# NWSSP Audit Committee Meeting

*Tuesday 7 July 2026, 14:00 - 16:00*

**Meeting taking place in Person at IP5 in Newport**

*Meeting Chaired by Gareth Jones*

# Agenda

**14:00 - 14:10**
10 min

## 1. Standard Business

*Verbal* *Gareth Jones, Chair*

### 1.1. Welcome and Introductions

*Verbal* *Gareth Jones, Chair*

### 1.2. Apologies

*Verbal* *Gareth Jones, Chair*

Apologies received in advance of the meeting are as follows:

- *Carl James, Chief Executive Officer;and*
- *Non Gwilym, Interim Director of Corporate Governance.*

### 1.3. Declarations of Interest

*Verbal* *Gareth Jones, Chair*

### 1.4. Minutes of the last meeting held on 28 April 2026

*Decision* *Gareth Jones, Chair*

Draft Audit Committee Minutes 28042026 (2).pdf (13 pages)

### 1.5. Matters Arising

*Information* *Gareth Jones, Chair*

Matters Arising 7 July 2026.pdf (3 pages)

**14:10 - 14:25**
15 min

## 2. NWSSP Update

*Neil Frow, Managing Director, OBE*

### 2.1. Managing Director Update

*Discussion/Noting* *Neil Frow, Managing Director, OBE*

NWSSP Audit Committee Managing Directors Report 7 July 2026.pdf (6 pages)

**14:25 - 14:35**
10 min

## 3. External Audit

### 3.1. Audit Wales Update

*Discussion/Noting* *Steve Wyndham, Audit Wales*

Audit Wales update paper - NWSSP July 2026 AC meeting.pdf (2 pages)

14:35 - 14:55
20 min

# 4. Internal Audit

## 4.1. Progress Update

*Discussion/Noting* *James Johns, Head of Internal Audit*

- A&A NWSSP Audit Cttee Progress Report 7 July 2026 .pdf (6 pages)

## 4.2. Internal Audit Reports

### 4.2.1. Medical Examiner Service Internal Audit Report

*Discussion/Noting* *Sophie Corbett, Deputy Head of Internal Audit*

- SSP-2526-07 Medical Examiner Service Final Internal Audit Report.pdf (8 pages)

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14:55 - 15:15
20 min

# 5. Counter Fraud

## 5.1. Counter Fraud Annual Report 2025-26

*Discussion/Noting* *Mark Weston, Local Counter Fraud Manager*

- NWSSP 2025 2026 LCFS Annual Report Final.pdf (12 pages)

## 5.2. Progress Report

*Discussion/Noting* *Mark Weston, Counter Fraud Manager*

- NWSSP Q1 2026 2027 LCFS Progress Report Final.pdf (7 pages)

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15:15 - 15:55
40 min

# 6. Governance, Assurance and Risk

## 6.1. NWSSP Grip and Control Arrangements

*Discussion/Noting* *Alison Ramsey, Director of Finance and Corporate Services*

- NWSSP Grip and Control Update June 26 Final.pdf (22 pages)
- NWSSP Grip and Control Report June 2026.pdf (32 pages)

## 6.2. Annual Conflicts of Interest Declarations and Gifts, Hospitality and Sponsorship 2025-26

*Discussion/Noting* *James Quance, Assistant Director of Corporate Services*

- Annual CoI Declarations and Gifts, Hospitality and Sponsorship 202526.pdf (14 pages)

## 6.3. Governance Matters

*Discussion/Noting* *Alison Ramsey, Director of Finance and Corporate Services*

- NWSSP Expenditure July 2026.pdf (9 pages)
- All Wales Contracting Expenditure Final.pdf (7 pages)

## 6.4. NWSSP Risk Management

*Discussion/Noting* *James Quance, Assistant Director of Corporate Services*

### 6.4.1. Risk Protocol

*Decision* *James Quance, Assistant Director of Corporate Services*

- NWSSP Audit Commitee Risk Management Protocol CP.pdf (2 pages)
- NWSSP Risk Protocol July 2026 updated.pdf (20 pages)

### 6.4.2. NWSSP Corporate Risk Register

*Discussion/Noting* *James Quance, Assistant Director of Corporate Services*

- NWSSP Corporate Risk Register July 2026 CP Final.pdf (5 pages)
- Appendix 1 NWSSP Corporate Risk Register.pdf (6 pages)

### 6.5. NWSSP Agreed Management Actions Tracker

*Decision* *James Quance, Assistant Director of Corporate Services*

- Tracking of Agreed Management Actions July 2026.pdf (3 pages)
- Appendix A Progress of Agreed Management Actions July 2026.pdf (2 pages)

### 6.6. NWSSP Audit Committee Annual Report 2025-26

*Decision* *Gareth Jones, Chair*

- Audit Committee Annual Report Cover Paper 7 July 2026.pdf (2 pages)
- Draft NWSSP Audit Committee Annual Report 2025-26 Final (1).pdf (14 pages)

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**15:55 - 15:55**
0 min

## 7. Items for Information

*Information* *Gareth Jones, Chair*

### 7.1. NWSSP Welsh Language Annual Report 2025-26

*Information*

- NWSSP Welsh Language Annual Performance Report 2025.2026.pdf (31 pages)

