Neath Port Talbot & Singleton Service Group Governance Arrangements

Final Internal Audit Report

2024/25

Swansea Bay University Health Board

Reasonable Assurance

Contents

Review Reference	SBU-2425-02
Fieldwork	February-March 2025
Executive Sign Off	14 May 2025
Audit Committee	21/22 May 2025
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Executive Summary

Purpose

Review of the Neath Port Talbot & Singleton Service Group's (NPTSSG) governance arrangements, including the management of risk; and consideration of the approach to planning and performance, quality and safety, finance and workforce.

Overview

Swansea Bay University Health board ('the health board') has four service groups. The health board has outlined its intention to develop centres of excellence as part of the Acute Medical Services Redesign (AMSR) programme. This includes Singleton and Neath Port Talbot sites focusing on planned care and rehabilitation services.

An Audit Wales review (September 2024) compared governance arrangements across all four Service Groups (SGs) at the health board. The review concluded that, "*operational governance arrangements in the Health Board's service groups need strengthening. Action is needed to address long standing vacancies and reliance on interim roles, and to strengthen escalation arrangements, quality and safety reporting, and risk management*." We undertake an annual review of governance arrangements, covering each SG on a rotational basis. Our audit of the Mental Health and Learning Disabilities Group (MHLDSG) highlighted similar themes to the Audit Wales review, which are also consistent with those raised in the report. Cross-organisational learning could be strengthened to enable SGs to identify and rectify similar gaps within their governance arrangements.

NPTSSG underwent an Organisational Change Process (OCP) during 2024, that included the restructuring of its portfolio of operational services and its leadership team. We note that these changes have not come without its challenges, including the maternity and neonatal services, which sits within the Children, Young People & Women's Health (CYPWH) Division (our area of focus during the review). Both areas were placed by Welsh Government into enhanced monitoring in December 2023 following an unannounced inspection by Healthcare Inspectorate Wales (HIW) with all actions being reported as implemented.

We have concluded reasonable assurance on this area. The matters requiring management attention include:

- The content of terms of reference for key groups within the NPTSSG structure need to be enhanced and their approvals require evidencing. Meetings were well administered but could be further improved by putting in place work programmes.
- While there is regular monitoring of performance, quality and safety, workforce metrics and the SG's financial position, reporting of the status of progress was not always clear.
- Divisional accountability letters should be signed.
- There needs to be a more robust mechanism for prompting for the reviews of policies and procedures and for managing declarations of interest.
- While the SG is currently undertaking work to improve the quality of its risk register, there are still several risks that do not record an action or progress update. We note that consideration of the mechanisms and processes for reporting operational risks has been included in the current 'reset' of the health board's risk and assurance processes. However, SG reporting needs to be enhanced to ensure there is sufficient focus and scrutiny of key risks.
- The SG regularly reports to various Board-level committees including on key areas of concern. However, there is no formal mechanism within the SG to confirm that key issues and risks have been escalated appropriately within the health board. As noted by Audit Wales, there were no formal lines of reporting from the SG management boards into the health board's bimonthly Management Board.

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

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The Service Group has a clear organisational structure, with approved terms of reference and work programmes.	1,2	**Reasonable**
2	The Service Group terms of reference and work programmes are in alignment with key objectives and health board priorities.	3,4,5,6	**Reasonable**
3	Divisional arrangements support the Service Group's delivery of key objectives, and operate in accordance with terms of reference and work programmes.	1,2,3,4,7	**Reasonable**
4	The Service Group has mechanisms to provide oversight and assurance regarding key risks and issues.	1,8,9	**Reasonable**

Management Actions

0	9
High Priority	Medium Priority

Themes

Risk Types

Quality or Safety Issues

Public Perception & Reputational Risk

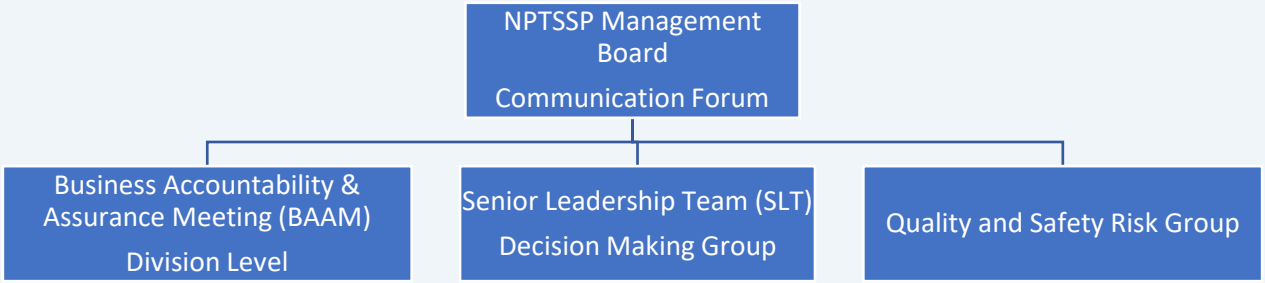
Financial Loss

Choose an item.

