) & assoc fees	**Audit Wales**	✓						✓	✓
Review of External Audit Reports including results & the adequacy of executive & mgmt responses to any issues identified and ensure that the other Cttees monitor & report back	**Audit Wales**	✓		✓	✓	✓	✓	✓	✓
Consider any Audit Wales National Value for Money Examinations & Performance Reports	**Audit Wales**	✓		✓	✓	✓	✓	✓	✓
Receive the Auditor's General report to those charged with governance (Year-end)	**Audit Wales**		✓						
Structured Assessment 2024 Management Response Update	**Audit Wales/JW**				✓			✓	
Structured Assessment 2025	**Audit Wales**						✓	✓	
Review of Urgent and Emergency Care (Part 1 and Part 2)	**Audit Wales/AC**	D		✓	D	✓	✓		
Planned Care Review	**Audit Wales/AC**	D		✓					
Review of Capital Investment Prioritisation	**Audit Wales/LD**			✓					
Cancer Services in Wales: A review of the strategic approach to improving the timeliness of diagnosis and treatment	**Audit Wales/AC**	✓							
Review of the Management of Outpatients	**Audit Wales/AC**				D	D	D	✓	
Deep Dive - Review of Investment in Digital Systems	**Audit Wales/HT**				D		D	✓	

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
Review of Radiology Services	**Audit Wales/AC**							✓	
Deep Dive - Review of the Arrangements to Manage Estates	**Audit Wales/JS**								✓
Review of Cancer Services	**Audit Wales/AC**								D
National Fraud Initiative Briefing Note	**Audit Wales**					✓			
Audit Fees Consultation 2026/27	**Audit Wales**						✓		
INTERNAL AUDIT									
Internal Audit: Audit Plan Progress Report	**JJ**	✓	✓	✓	✓	✓	✓	✓	✓
Review and approve Annual Internal Audit Plan	**JJ**	✓							✓
Review of Internal Audit Reports including results & the adequacy of executive & management responses to any issues identified and ensuring that they are acted upon	**JJ**	✓	✓	✓	✓	✓	✓	✓	✓
Review and approve Internal Audit terms of reference (charter) and the effectiveness of internal audit	**JJ**	✓							
Standards of Cleanliness IA Update and Action Plan	**JS**				✓				
Learning Lessons (Reasonable Assurance)	**JJ/SD**	✓							
Elective Waiting List Management (Substantial Assurance)	**JJ/AC**	✓							
Consultant Job Planning Follow-up (Reasonable Assurance)	**JJ/MH**	✓							
Financial Management (Reasonable Assurance)	**JJ/HT**	✓							
Performance Management (Substantial Assurance)	**JJ/HT**	✓							

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
Executive Team Governance (Substantial Assurance)	**JJ/PK/JW**	D	✓						
Annual Planning (Reasonable Assurance)	**JJ/LD**	D	✓						
Digital Strategic Partner (Substantial Assurance)	**JJ/HT**		✓						
Discharge Management Follow-up (Advisory Report)	**JJ/AC**			✓					
Standards of Cleanliness Follow-up (Limited Assurance)	**JJ/AC/JS**	D	D	✓					
Withybush Hospital (WGH) RAAC (Reasonable Assurance)	**JJ/AC/JS**	D	D	✓					
Continuing Healthcare – Database Maintenance and Finance Processes (Substantial Assurance)	**JJ/HT**	D	D	✓					
Contract Management (Advisory Report)	**JJ/HT**			✓					
Follow Up Review (Reasonable Assurance)	**JJ/JW**			✓					
Corporate Risk: Ophthalmology (Reasonable Assurance)	**JJ/AC**				✓				
Sickness Management (Limited Assurance)	**JJ/LG**				✓				
Nursing Management (Limited Assurance)	**JJ/SD**				✓				
Validation of Emergency Department Waiting Time Data (Limited Assurance)	**JJ/AC**					✓			
Control of Contractors (Advisory Report)	**JJ/JS**					✓			
Human Tissue Authority (Limited Assurance)	**JJ/JS**					✓			
Commissioning – Long Term Agreements (Reasonable Assurance)	**JJ/LD**					✓			
Capital Governance Arrangements (Advisory Report)	**HR/EJ/LD**					✓			