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**15:55 - 15:55**
0 min

## 8. Any Other Business

*Verbal* *Gareth Jones, Chair*

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**15:55 - 15:55**
0 min

## 9. Date and Time of Next Meeting, 13 October 2026, from 14:00 to 16:00, by Microsoft Teams

*Information* *Gareth Jones, Chair*

**VELINDRE UNIVERSITY NHS TRUST AUDIT COMMITTEE FOR NHS WALES SHARED SERVICES PARTNERSHIP**

**MINUTES OF THE MEETING HELD ON TUESDAY 28 APRIL 2026 / 14:00-16:00 VIA MICROSOFT TEAMS**

| **Attendance** | **Designation** | |
|---|---|---|
| **Members** | | |
| Gareth Jones (GJ) Chair | Independent Member | |
| Vicky Morris (VM) | Independent Member | |
| **In Attendance** | **Role** | **Organisation** |
| Alison Ramsey (AR) | Director of Finance & Corporate Services | NWSSP |
| Carly Wilce (CW) | Corporate Services Manager | NWSSP |
| David Burridge (DB) | Audit Lead (*attending for Steve Wyndham*) | Audit Wales |
| James John (JJ) | Head of Internal Audit | NWSSP |
| James Quance (JQ) | Assistant Director of Corporate Services | NWSSP |
| Jonathan Irvine (JI) | Director of Procurement, Supply Chain Logistics and Transport and Laundry Services | NWSSP |
| Linsay Payne (LP) | Deputy Director of Finance & Corporate Services | NWSSP |
| Mark Weston (MW) | Local Counter Fraud Specialist | NWSSP |
| Martyn Lewis (ML) | Audit Manager, Audit and Assurance Services | NWSSP |
| Matthew Bunce (MB) | Director of Finance | Velindre |
| Neil Frow (NF) | Managing Director | NWSSP |
| Non Gwilym (NG) | Director of Corporate Governance | Velindre |
| Sophie Corbett (SCo) | Deputy Head of Internal Audit | NWSSP |
| Simon Cookson (SC) | Director of Audit & Assurance Services | NWSSP |
| Jillian Haynes (JH) | Secretariat | NWSSP |
| David Burridge (DB) | Audit Lead | Audit Wales |

| **Item** | | **Action** |
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| **1. STANDARD BUSINESS** | | |
| 1.1 | **Welcome and Introductions**<br>The Chair welcomed all attendees to the meeting. | |
| 1.2 | **Apologies**<br>Apologies were received from:<br>• John Union, Independent Member<br>• Tracy Myhill OBE, Chair, NWSSP<br>• Carl James, Interim Chief Executive Officer, Velindre<br>• Steve Wyndham, Audit Lead, Audit Wales | |
| 1.3 | **Declarations of Interest**<br>No declarations of interest were presented. | |
| 1.4 | **Minutes of Meeting held on 10 February 2026**<br>The minutes of the meeting held on 10 February 2026 were **APPROVED** as an accurate record of the meeting. | |

| Item | | Action |
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| 1.5 | **Matters Arising**<br>Action #5.1: Benchmarking information was required between organisations for future Counter Fraud reports (MW). This had been partially achieved. **The target recorded was 28 April and Members agreed to amend this date to 7 July, the date of the next NWSSP Audit Committee meeting.** JQ added that more information could be derived from national reports and this was in hand.<br><br>JQ stated that the actions numbered 6.2, 1.5, 4.3 and 6.1 around risks due to the Governance Review, were to be progressed during the implementation process of the recommendations. He advised that these risks would not impact on business as usual, nor on assurances which could still be given, nor on approvals which could be awarded.<br><br>The other actions were accepted by Committee Members as complete. | **CW** |
| **2. NWSSP UPDATE** | | |
| 2.1 | **Managing Director's Update Report**<br>NF presented an update on recent developments within NWSSP since the previous meeting. Key points to note included:<br><br>• The Governance Review of December 2025 had made a number of suggested recommendations. An Implementation Group had been established to oversee their implementation and had already met on several occasions.<br>• The process for appointing a successor for the role of NWSSP Chair was underway, as Tracy Myhill steps down from the role. The Velindre University Trust Board had approved the amendments to the Shared Services Partnership Committee Standing Orders on 26 March 2026.<br>• Appointments: Dr Martin Edwards had been appointed to the post of Medical Director following Dr Ruth Alcolado's retirement; Laura-Jayne Keating had been appointed as Director of Pharmacy Technical Services following Colin Powell's retirement.<br>• Finance: NF reported that the NWSSP had achieved a break-even position for the 2025-26 financial year, with £9k surplus (subject to audit) and £6m savings distributed back to NHS Wales organisations and Welsh Government (WG). The Integrated Medium-Term Plan (IMTP) had been submitted to WG and feedback was awaited. The Welsh Risk Pool (WRP) remained a significant cost pressure for NHS Wales at £192m in 2025-26; the WG had funded an additional £46m. Work continued with WG and partners to strengthen forecasting and assurance. WG had agreed additional WRP funding in 2026/27 for those presenting a balanced financial plan. Total clinical negligence provisions were around £2bn. NF would attend the Quality and Safety Chairs' meeting and would be discussing the programme of work agreed by the Leadership Board for 2026/27 including lessons learnt and greater consistency in embedding this across NHS Wales.<br>• The capital expenditure allocation of £11.5m for 2025-26 had been fully utilised. Payment performance was strong with over 98% of NWSSP | |