At a Glance: NPTSSG's Structure and Governance Arrangements

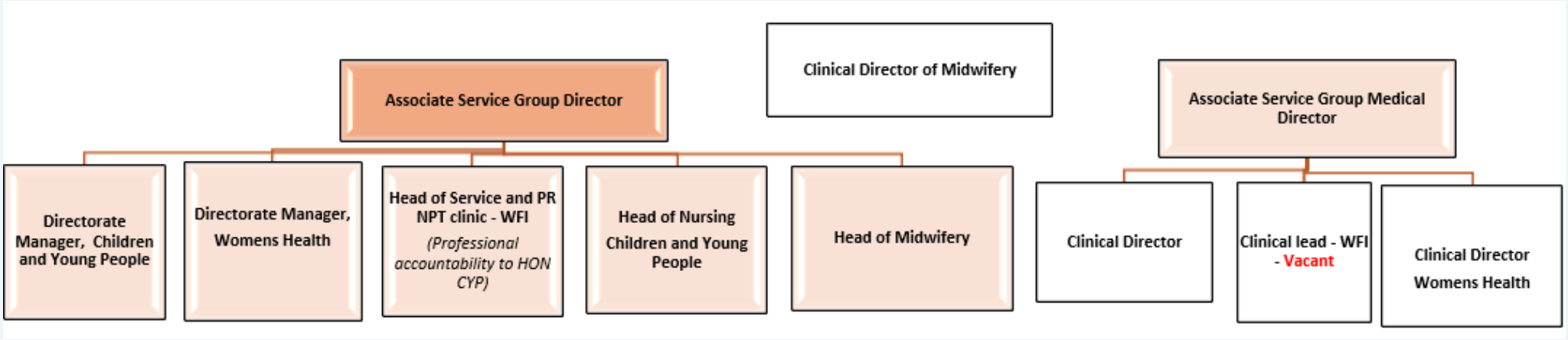
The senior leadership structure for NPTSSG is noted below (figure 1):

The key groups for NPTSSG are detailed below (figure 2):

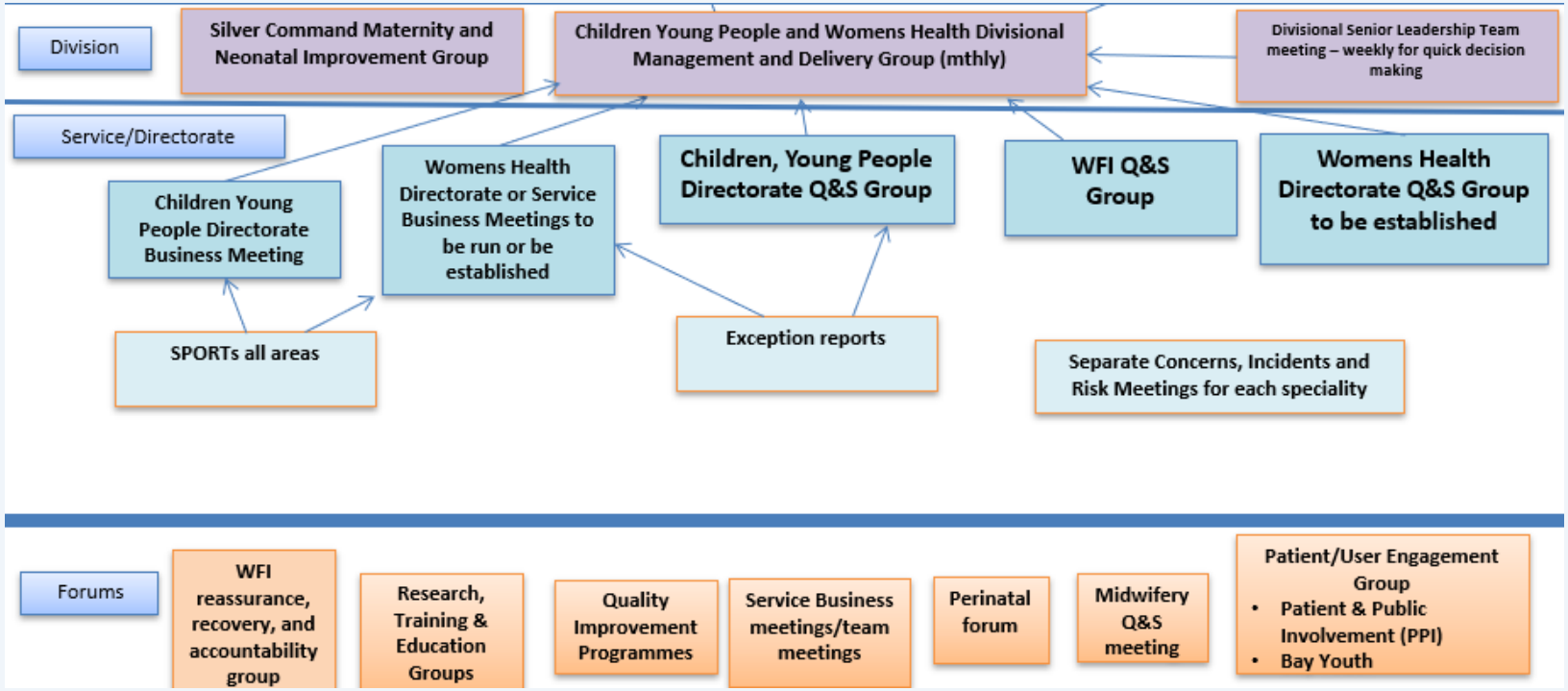


At a Glance: CYPWH Division's Structure and Governance Arrangements

The divisional structure for CYPWH is noted below (figure 3):