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
Medical Devices Regulations (Substantial Assurance)	**JJ/AC**						✓		
Vaccination and Immunisation	**JJ/AG**					D	D	✓	
Level 3 / 4 Directorates	**JJ/AC**						D	✓	
Managed Practices	**JJ/AC/JP**						D	✓	
Operational Governance Arrangements	**JJ/AC**						D	✓	
Cyber Security (IC)	**JJ/HT**						D	✓	
Theatre Stock System Implementation	**JJ/AC**							✓	
Health & Safety	**JJ/JS**							✓	
Escalation Governance	**JJ/PK/JW**							✓	
Decision Making for High Cost Drugs	**JJ/HT**							✓	
Departmental / Local IT systems management	**JJ/HT**							✓	
Estates Assurance – Space Utilisation	**JJ/LD**							✓	
Joint Committee with SBUHB	**JJ/JW**								✓
Medical Workforce Stabilisation	**JJ/MH**								✓
GP Out of Hours	**JJ/AC/JP**								✓
Major Infrastructure Investment Plan	**JJ/LD**								✓
Patient Experience	**JJ/SD**								✓
Infection Prevention & Control	**JJ/SD**								✓
IRMER	**JJ/JS**								✓
Estates/Facilities Directorate – Cleaning Standards	**JJ/JS**								
Commissioning – Third Sector	**JJ/AC**								
Follow up and agreed Action Implementation Tracking -	**JJ/JW**								
Integrated Audit & Assurance Plans (SSU) – Withybush General Hospital Fire – Phase 2	**EJ/LD**								
Glangwili General Hospital Fire – Phase 2	**EJ/LD**								
CLINICAL AUDIT									
Review annual forward clinical audit plan and terms of reference	**SD**	✓				✓			✓

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
Review the effectiveness of clinical audit – consider recs from the ECPG on suggested areas of activity for review by internal audit	**SD**	✓				✓			✓
FINANCIAL FOCUS									
Review risks and controls around financial management (via Financial Assurance Report)	**HT**	✓		✓	✓	✓	✓	✓	✓
Review Annual Summary of Single Tender Actions (STAs)	**HT**			✓					
Annual statement of financial procedures	**HT**							✓	
Receive Post Payment Verification (PPV) report	**HT**			D	✓			✓	
Receive PPV annual report	**HT**			D	✓				
Receive Primary Care PPV report	**JP**			D	✓			✓	
Review of Schedule of Losses & Compensation*	**HT**								
Receive reports which record the basis of decisions where the HB awards additional funding to contractors outside the terms of the contract *	**HT**								
COUNTER FRAUD									
Review work plan & results from Counter Fraud activities, including anti fraud policies, etc.	**CFO**	✓		✓	✓	✓	✓	✓	✓
To provide an update on the cases highlighted as part of the counter fraud update report (In-Committee)	**CFO**	✓		✓	✓	✓	✓	✓	✓
Review and approve Counter Fraud Annual Report	**CFO**	✓							✓
Review and approve annual forward work plan for Counter Fraud activities	**CFO**	✓							✓
NHS CF Authority SRT Return	**CFO**	✓							✓