| Item | | Action |
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| | invoices having been paid within 30 days and performance against key controls was positive. The financial context continued to be challenging.<br>• Transforming Access to Medicine Services (TrAMS) Programme: the keys for the Radiopharmacy had been received from the contractor and all was progressing as expected, in readiness to commence shipping the product in June, subject to the Medicines and Healthcare products Regulatory Agency (MHRA) approval. In North Wales, the Hub project had been mobilised following engagement with Betsi Cadwaladr University Health Board (BCUHB). In the South west, a request had been submitted to the WG for approval to acquire a building to support the South West hub. The Full Business Case (FBC) for the South East Hub was awaiting final approval.<br>• Influenza vaccination programme: preparatory work was underway for 2026-27. A paper had been submitted to the Velindre Trust Board regarding procurement for the 2026-27 programme.<br>• Procurement: there was no indication of immediate risk of disruption to UK product supply chains because of the Iran war. The situation was being monitored and was dependent on the duration of the conflict in the Middle East, with the cost of fuel and energy prices becoming an increased pressure and risk.<br>• The new Resident Doctor contract sought to improve pay and working conditions. NWSSP was collaborating on its implementation. The Chief Executives' meeting had been appraised of progress.<br><br>Following a query from VM on validations received for IP5, NF confirmed that validations were successful for equipment, isolators and the air handling unit. Validations for internal rooms etc, was now in progress and it was hoped that MHRA approval would be awarded.<br><br>VM enquired whether the effective winter surge management arrangements within the Medical Examiners' Service would be continued. NF replied that lessons learned would be embedded and the Service has been new to everyone and had significantly improved. The procedure had been amended so that communication with bereaved families occurred at the beginning of the process, rather than at the end.<br><br>GJ noted the challenges facing the WRP. He queried, whether, alongside the lessons learned exercise, there was an investigation as to why the figure had reached £2bn. AR explained that the £2bn was an increase from £1.7bn the previous year. The highest value cases were in obstetrics, and there had been in an increase in the volume of cases settling in 2025/26 and likely to be the case again in 2026/27, compared to prior years. This is thought to be due to the backlog in cases that could not be progressed during the pandemic. However, the NWSSP team is working to identify any additional trends that can be used to improve and strengthen forecasting. The key challenge is to minimise the risk of harm occurring in the first instance, and only then will this increasing financial cost be addressed. Following discussions with Jacqueline Totterdell, Hywel Jones and Mark Harris (L&RS), three workstreams had been established to look at:<br><br>1. the forecasting model/stress testing; | |

| Item | | Action |
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| | 2. the qualitative aspects of case management; and<br>3. the potential oversight within organisations around claims and whether there had been opportunities to manage the claim earlier.<br><br>AR reported that the situation was similar to that experienced in NHS England. GJ suggested that given the scale of the sums involved, any interim reports should be shared with Members and it would be helpful for them to be presented at future NWSSP Audit Committee meetings for oversight.<br><br>**Action: NF agreed to share with Independent Members the WRP report endorsed by the NHS Wales Leadership Board, which was subsequently presented in the private session of the SSPC. Progress with the programme of work would be shared with the Committee.**<br><br>GJ queried the date on which the TrAMS programme was estimated to be implemented. NF confirmed that this was dependent on when WG approved the business case and that it would be early 2028 at the earliest.<br><br>The Committee **NOTED** the Managing Director's Update Report. | **NF** |
| **3. EXTERNAL AUDIT** | | |
| 3.1 | **Audit Wales Update**<br>DB provided an update on progress and reported that the process for Velindre's accounts was underway, with the NWSSP Remuneration Report being incorporated into the VUNHST Annual Report, for the first time. The WRP accounts had been received. There had been two recent audit publications around the Velindre Cancer Centre and the Regional Integration Fund, relating to funding with Health Boards.<br><br>The Committee **NOTED** the Audit Wales Update. | |
| 3.2 | **2025-2026 NWSSP Audit Assurance Arrangements**<br>DB explained that the work had been scoped with local audit teams to ensure effective and efficient use of NWSSP Divisions' time. DB referred to additional work being completed in Legal and Risk Services (L&RS), due to the replacement of the database used for recording WRP provisions.<br><br>DB further confirmed that no issues had been identified in relation to the transfer of data to the new Legal and Risk database.<br><br>Once all work was completed any issues would be detailed in the Management letter to be reported later in the year to the Committee.<br><br>The Committee **NOTED** the 2025-2026 NWSSP Audit Assurance Arrangements. | |
| **4. INTERNAL AUDIT** | | |