The key groups for CYPWH division are detailed below (figure 4):



Findings & Agreed Action Plan

Objective 1: NPTSSG's Structure — Reasonable

Overview / Summary of Observations

The leadership team of the NPTSSG consists of a SG Director, Nurse Director, and Medical Director. We were provided with a hierarchy (see figure 1 on page 3) setting out the operational senior management, - this included divisions relating to Children, Young People & Women's Health (CYPWH); Surgery; Hospital Operations; and Pharmacy. SG leadership has remained stable, and we note that at the date of fieldwork, there was a recruitment exercise for the Medical Director post (the existing postholder will remain within the SG as an Assistant Medical Director allowing for consistency).

NPTSSG has a structure of key groups supporting its Management Board (see figure 2 on page 3), which has oversight of performance, finance, workforce, risks, and quality. This included a Business Assurance and Accountability Meeting (BAAM); Senior Leadership Team (SLT), and a Quality, Safety and Risk Group (QSRG). The Senior Nursing and Midwifery Forum and a Medical Leadership Forum are recent additions to the governance structure. This replicates the core structure ascertained in our 2023/24 review of MHLD's governance arrangements.

Terms of reference (ToR) were provided for all the above groups, as well as for the Health & Safety and Emergency Preparedness, Resilience and Response (EPRR) Group. The ToRs were current, but we were not able to evidence their approval (see **Key Finding 1**). The ToRs contained key details relating to the group's purpose, membership, quorum, meeting frequency, and reporting arrangements. However, the content of some of the ToRs could be strengthened to confirm membership and escalation arrangements (see **Key Finding 1**).

A review was carried out of recent papers for the Management Board, SLT, BAAM and QSRG meetings. Despite operational pressures, written reports were provided to the meetings with only a few occasions where a verbal update was provided. Generally, meetings were well administered, but there were few work programmes in place to assist with the effective planning of meetings (see **Key Finding 2**).

While we recognise that clinical duties must be prioritised, some of the clinical directors did not attend three out of the four Quality, Safety and Risk Group (QSRG) meetings reviewed and no deputy attended in their absence as required by the ToR. Audit Wales noted a similar enhancement in their review of Operational Governance, particularly for NPTSSG, therefore we have not replicated a recommendation. As per the health board's recommendation tracker, we note that this recommendation remains in progress with an expected completion date of 31 July 2025. A similar theme was also identified in our 2023/24 review of MHLDSG's governance arrangements.

Key Findings		Risk & Impact	Agreed Management Action
1	**Terms of Reference** Terms of reference (ToR) were provided for the key groups within the NPTSSG's governance structure, but the following weaknesses were identified in the expected governance framework: • No documentation was provided to evidence the approvals of the ToRs for the Senior Leadership Team (SLT) (SLT minutes (11 June 2024) detail that the ToR were agreed but would go to the Management Board for approval, which has not been evidenced); Business Assurance and Accountability Meeting (BAAM); the Health & Safety and Emergency Preparedness, Resilience and Response (EPRR) Group; and the CYPWH Division's Silver Command Maternity and Neonatal Improvement Group (SCNIG). • The ToRs did not always record version control or note key changes made to the document content. • While the Management Board's ToR detailed the reporting of various groups to the Board; it did not detail its own reporting arrangements. Neither did it specify its objectives for oversight of key areas, e.g. risk. • The ToRs for Management Board, SLT, BAAM, the Senior Nursing and Midwifery Forum, the Divisional Management and Delivery Group, the CYPWH's Divisional Senior Leadership Team and SCNIG did not detail escalation arrangements. • The SLT's ToR requires updating to confirm its membership. Of the three SLT meeting minutes reviewed, two appeared not to be quorate and the Performance Manager did not attend any of these meetings. Further discussion identified that this was because the group membership had recently changed, e.g. divisional directors are now only required to attend monthly. • The SCNIG's TOR did not detail quorate arrangements.	Unclear roles and responsibilities leading to a lack of accountability and failure to deliver key priorities.	**Agreed Action:** All Service Group-level terms of reference will be reviewed including sign off process, quoracy, reporting arrangements, and escalation arrangements. Terms of reference template documents to be reviewed for version control and changes to previous versions. Terms of reference template to be sent to all divisions for review/amendment of their terms of reference. **Expected Evidence of Implementation:** Updated terms of reference template; email to Associate Service Group Directors.
	Theme: Governance	**Medium Priority** Control Design	**Officer:** Service Group Director, NPTSSG **Target Implementation Date:** 30 September 2025