AGENDA ITEM/ISSUE	LEAD	15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
Right To Work Governance and Checks (In-Committee)	**AC/RE**	✓		✓					
Annual Review of Requisitions (as part of main Counter Fraud update)	**CFO**							✓	
Counter Fraud, Bribery and Corruption Policy Review (3 yearly)	**CFO**				✓				
Review the Health Board's assessment against NHS Protect Qualitative Assessment Reviews*	**CFO**								
ASSURANCE AND RISK									
Internal & External Recommendations and WHC Tracking Assurance Report	**JW/CW**			✓		✓		✓	
Risk Assurance Report	**JW/CW**	✓			✓		✓		✓
Risk Management Framework and Strategy	**JW/CW**				✓				
Scrutiny of Outstanding Impr Plans *	**JW/CW**								
DEEP DIVE									
TBC *									
FOR INFORMATION									
ARAC Work Programme 2025/26	**Chair**	✓		✓	✓	✓	✓	✓	✓
Audit Wales Letter regarding Future Report Writing Style					✓				
National Internal Audit Reports *									
REVIEW OF THE MEETING									
Matters & Risks for Escalation to the Board	**Chair/JW**	✓		✓	✓	✓	✓	✓	✓

* To be included on agenda as applicable

Initials

AC – Andrew Carruthers	**IMs – Independent Board Members**	**LG – Lisa Gostling**
AG – Ardiana Gjini	**JJ – James Johns**	**MH – Mark Henwood**
CH – Carly Hill	**JP – Jill Paterson**	**NLl – Nicola Llewellyn**
CW – Charlotte Wilmshurst	**JS – James Severs**	**PK – Philip Kloer**
CFO – Counter Fraud Officer	**JW – Joanne Wilson**	**RE – Rob Elliott**
CSO – Committee Services Officer	**KJ – Keith Jones**	**SA – Shaun Ayres**
EDs – Executive Directors	**LC – Liz Carroll**	**SD – Sharon Daniel**
EJ – Eifion Jones	**LD – Lee Davies**	**SMJ – Sian-Marie James**
HIW – Healthcare Inspectorate Wales	**LO'C – Louise O'Connor**	**TP – Tracy Price**
HT – Huw Thomas		

Audit Committee Tasks		15 April 2025	8 May 2025	24 June 2025	12 Aug 2025	14 Oct 2025	9 Dec 2025	10 Feb 2026	April 2026
Prepare Schedule of meeting dates	**JW/CSO**						✓		
Agenda Setting Meeting with Chair & Exec Lead (at least 1m prior to mtg)	**Chair/JW**	✓	✓	✓	✓	✓	✓	✓	✓
Disseminate agenda & papers 7 days prior to meeting	**CSO**	✓	✓	✓	✓	✓	✓	✓	✓
Minutes and action log to be circulated within 7 days of the meeting	**CSO**	✓	✓	✓	✓	✓	✓	✓	✓
Produce ARAC Update Report for Board	**Chair/JW/ CSO**	✓	✓	✓	✓	✓	✓	✓	✓
Monitor agreed actions from previous meetings	**CSO**	✓	✓	✓	✓	✓	✓	✓	✓
Develop & monitor annual work plan linked to corporate objectives, assurance framework and Local and national priorities for Audit	**Chair/JW**	✓	✓	✓	✓	✓	✓	✓	✓
Ongoing Development of IMs (Briefings/Training/Development sessions)	**Chair/JW**	✓	✓	✓	✓	✓	✓	✓	✓
Annual Report on Committee's activity for onward submission to the Board – timed to support AGS	**Chair/JW**		✓						
Process for regular and rigorous self assessment of Committee's effectiveness	**Chair/JW +IMs**			D	✓		✓		
Annual bi-lateral meeting between Chair & LCFS *	**CFO**							✓	
Independent Members private discussions with Internal & External Audit, HIW and LCFS *	**All IMs**							✓	
Assess performance of Internal Audit *	**Chair/IMs**							✓	
Assess performance of External Audit *	**Chair/IMs**							✓	

* Separate meeting

8

12:00, 0 Mins

8 - Any Other Business

9

12:00, 0 Mins

9 - Review of Meeting

9.1

12:00, 0 Mins

9.1 - Matters and Risks for Escalation to the Board

For discussion

10

12:00, 0 Mins

10 - Date and Time of Next Meeting

9.30am, 10 February 2026