| Item | | Action |
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| 4.1 | **Internal Audit Progress Report**<br>JJ summarised the key points of the Internal Audit Progress Report. Key points to note were that three Internal Audits had been finalised since the last meeting and were on the agenda, with several audits in progress which would be completed by 31 May 2026.<br><br>A request had been made to defer the regulatory compliance audit until the next audit year and JJ asked Members for their approval. VM queried the source of the request. JJ replied that it was the result of dialogue with senior management, and the parties had agreed that it would be more appropriate to undertake the audit in early summer. AR agreed this would allow for the Governance Review recommendations to be progressed and implemented. GJ had attended a meeting of the Implementation Group and was under the impression that WG was keen to produce results on the Review's recommendations as soon as possible and therefore he appreciated the reason for the request.<br><br>VM queried whether JJ was confident in completing the audits to the deadlines stated, for the Annual Report. JJ provided assurance that the timescale would be met as much of the work was already complete.<br><br>The Committee **APPROVED** the deferral of the regulatory compliance audit into 2026-27 and **NOTED** the Internal Audit Progress Report. | |
| 4.2 | **Internal Audit Reports** | |
| 4.2.1 | **Payroll Services Internal Audit Report**<br>SCo presented the Payroll Services Internal Audit Report and confirmed that the assurance rating awarded was Substantial.<br><br>SCo reported that core processes and lower frequency areas, such as maternity, were analysed. The rollout of the staff movement advice (SMA) platform would be completed in 2026 and transactions were prompt and accurate. Overpayment processes were effective. One medium priority finding had arisen regarding term-time working and a tool had been developed to support calculations. This tool would be refined and it was noted that it would be beneficial to develop guidance to support use. VM queried the target date of 30 April and asked if that was realistic, with SCo providing assurance that the timescale should be met, noting that the majority of the work had been completed prior to the report being finalised.<br><br>The Committee **NOTED** the Payroll Services Internal Audit Report. | |
| 4.2.2 | **Single Lead Employer Internal Audit Report**<br>SCo presented the Single Lead Employer (SLE) Internal Audit Report and confirmed that the assurance rating awarded was Reasonable.<br><br>The audit analysed new starters, changes and leavers within the SLE, plus absence management and the recharging of costs to Health Boards. No issues were found and good practice was observed in the use of robotics to support the processing of rotations. Recharges to Health Boards was | |

| Item | | Action |
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| | accurate. There were some gaps in the management of the Attendance at Work Policy and one area of high priority, which was Return to Work Interviews.<br><br>VM queried the process of classifying the audit findings. SCo replied that sickness was a significant issue across NHS Wales and if not appropriately managed, it could have a financial impact. The significance of the finding was key to the classification; the objectives would not necessarily have equal status. VM appreciated that implementation would be dependent upon each party, and not solely NWSSP, taking accountability for separate elements of the process and to drive improvement.<br><br>NF confirmed that the Shared Services Partnership Committee, as well as several different forums, had discussed the improvement and compliance aspect for sickness with the Director of People, Organisational Development and Employment Services would also escalate any issues to Executive Workforce Directors as appropriate.<br><br>GJ suggested the narrative on page 6 of 159 did not fully reflect the shared responsibility, as it stated that the 'NWSSP was not fulfilling its responsibilities as SLE, potentially resulting in reputational damage'. However, the primary responsibility lay with the relevant Health Boards as the host organisation, rather than the NWSSP.<br><br>The Committee **NOTED** the Single Lead Employer Internal Audit Report. | |
| 4.2.3 | **Digital Strategy Internal Audit Report**<br>ML presented the Digital Strategy Internal Audit Report and confirmed that the assurance rating awarded was Reasonable.<br><br>ML reported that the objective was to provide assurance that progress in delivery was being achieved and reported, that a roadmap for deliverables was in place, and to ensure the required resources had been identified and at hand. The strategy supported the IMTP. Progress and reporting within each workstream was good. Some findings were recorded around monitoring of the strategy, which was within digital reporting rather than via a digital steering group. There was no aggregated digital risk reflecting the impact on the organisation if the strategy was not implemented. There was no single digital roadmap setting out how the workstreams fitted together over the years.<br><br>GJ suggested that planning had possibly not been sufficient in this area, although good progress had been made. He noted that Bryn Harries, the Chief Digital Officer, was the accountable manager and was new in post. AR stated that Bryn, who reported to Rebecca Nelson, would find the audit useful.<br><br>The Committee **NOTED** the Digital Strategy Internal Audit Report. | |

| Item | | Action |
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| 4.3 | **Draft Internal Audit Plan and Charter 2026-2027**<br>JJ presented the detailed workplan for 2026-27 period, together with the Charter and Mandate. The overarching document set out the risk-based approach within the Audit Plan, with the Charter and outlined further detail. The workplan took into account national systems, All-Wales systems and NWSSP's corporate arrangements. Provision had been made for the impact of the Governance Review and the workplan would be monitored throughout the year.<br><br>VM enquired whether the key performance indicators (KPIs) had changed from previous years. JJ stated that the compliance around fieldwork draft reporting had been amended up to 95%, but there were no further amendments.<br><br>GJ noted an error on page 4 item 5, which referred to key components which make up the plan, and asked if NWSSP should be included in the list. JJ stated that there appeared to be a typo and he would therefore revise the paragraph as the intention was to underline the impact on NWSSP of audits undertaken by other bodies.<br><br>**Action: JJ to amend the narrative on page 5, to clarify the intended meaning.**<br><br>GJ noted that on page 6, the plan would be kept under review and revisited when the focus and timing may need to be addressed further. He asked when this would likely occur and JJ replied it would be an ongoing discussion via regular meetings with the NWSSP, rather than a fixed date.<br><br>JJ confirmed that the Regulatory Compliance Review would be undertaken in Q1 and Q2 in 2026.<br><br>The Committee **APPROVED** the Internal Audit Plan, Charter and Mandate for 2026-27. Members also **NOTED** the KPIs and the resource requirements. | **JJ** |
| **5. Counter Fraud** | | |
| 5.1 | **Counter Fraud Progress Update**<br>MW presented the Counter Fraud Progress Report for quarter 4. There had been 42 days spent on proactive work in the quarter, amounting to 115.5 for the year and 16.75 days on reactive work totalling 95.5 days for the year. Cumulatively 211 days overall had been worked, which exceeded the 210 days featured in the workplan due to additional work with Swansea Bay University Health Board (SBUHB). The reactive days had been used to conduct eight investigations; of which, four were closed, one was transferred and three were ongoing.<br><br>Eight fraud awareness sessions had been held in the quarter, covering 266 staff and 58 staff had completed the new e-learning model. A total of 579 staff had been reached in the quarter via these engagement methods. | |