Key Findings		Risk & Impact	Agreed Management Action
2	**NPTSSG's Meeting Administration** With the exception of SLT and QSRG, there are no work programmes for the remaining key groups within the NPTSSG governance structure or those within the CYPWH division. However, we do note that the BAAM meetings operate on a rotational basis with periodic divisional performance updates provided. Meeting minutes are not taken for BAAM meetings, but there is nothing documented to confirm quoracy.	Meetings may not be effective if they are not planned appropriately, and there may be a lack of accountability of issues escalated.	**Agreed Action:** Work programme to be developed for Service Group-level meetings. Divisions to be contacted on importance of workplans for meetings and templates. Additional tab added to action notes to confirm quoracy.
			Expected Evidence of Implementation: Updated workplans; email to Associate Service Group Directors; copy of new BAAM action log template.
		Medium Priority	**Officer:** Service Group Director, NPTSSG **Target Implementation Date:** 30 June 2025
	Theme: Governance	Control Operation	

Objective 2: Key Objectives and Health Board Priorities — Reasonable

Overview / Summary of Observations

Planning & Performance:

Historically, the health board has taken a predominantly 'top-down' approach to ascertaining its key areas of focus, e.g. ministerial priorities with no expectation for SGs to have their own annual plans. However, the process is currently in transition with more impetus on divisions to generate ideas and have increased accountability and ownership of priorities.

Progress with the delivery of NPTSSG's current priorities is reported at both the SG's BAAM meetings (on a divisional basis) and quarterly performance reviews. Performance overall was positive for Quarter 3 (2024/25) in terms of meeting the ministerial targets, but noted that there were issues with addressing follow up waiting lists. However, reporting was unclear to determine why the number of Goal, Method and Outcomes (GMOs) differed in quarterly reporting (see **Key Finding 3**). Reporting to the health board's Management Board (22 January 2025) noted two GMOs that will not be delivered.

Quality and Safety:

Templates are utilised by Divisions when reporting to the QSRG, which provided consistency on the information detailed for incidents, concerns and complaints, infection prevention and control, and quality priorities. QSRG agendas were extensive and, as noted by Audit Wales in its wider review of SGs (Operational Governance), were dominated by services of concern, such as maternity. We note that this recommendation has an expected completion date of June 2025.

Workforce:

The SG is undertaking work to link with the workforce priorities detailed within the health board's People Strategy (2024-29). This includes developing divisional workforce plans and Staff Experience, Wellbeing and Retention (SEWR) Plans. There was initial focus on SEWR plans for maternity and neonates (aligning with Welsh Government's escalation requirements and the Healthcare Inspectorate Wales (HIW) improvement plans) with Theatres and Children and Young People prioritised next, before rolling out across the other SG areas.

There is workforce metric reporting (sickness absence/mandatory training/PADR – see table below noting performance in line with the health board's target and actual position) to the SG's Management Board, BAAM, quarterly performance reviews, and to the health board's Workforce & Organisational Development (WOD) Committee:

Workforce Indicator	Sickness Absence	Statutory & Mandatory Training	PADR
NPTSSG – February 2025	6.93%	89.53%	77.90%
NPTSSG – December 2024	7.77%	91.84%	79.14%
Health Board – February 2025	7.06%	89.2%	72.04%
Health Board – December 2024	7.73%	89.36%	74.04%
Health Board Target	5.5%	85%	85%

Management Board reporting noted that maternity and theatre's compliance with sickness absence needed to improve, but Sickness Absence Summit meetings will be introduced to provide assurance to BAAM that there is appropriate management and support provided. Maternity, children and young people, and hospital operations needed to improve their PADR compliance. However, there was no mechanism for oversight of the number of improvement plans in place to address performance issues (see **Key Finding 4**).

Finance:

The health board took a different financial approach during 2024/25 with the focus being on all SGs reducing spend to meet their control total. Schemes were submitted for key areas of overspend, which were RAG rated. Reporting to Performance and Finance Committee (PFC) (25 March 2025) noted the NPTSSG's progress with delivery of 39 'green' cost reduction schemes totalling £15.183m. However, the delivery status was unclear (see **Key Finding 3**). There are also three 'amber' schemes totalling £121k that are currently delayed or at risk.

Financial reporting is carried out to the SG's Management Board, BAAM, quarterly performance reviews, and to the health board's Recovery and Sustainability Board and PFC. Reporting to PFC (25 March 2025) noted that the SG's end of year control target is £11.8m and the forecast outturn is £9.9m. NPTSSG (-£2m) and PCT (-£1.3m) are the only SGs forecasting over delivery against their control totals and Morriston (£8.1m) and MHLD (£4.2m) continue to report a variance. At month 11, NPTSSG is £9.4m overspent (year-to-date) with key budgetary pressures being within the Surgical Division (particularly Theatres and Anaesthetics).