| Item | | Action |
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| | Members had requested benchmarking data and MW had included the e-learning participation figures for the remainder of Wales in quarter 3 but quarter 4 was unavailable due to timing. NWSSP compared favourably in a mid-table position, with 5 of the 6 organisations above NWSSP in the table using a mandatory learning style. Further benchmarking data would be available at the next meeting. MW planned to discuss training for resident doctors under SLE with the Medical Director, as SLE training could be strengthened.<br><br>MW reported that £1,200 had been recovered in 2025-26, against £11,474 in the previous year.<br><br>MW reported that with regard to local proactive work, a risk assessment had been concluded on mandate fraud to review processes in place around updating creditors' bank accounts. Assurance was given to confirm that the risk was as low as possible.<br><br>A number of alerts had been received from the Counter Fraud Authority around corporate impersonation, with the potential for NHS email addresses to be compromised. There had been an asset management risk recorded regarding the theft, purchase and resale of IT equipment and a review was ongoing, to ensure processes were in place. Another incident involved mandate fraud where fraudsters had set up companies and had named their bank accounts similarly to other businesses, in order to divert payments.<br><br>MW continued that under the National Fraud Initiative (NFI), of 364 matches, 312 were closed, with 41 ongoing and 11 not yet opened, although they were in hand. He had met with Audit Wales on the NFI feature called AppCheck, a vast fraud prevention database, to which he and colleagues had been provided access. MW would meet with the Cabinet Office and Audit Wales to discuss how the app could assist the NHS Counter Fraud Service (NHSCFS) in Wales.<br><br>GJ stated that it was pleasing to see a high number of attendees for the Fraud Awareness sessions and that 171 had engaged from Primary Care Services. MW stated that there was more work to be completed with services and he would arrange sessions with JI.<br><br>GJ enquired around benchmarking and the table on page 5. The total number attending from Velindre had been just four in 2024-25 and he asked why the figure was so low. MW replied that Velindre had since made the session mandatory and the numbers had increased significantly at a later stage. The figures had been 119 for the previous period.<br><br>The Committee **NOTED** the Counter Fraud Progress Report. | |
| 5.2 | **Draft Counter Fraud Annual Plan 2026-27**<br>MW presented the Draft Counter Fraud Annual Plan for 2026-27 and stated that the Plan aligned to the Counter Fraud Functional Standards, seeking approval from the Committee. If an agreement was to be made with SBUHB for the future, supporting risk assessments and the plan would be reviewed. | |

| Item | | Action |
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| | JQ suggested that investment may be required in that area to achieve the required standards.<br><br>The Committee **NOTED** and **APPROVED** the Draft Counter Fraud Annual Plan 2026-27. | |
| **6. GOVERNANCE, ASSURANCE AND RISK** | | |
| 6.1 | **Governance Matters**<br>AR reported that greater compliance with the Standing financial Instructions (SFIs) continued to be the aim across NHS Wales. As part of the implementation of the Procurement Act, JI's team had offered training sessions on contract management.<br><br>VM sought further clarification on the urgent order shown on the report for Laundry Services, enquiring if the business continuity plan for each Laundry site would need to be updated. AR replied that an unprecedented series of events had occurred at all sites at the end of the previous year and loss of service had been experienced on all four sites simultaneously, for different reasons. The downtime was reported as between half a day to two days and resilience normally involved another site assisting the affected site with their workload. Employed engineers were often able to manage the fault on site but it was not possible on that occasion. AR stated that a maintenance contract would be considered.<br><br>GJ asked if the fault was due to the age of the equipment. JI stated that this was an element of the issues encountered and mitigation would involve ongoing replacement of the equipment. Without a national Laundry Services, the incident could have increased in severity of impact.<br><br>GJ brought the All-Wales contracting activity to Members' attention and highlighted page 122, where a number of contracts had been returned to WG. JI stated that there were several delays with approvals and that these had been expedited with WG. The page showing returns referred to the briefing papers, which did not delay the procurement process, but he confirmed that approval had not been received at the date of the meeting, and therefore the contract could not be formally awarded.<br><br>GJ referred to the third page of Appendix B regarding 'Facilities Management – the Provision of Cleaning and Security Services'. Under the heading 'WG approval >£500k', JI confirmed that a briefing paper would not need to be forwarded to WG, as a contract could be forwarded directly for signature. He explained that there was no requirement for a briefing paper, as the award was against a pre-approved, third-party framework already in existence and no secondary approval was required. Approval would only be required if the formerly authorised agreement had been modified, even if the amount was in excess of £1m. SCo confirmed this position and added that this had been the subject of a review with WG in recent years.<br><br>Regarding the delay on contract briefing papers, GJ asked if responses on the several documents itemised were still awaited. JI explained that if it had | |