Policies and Procedures:

Policy and procedure reviews within NPTSSG are managed locally within divisions and approval would depend on the nature of the policy, e.g. a Maternity Standard Operating Procedure was approved by the division's Management Group (although a Guideline and Policy Group for maternity has recently been put in place). Discussions with staff identified there needs to be a robust mechanism to effectively monitor policies and procedures (see **Key Finding 5**).

Some of the SG policies are available to staff through the health board's Clinical Online Information Network (COIN) and there is a prompt to ensure that policies are reviewed within the designated timeframe. Our review of seven policies listed established that they were in date. However, guidance retained on WISDOM (Wales Information System for the Dissemination of Obstetrics, Gynaecology & Midwifery Material) needs to be reviewed to ensure they are current (see **Key Finding 5**).

Declarations of Interest:

There is no robust mechanism in place for maintaining and reviewing registers of declarations of interest (see **Key Finding 6**).

Key Findings		Risk & Impact	Agreed Management Action
3	**Performance Status** Progress with the NPTSSG's current priorities (contained within the health board's Recovery and Sustainability Plan) is reported at quarterly performance reviews. However, reporting of delivery was unclear from Quarter 2 to Quarter 3: • A yellow RAG status (completed waiting outcome) was utilised for 17 Goal, Method and Outcomes (GMOs) in Quarter 2 but not used at all for reporting within Quarter 3. • There were 12 GMOs reported for the Cancer Plan in Quarter 3 compared to 17 in Quarter 2; 9 GMOs for Planned Care compared to 6 in Quarter 2; and 30 GMOs reported for CYPWH compared to 26 in Quarter 2. Similarly, CYPWH's divisional reporting of delivery with its GMOs was unclear in its reporting to BAAM and the quarterly performance reviews, e.g. 14 CYP GMOs were detailed but the report detailed there were 16 GMOs. We also noted that financial reporting of progress with the delivery of cost reduction programmes was unclear to distinguish between some of the statuses, e.g. delivering and	Performance is not effectively monitored or reported resulting in a lack of accountability and oversight.	**Agreed Action:** The Service Group will confirm with Planning team on utilisation of RAG in the GMO (NEW Delivery actions) reporting. The Service Group will ensure data for performance reviews are validated with Performance Manager and Associate Service Group Director – Deputy before submission. The Service Group will clearly mark and annotate on the Service Group Tracker the status of all finance schemes, this will be aligned to PFC reporting as required once the PFC finance pack has been finalised. **Expected Evidence of Implementation:** Copy of Service Group Tracker, email with confirmation of RAG status; Copy of Service Group performance review slides.

	Key Findings	Risk & Impact	Agreed Management Action
	partially delivered. Reporting to Performance & Finance Committee (25 March 2025) noted that of 39 cost reduction schemes, 8 were on target to be delivered; 1 off target; 20 delivered; 1 delivering; 2 partially delivered; 2 overdelivered; 3 delayed; and 2 did not have a status.	**Medium Priority**	**Officer:** Finance Business Partner/Associate Service Group Director -Deputy/Performance Manager **Target Implementation Date:** 30 June 2025
	Theme: Performance Monitoring	Control Design	
4	**Workforce Reporting** Service Group (SG) reporting clearly encompasses compliance with workforce metrics (including sickness absence, PADRs and statutory and mandatory training). Where the SG does not meet the health board's target, e.g. PADR compliance, improvements plans should be in place. However, it was unclear from reporting whether all the areas that were below 85% had these plans in place and whether these were having the required impact on performance. Similarly, reporting did not clearly indicate if all required sickness absence improvement plans had been developed. Reporting also noted that a deep dive was scheduled to be carried out by November 2024 to improve the quantity and quality of PADRs. The HR Business Partner confirmed that the deep dive had not yet happened. The timescales for workforce priorities and programme of work would benefit from a review to ensure that they are realistic.	Ineffective reporting could result in poor decision making and a lack of accountability and oversight.	**Agreed Action:** The Service Group will develop a standard slide for BAAM which will require Divisions to identify all cost centres where workforce KPIs for PADR, Sickness and Mandatory training are not compliant with WG targets. The Division will be responsible for confirming which cost centres have robust improvement plans in place which are being actively monitored. Where cost centres do not have improvement plans there will be an expectation that these will be developed and timescales agreed as part of a discussion in BAAM. Workforce priorities and timescales will continue to be part of regular BAAM discussions. **Expected Evidence of Implementation:** Updated BAAM slide deck
		Medium Priority	**Officer:** HR Business Partners **Target Implementation Date:** 30 September 2025
	Theme: Reporting	Control Design	
5	**Policies and Procedures** There is not a consistent mechanism in place within NPTSSG to provide oversight and ensure that policies and procedures are reviewed within the designated timeframe. For example, within the Children, Young People & Women's Health Division (which is a relatively new division), the Wales	Inconsistent processes leading to confusion or a lack of accountability and oversight.	**Agreed Action:** The Service Group will establish how many policies and procedures are within the Service Group's gift to update. Once the number has been established, the Service Group will decide whether a new forum should be established or if oversight can form part of the existing meeting in the structure.

	Key Findings	Risk & Impact	Agreed Management Action
	Fertility Institute maintains a database managed by their Quality Manager, but this is not replicated elsewhere. However, we do note that the Associate SG Director plans to implement a divisional mechanism. Health Board staff can access WISDOM (Wales Information System for the Dissemination of Obstetrics, Gynaecology & Midwifery Material). However, 32% of maternity guidelines and 76% of gynaecology guidelines had passed their review date.		Regular report to be submitted to Service Group Management Board on the status of policy & procedure compliance. **Expected Evidence of Implementation:** Agenda for either new meeting or existing meeting in the structure.
		Medium Priority	**Officer:** Service Group Director/Group Nurse Director **Target Implementation Date:** 30 September 2025
	Theme: Policies & Procedures	Control Design	
6	**Declarations of Interest** Section 6.4 of the health board's Standards of Business Conduct Policy (the Policy) states that *Service Group Directors are responsible for maintaining and reviewing registers of declarations of interest (DOI)*. We were advised that DOI returns were completed for SG Directors as part of the corporate process, but the SG does not retain copies of the forms. There is no process to prompt and record for other DOIs, e.g. Associate SG Directors. Section 18.2 of the Policy requires all consultants to complete a standard DOI and declare when undertaking private practice. We were advised that this would be recorded as part of the job planning and PADR processes, but there was a lack of clarity how the outcomes would be shared within the SG. Further, there was a lack of awareness of the Policy's content, e.g. while there is a prompt during key SG meetings to declare interests in relation to agenda items, staff were unclear what they would do if an interest was declared.	Undisclosed conflicting interests compromise the Health Board's integrity, impartiality and transparency.	**Agreed Action:** Service Group Directors to request final copy of their declaration of interests from Executive team to be kept on file by the Service Group. Service Group Director to request DOIs are completed for the wider Service Group senior team (including divisional triumvirates) to be kept on file by the Service Group. Consultant compliance will be recorded to evidence all consultants have completed an annual DOI. **Expected Evidence of Implementation:** Copy of database
		Medium Priority	**Officer:** Service Group Director **Target Implementation Date:** 30 June 2025
	Theme: Governance	Control Design	

Objective 3: Children, Young People & Women's Health Divisional Arrangements — Reasonable

Overview / Summary of Observations

Our review focused on the Children, Young People & Women's Health (CYPWH) Division, which was formed as part of the SG restructure during 2024. We were provided with a structure (see figure 3 on page 4) setting out the key areas within the division – Children and Young people, Women's Health, Wales Fertility Institute (WFI), Neonates and Midwifery. The division is led by the Associate SG Director who has been in post since July 2024; and we noted that during our review, there were three vacancies within the structure (WFI clinical lead, Midwifery Service Manager and the Neonates Service Manager).

The Division has a governance structure (see figure 4 on page 4) that includes a monthly Divisional Management and Delivery Group (DMDG), which has oversight of performance, quality and safety, risks, finance and workforce; Divisional Senior Team (DST); and Silver Command Maternity and Neonatal Improvement Group (SCNIG). As the Division is relatively new, governance arrangements were still being developed during our review, e.g. not all directorate business meetings are in place and forums need to be reviewed to ensure there is appropriate reporting.

Up-to-date terms of reference (ToR) were provided for all the above groups, but we were not able to evidence the approval of the SCNIG's TOR (see **Key Finding 1**). The ToRs contained key details relating to the group's purpose, membership, quorum, meeting frequency, and reporting arrangements. However, the content of some of the ToRs could be strengthened to confirm quorate (SCNIG) and escalation arrangements (DMDG, DST and SCNIG) (see **Key Finding 1**). While we acknowledge that Gold Command would be the natural route for escalation for SCNIG, there needs to be clarification on when items need to be escalated.

Generally, meetings were well attended and administered with few verbal updates provided, but there were no work programmes to assist with the effective planning of meetings (see **Key Finding 2**).

Planning & Performance:

As noted in **Objective 2**, the health board is currently transitioning away from a 'top-down' approach and the CYPWH has developed a draft annual plan detailing its key priorities that takes account of the health board's three key priorities for 2025-28 (deliver financial balance; achieve Targeted Intervention targets and maintain Quality and Safety).

Progress with the delivery of the division's current priorities is reported at both the SG's BAAM meetings and the SG's quarterly performance reviews. Performance was overall positive for Quarter 3 (2024/25) in terms of meeting the ministerial targets but highlighted issues in relation to workforce constraints within Gynaecological Oncology and the Early Years Neurodevelopment Service; both of which have been included in the divisional risk register. However, reporting was unclear to determine why the number of Goal, Method and Outcomes (GMOs) differed in quarterly reporting (see **Key Finding 3**).