| Item | | Action |
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| | been sent to WG and showed a date, the response was awaited. If the table showed a date only, it meant that a response had been received. JI assured Members that delays would not impede procurement significantly.<br><br>The Committee **NOTED** the Governance Matters report. | |
| 6.2 | **Losses and Special Payments Paper**<br>LP presented the Losses and Special Payments Paper for 2025-26, which now included SLE, which would be a recharge to Health Boards. The reported loss was £906k gross, or £615k net. This was a reduction of 35% against figures reported in 2024-25. The value of stock at 31st March 2026 was £25.713m and the value of stock issues from 1st April 2025 to 31st March 2026 was £54.427m. Losses related to slow moving, obsolescent stock and special payments.<br><br>GJ queried the position regarding a payment shown on page 5 under the COT3 agreement, which had been signed in March 2026, and which had been an accrual. The payment would not be made until 2026-27 and subsequently would be presented to the Remuneration Committee in May and then forwarded for formal noting to WG. GJ asked if approval should have been sought prior to the COT3 agreement. LP replied that the COP3, once signed by ACAS, was legally binding and WG would not formally note it until it has been presented to the Remuneration Committee in May.<br><br>The Committee **NOTED** the Losses and Special Payments Paper. | |
| 6.3 | **NWSSP Annual Reporting Timeline**<br>JQ summarised annual reporting and governance output within one source for completeness, clarification and transparency purposes.<br><br>An extraordinary NWSSP Audit Committee meeting was proposed for mid-June to ensure that the final Annual Governance Statement and Head of Internal Audit Opinion were reported to the Committee for assurance, prior to the Velindre accounts being signed and the production and approval of the overarching Trust Annual Report.<br><br>JQ confirmed to VM that he had been working with NG in terms of Committee papers and which documents required presentation either to the Trust Board or to the Quality, Safety and Performance Committee. NG suggested it would be useful to meet with JQ and review the necessary paperwork.<br><br>**Action: JQ/NG to meet discuss both Trust Board and Quality, Safety and Performance Committee.**<br><br>The Committee **NOTED** the NWSSP Annual Reporting Timeline. | **JQ/NG** |
| 6.4 | **NWSSP Corporate Risk Register**<br>JQ presented the NWSSP Corporate Risk Register which set out risk trends since the previous meeting. Members had asked for more context around the risks which remained stable. JQ explained that while the scores may remain at the same level, they were different for each risk. The Senior | |

| Item | | Action |
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| | Leadership Group would analyse the Register in more detail to gauge whether further actions could be taken. A number of risks could not be mitigated completely due to their nature, and some deadlines had required an extension.<br><br>VM noted that revised target deadlines were noted for areas which had de-escalated and she stated that deadlines had moved for another five risks, enquiring if they had also been de-escalated. AR explained that if the scores had not changed, it would not be due to complacency, as mitigation would have been implemented and the work was ongoing in the background although operating within a higher risk threshold. VM suggested that more information on the spreadsheet to explain what work was in progress would be useful and would validate the new deadline, for example, on Risks A1, A4, A8, A10, A14.<br><br>GJ echoed VM's query around A10 and the threat to patient services, and he asked if the matter would be clearer by the deadline of 31 July. NF stated that the FBC should have been presented to respective Boards by 31 July and possibly also to the WG, although that was uncertain.<br><br>JI added that the risks mentioned, especially A4 and A1, were dependent on geopolitical factors and therefore the inherent risk level needed to be maintained. He advised that this would continue to be a risk going forward, but it was being managed as far as possible.<br><br>The Committee **NOTED** the NWSSP Corporate Risk Register. | |
| 6.5 | **Audit Recommendation Tracker**<br>JQ presented the Audit Recommendation Tracker and stated that two recommendations were overdue, for which requested deadline extensions were proposed, as they were not within NWSSP's control:<br><br>• SSP-2526-08: *Digital Service Management: to produce a process map, example disseminated documentation and example feedback*. JQ requested an extension to 31 October, as work was required on the service catalogue and the new Chief Digital Officer had recently been appointed.<br>• NWSSP-2425-10: *NWSSP Risk management: to review and update the risk management protocol and report to the NWSSP Audit Committee and communicate it to staff.* JQ requested an extension to 30 June and was confident that it could be reported to the NWSSP Audit Committee meeting to be held on 7 July.<br><br>GJ enquired how the recommendations which were out of NWSSP's control could be managed. He asked if reports and management responses should be clear that this was the case and revert to Internal Audit. JQ stated that making the situation clearer would be useful.<br><br>JJ added that when findings were identified, actions would be agreed with management, which was a process introduced over the last year. If a | |