The health board is currently at Level 3 enhanced monitoring for maternity and neonatal services. Reporting to PFC (25 March 2025) noted that the Healthcare Inspectorate Wales (HIW) improvement plans and Health Education and Improvement Wales' (HEIW) action plan have been implemented. A dashboard was being developed to allow maternity and neonatal services' data to be triangulated and escalated to the health board's quality and safety forums.

Workforce:

The division reports its workforce metrics (sickness absence/mandatory training/PADR – see table below noting performance in line with the health board's target) to the SG's BAAM and quarterly performance reviews:

Workforce Indicator	Sickness Absence	Statutory & Mandatory Training	PADR
CYPWH – February 2025	8.25%	92.04%	70.39%
Health Board Target	5.5%	85%	85%

Colposcopy, paediatric continuing care and maternity are key areas to improve sickness absence compliance. Reporting to WOD Committee (10 April 2025) noted that sickness absence levels within maternity have fluctuated over the past year, but there had been an improvement in January and February 2025. Actions are being put in place to further improve performance, e.g. improvement plan and a SEWR Plan. Maternity, children and young people, and hospital operations are detailed as 'hotspots' for improving PADR compliance. As noted in **Key Finding 4**, it was difficult to ascertain whether the areas of concern had

the required improvement plans in place. At February 2025, the division had 12 outstanding job plan reviews for Children and Young Persons; and eight under review within gynaecology.

Finance:

Schedule 6 of the Standing Financial Instructions state that the budget holder must sign an accountability letter formally delegating the budget. However, the Associate SG Director (CYPWH Division) confirmed she did not sign an accountability letter for financial year (2024/25) (see **Key Finding 7**).

Financial reporting is carried out to the divisional finance recovery meetings, DMDG, SG's BAAM and quarterly performance reviews. As part of the wider SG reporting to PFC (25 March 2025), the division was forecasting an overspend of £1.745m (year-to-date) for Month 11. The main budgetary pressures are in relation to maternity, obstetrics and gynaecology due to sickness absence and recruitment issues, although operational efficiency was going to be reviewed in some areas where the funding is not aligned to service delivery.

Progress with the delivery of the division's 11 'green' cost reduction schemes totalling £276k was reported as 3 delayed; 4 'on target to be delivered'; 2 delivered; and 2 with no status (see **Key Finding 3**).

Key Findings		Risk & Impact	Agreed Management Action
7	**Accountability Letter** The health board's Standing Financial Instructions (paragraph 5.2.1) state that where the management of a budget is delegated, this delegation must be in writing, in the form of an accountability letter, which must be signed. Within NPTSSG, generic financial letters were issued to divisions that detailed the budgetary process for the financial year (2024/25), but did not specify the amount of the budget delegated to the division nor did the letter need to be signed.	Budget accountability is not formally agreed, as required by the SFIs.	**Agreed Action:** Divisional budgets will be set out in 25/26 accountability letter when agreed. The requirement for the letter to be signed will be set out in the 25/26 accountability letter. **Expected Evidence of Implementation:** Copy of divisional letter.
		Medium Priority	**Officer:** Service Group Director **Target Implementation Date:** 30 June 2025
	Theme: Finance Management & Control	Control Operation	

Objective 4: Governance Arrangements — Reasonable

Overview / Summary of Observations

Risk Oversight and Assurance:

The health board's Risk Management Policy states that SG Management Boards are*, "responsible for management of its operational risks",* and need to, *"establish processes for the review of new risks, and oversight of those accepted onto risk registers"*. Appendix A of the Policy also details that there should be a, "*focus on the most significant risks (typically risks assessed as scoring 12 or above might trigger oversight at management level*." The NPTSSG Management Board's ToR does not specifically define its role for risk oversight, only noting that a report will be submitted by the QSR Group (see **Key Finding 1**).

We note that risk management arrangements are currently under review within the health board. At Audit Committee (20 March 2025), it was highlighted that with the strategic risk development that high risks raised by SG leaders were not documented by the health board. Gateway reviews are planned to allow the connectivity between the service operational risks to the strategic risk registers, and system improvements will make the escalation of risks by SGs more visible.

The Audit & Assurance review of Risk Management & Assurance (report issued: August 2024; reasonable assurance) highlighted that, "*not all the SGs have oversight of risks at SG management board, and where these were discussed, meeting minutes do not always reflect that sufficient time has been allocated for full consideration of and scrutiny of risks due to their busy agendas"*. During this review, we identified that there is oversight of risks scored above 20 to several of the SG's key groups including QSRG and Management Board, and whilst it was embedded within quality and safety reporting, there was little evidence of discussions within meeting minutes (see **Key Finding 8**). Risk management responsibilities were documented in the CYPWH DMDG's ToR and there was more detail of discussions in the CYPWH's divisional meeting minutes focusing on risks scored above 20.