| Item | | Action |
|---|---|---|
| | separate recommendation and management response had been given, the dialogue should agree the action and those responsible.<br><br>It was noted that, going forward, the tracker would be referred to as the Key Audit Findings Tracker, reflecting the change in terminology from audit recommendations to key findings.<br><br>The Committee **APPROVED** both extensions and **NOTED** the Audit Recommendation Tracker. | |
| **7. ITEMS FOR INFORMATION** | | |
| 7.1 | The Committee received the NWSSP Audit Committee Forward Plan of Business 2026-27, for information.<br><br>JQ confirmed that the Forward Plan for 2026-27 contained items with which the Members would be familiar and stated that an extraordinary meeting would be scheduled on 15 June, to approve the NWSSP Annual Governance Statement for 2025-26 and the Head of Internal Audit Opinion. He also took the opportunity to remind Members that the next NWSSP Audit Committee meeting on 7 July would be held in-person at IP5. | |
| **8. ANY OTHER BUSINESS** | | |
| 8.1 | The following items were raised under Any Other Business:<br><br><u>Audit Committee Assessment of Effectiveness Process 2026</u><br>GJ had agreed with AR and JQ to highlight the survey and raise awareness of the need for completion. GJ encouraged attendees to respond so that Members may assess the Committee's effectiveness and identify any areas for improvement.<br><br><u>Audit Plan and Charter for 2025-26</u><br>SC noted that the Members had approved the Audit Plan and Charter for 2026-27 but had not approved the same documents for 2025-26 at the meeting the previous year. SC explained that additional narrative had been included in 2026-27 defining the Board and the Accountable Officer. This aligned with the new standards. SC asked the Committee to agree the narrative for 2025-26 retrospectively.<br><br>During the discussion which followed, GJ asked whether Velindre colleagues had been given the opportunity to analyse the narrative. SC stated that the requirement was to define it, but it was only for NWSSP's audit programme purposes. Velindre colleagues raised no objections or comments. GJ considered taking a Chair's Action outside the Committee and asked if there was any consequence to agreeing retrospectively. SC directed Members' attention to Section 1.2. The date would be referenced when the Plan was approved and if not agreed, it would mean that two dates would be shown for the 2025-26 plan, rather than one. | |

| Item | | Action |
|---|---|---|
| | The Committee **APPROVED** the Audit Plan and Charter for 2025-26, in retrospect. | |
| **9. DATE/TIME OF NEXT MEETING** | | |
| 9.1 | An extraordinary meeting of the NWSSP Audit Committee would be held at 13:00-14:00 on 15 June 2026, by Microsoft Teams.<br><br>The subsequent meeting would be held in-person on 7 July 2026 between 14:00-16:00 at IP5. A guided tour of Radiopharmacy would commence at 13:00, promptly. | |

**Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership**

**Matters Arising**

| ***Actions arising from the meeting held on 28 April 2026*** | | | | **Action by** |
|---|---|---|---|---|
| 6.2 | **JQ** | ***Corporate Risk Register***<br>*To present the Risk Appetite paper that was developed and agreed by the Shared Services Partnership Committee, to the Audit Committee meeting scheduled on 15 April 2025.* | **To be taken forward through implementation of Governance Review recommendations**<br>This action has been superseded by the Welsh Government Accountability and Governance Review which has now been published and the recommendations will be implemented in coming months. | Dependent upon timetable for implementation of Governance Review recommendations - to be confirmed when Welsh Government implementation group meets. |
| 1.5 | **JQ/NG** | ***Matters Arising***<br>*To amend the classification of Action 6.2 to amber. The Interim Director of Corporate Governance at Velindre NHS Trust, will liaise with NWSSP's Assistant Director for Corporate Services to discuss the Trust's risk policy review to ensure alignment.* | **Closed**<br>The matter arising relates to the NWSSP Risk Protocol which is on the agenda for the July meeting for re-approval following discussion between the Interim Director of Corporate Governance of the Trust and NWSSP's Assistant Director of Corporate Services and review by both the Trust and NWSSP governance teams. The updated Protocol remains in alignment with the Trust's overall policy. | |
| 4.3 | **SC** | ***Draft Internal Audit Annual Plan and Charter 2025/26***<br>*The Chair directed that a note be added to the 2025/26 Annual Internal Audit Plan to inform readers that it may be subject to changes following the governance review, and that the Charter would also be updated accordingly.* | **Closed**<br>The Governance Review has reported and there were no obvious implications for internal audit and therefore the Committee has approved the 2025/26 plan and charter.<br><br>All work in respect of the 2025/26 plan has been concluded with the final report being reported to the July 2026 meeting of the Committee. | |

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|---|---|---|---|---|
| 6.1 | **AR** | ***Governance Matters***<br>*Discussion took place on the arrangements surrounding Framework Agreements in general terms, using the example of the Agency Framework Agreement reported to the Committee in the Governance Matters report in May 2025.* | **To be taken forward through implementation of Governance Review recommendations** Assurance provided to the July 2025 meeting that the All-Wales Agency Framework Agreement had followed the appropriate governance process. | |
| | | *To revert to the Audit Committee in July 2025 with assurance surrounding the Agency Framework Agreement.* | A meeting was held between AR and GJ prior to the previous Committee session.<br>The Trust has expressed a strong desire for clarity regarding the All-Wales contracting arrangements. It was agreed that this matter arising would be updated and marked as pending, subject to the outcome of the Welsh Government's review of Accountability and Governance review. | |
| 5.1 | **MW** | ***Progress Update***<br>*To include comparative benchmarking information between organisations in future reports.* | **Complete**<br>Benchmarking information on e-learning included in the report to the April 2026 and July 2026 meetings and further opportunities will be reviewed for each quarterly progress report going forward benchmarking information will be obtained from the Counter Fraud Service Wales operational report for future reports in an appropriate format. | **7 July 2026** |
| 2.1 | **NF** | ***Managing Directors Update***<br>*To share the Welsh Risk Pool (WRP) report endorsed by the NHS Wales Leadership Board, which was subsequently presented in the private session of the SSPC with Independent Members. Progress with the programme of work would be shared with the Committee.* | **Complete**<br>Circulated to Gareth Jones and Vicky Morris on 22 June 2026. | **7 July 2026** |
| 4.3 | **JJ** | ***Draft Internal Audit Plan and Charter 2026-2027***<br>*To amend the narrative on page 5 of the report, to clarify the intended meaning.* | **Complete**<br>Updated report received from JJ on 23 June 2026. AdminControl has been updated and the revised papers have been republished on the website. | **7 July 2026** |