The Risk Management & Assurance review highlighted that there were some risks with SGs that had not been actioned for several years, and that scoring was unnecessarily high. There is currently a review of risks being undertaken within the NPTSSG with the initial focus being on risks scored above 20; although we note that divisions were having weekly risk meetings to improve their risk registers. Work had not been completed by the conclusion of our review, but evidence was provided demonstrating the reduction in the number of the SG's risks. Despite this, our analysis of the SG risk register (31 March 2025) that had 226 detailed identified the following issues:

- The earliest risk was opened in May 2006 (risk 348 CYPWH division). While the review date was 30/04/25, the last progress update was in 2018.
- 4 risks did not detail a control (risks 2530, 2975, 3127 and 3873).
- 160 did not detail an action.
- 182 risks did not detail a progress update.
- 62 review dates had passed (risks may have been reviewed, but the date field was not updated to reflect the review).

We have not raised a recommendation is raised in relation to this as it will be considered through our 2024/25 Risk Management & Assurance audit, which will establish progress with the actions arising from our previous audit including the review of arrangements to promote and monitor the consistency of completeness of operational risk registers.

Reporting and Escalation:

Routine reporting is completed by the SG, e.g. on a quarterly basis to Quality and Safety Committee and PFC (SGs will also periodically report to the WOD going forward). Additionally, there is bi-monthly Gold Command reporting for Maternity and Neonatal Services and senior members of the SG meet with Welsh Government on a monthly basis.

The NPTSSG SG Director meets with the Chief Operating Officer (COO) frequently and all SG directors attend a bi-weekly meeting with the COO. Both the 2023/24 review of MHDLSG's governance arrangements and Audit Wales noted in its Operational Governance review that there were no formal lines of reporting from the SG management boards into the health board's Management Board. It also recommended that report templates are amended to incorporate items

for escalation and to agree a clear process and threshold for escalation. While work has been undertaken against these recommendations, such has not addressed the agreed management action, we note that these are now overdue.

A Board Effectiveness Action Plan has been developed and was reported to Audit Committee (20 March 2025), which aims at strengthening and improving the links between the SGs and corporate structures. Actions include introducing a series of activities aimed at building connectivity between committees and SG leaders (target date: March 2024; current status: committee work programmes have been reviewed with a view of inviting senior leaders from the SGs); instigating a series of changes aimed at raising the status, profile and accountability for SG leaders (target date: December 2024; current status: the Performance & Assurance Framework sets out the escalation arrangements for SGs); and provide clear individual and team objectives to SG triumvirates, divisional teams and directorate teams to support annual plans and introduce 180 degrees appraisal systems (target date: September 2024; current status: appraisals with objectives have been undertaken. Each SG Director has been aligned with a specific pan Health Board area of responsibility).

Within NPTSSG, there are mechanisms to escalate key issues through the BAAM and quarterly performance review processes. These detail what the SG can address itself, and what needs to be escalated to a health board level. However, there is nothing evidenced to confirm these items have been escalated appropriately (see **Key Finding 9**).

	Key Findings	Risk & Impact	Agreed Management Action
8	**Risk Reporting** A review of risk reporting within the Service Group (SG) noted: • While the Triumvirate have just started receiving a weekly report containing the full risk register, QSRG agendas were extensive giving insufficient time for discussion and scrutiny of key risks. • High scoring risks are reported to the Management Board, but meeting minutes did not detail the discussion of these risks. • The frequency of reporting risks within the SG was not defined. We noted that Management Board was not given an update on risks at each of its meetings (held every 9 weeks), with the last update on risk provided to the monthly QSRG meetings in December 2024. • There was inconsistency as to how risk is reported within the CYPWH Division: CYP reported the distribution of its risks as well as those scored above 20; WFI reported new risks and those scored above 20; maternity reported risks above 15 and new risks; and gynaecology reported on risks above 20.	Inconsistent monitoring, management, and escalation of risks within the health board.	**Agreed Action:** The Service Group will amend the BAAM/QSR slide decks and circulate to division to ensure consistency in reporting. The QSR work programme will schedule a bi-annual QSR Group dedicated to review of divisional risks. A separate report will be added to the workplan for Service Group Management Board. **Expected Evidence of Implementation:** Copy of Management Board & QSR work plan; copy of new BAAM/QSR slide deck.
		Medium Priority	**Officer:** Group Nurse Director **Target Implementation Date:** 30 September 2025
	Theme: Risk Management	Control Design	

Key Findings		Risk & Impact	Agreed Management Action
9	**Escalation of Key Issues** While there is a mechanism within BAAM and quarterly performance reviews to escalate issues to the health board, nothing is evidenced to confirm that items have been escalated appropriately and the outcome of these discussions – there is no entry on the meetings BAAM action log where applicable.	Lack of escalation of key risks and issues for addressing by the health board.	**Agreed Action:** Standing agenda item to be added to Service Group agendas, 'items for escalation' and 'feedback from escalation' to ensure Chair of meetings are prompted to raise.
			Expected Evidence of Implementation: Copy of agendas; meeting minutes/action logs to evidence discussions.
		Medium Priority	**Officer:** Service Group Directors
	Theme: Governance	Control Design	**Target Implementation Date:** 30 June 2025

Appendix A Assurance Opinion & Prioritisation of Findings

Assurance Opinion

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

Prioritisation of Findings

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

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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 Swansea Bay 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.

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