| | | | | |
|---|---|---|---|---|
| 6.3 | **JQ** | ***NWSSP Annual Reporting Timeline***<br>*To meet with the Interim Director of Corporate Governance to discuss both Trust Board and Quality, Safety and Performance Committee.* | **Complete**<br>Completed for the NWSSP governance documentation for the 2025-26 financial year resulting in the Annual Governance Statement being presented to the Trust Audit Committee prior to approval of the Trust Annual Report.<br><br>Joint work continues on assurances as part of the<br>Welsh Government review implementation in order to agree arrangements for 2026-27. | **7 July 2026** |

| | |
|---|---|
| **MEETING** | Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership |
| **DATE** | 7 July 2026 |
| **PREPARED BY** | Roxann Davies, Corporate Services Manager and James Quance, Assistant Director of Corporate Services, NWSSP |
| **PRESENTED BY** | Neil Frow OBE, NWSSP Managing Director |
| **RESPONSIBLE HEAD OF SERVICE** | Neil Frow OBE, NWSSP Managing Director |
| **TITLE OF REPORT** | NWSSP Managing Director's Update |
| **PURPOSE**<br>To update the NWSSP Audit Committee on recent developments within NWSSP, since the last meeting which took place on 10 February 2026. | |

**Introduction**

This paper provides an update into the key issues that have impacted upon, and the activities undertaken by, NWSSP since the date of the last meeting on 28 April 2026 and the extraordinary meeting held on 15 June 2026.

**Governance and Accountability Arrangements**

The Welsh Government (WG)-commissioned independent review of NWSSP's governance and accountability arrangements has now concluded, with the report published in December 2025. The review confirmed that the existing governance framework is fundamentally sound, while identifying recommendations aimed at strengthening clarity, assurance and accountability.

NWSSP remains fully engaged in the work of the Implementation Group and welcomes the opportunity to contribute constructively to the next phase, ensuring that governance, assurance and accountability arrangements remain robust, proportionate and fit for purpose. Implementation work is progressing, although some challenges have been identified and further meetings are planned to work through the detail. Updates will continue to be reported through the relevant governance arrangements, with the latest position update included as a separate agenda item for today's Committee meeting.

**Senior Appointments**

At its extraordinary meeting on 25 June 2026, the Shared Services Partnership Committee (SSPC) noted that the appointment process for the new Chair had been undertaken in accordance with the SSPC Standing Orders and approved the recommendation of the appointment panel chaired by an Independent Assessor.

Since the last meeting, we have also successfully appointed Dr Helen Lane to the position of Deputy Medical Director, with effect from 1 July 2026.

**Finance**

NWSSP has maintained a stable financial position at th0e start of 2026/27, reporting a year-to-date surplus of £0.813m at month 2, primarily reflecting the impact of vacancies across a number of services, partially offset by underachievement of income in areas such as Legal and Risk where staffing shortfalls constrain delivery. This position is consistent with the trajectory delivered in 2025/26 and continues to rely on tight pay control and vacancy management to maintain in-year balance. Directors are being required to further strengthen grip and control arrangements, with a renewed focus on understanding cost drivers, maximising recurrent savings opportunities and ensuring robust forecasting across all divisions.

Clinical negligence costs met through the WRP remains a significant financial risk within the system. Month 2 expenditure totalled £7.430m with a minimum full-year forecast of £255.588m identified following a detailed case review, against an IMTP planning assumption of £271.466m. This continues to require substantial support through the risk-sharing arrangement, with £162.031m assumed within the plan. Whilst current forecasts remain within the agreed range, the position remains highly sensitive to changes in the timing and value of high-cost claims, and further work is ongoing with Welsh Government to strengthen forecasting, assurance and longer-term system responses.

Capital expenditure of £0.823m has been incurred to Month 2 against a £6.176m Capital Expenditure Limit (CEL), with delivery focused on key strategic priorities including the Transforming Access to Medicines (TrAMS) programme, estate infrastructure at Imperial Park, and specialist developments such as Radiopharmacy. Capital prioritisation processes are actively reviewing discretionary allocations and pipeline schemes, alongside preparation of further funding submissions to WG for backlog estates and digital investment.

Operational financial controls remain broadly stable, with no agency expenditure incurred to date and reductions in overtime and bank usage compared to the prior month, demonstrating improved cost discipline. Performance against the Public Sector Payment Policy remains strong for non-NHS invoices at 97.12% in-month, although NHS performance at 81.71% remains below the 95% target and continues to require focused improvement.

Looking ahead, the financial context for 2026/27 remains challenging. Delivery of recurrent savings, reduction in reliance on vacancy factors, and strengthened grip and control arrangements will be critical to sustaining financial balance. In addition, emerging cost pressures, particularly in relation to energy and fuel (estimated at up to £0.407m), alongside ongoing volatility within the WRP, present continued risks which will require close monitoring and active management throughout the year.

**Transforming Access to Medicines (TrAMS) – Radiopharmacy and Hub Programme Update**

Transforming Access to Medicines (TrAMS)
Progress across the TrAMS Programme continues at pace, with a particular focus on the South-East Hub following completion and circulation of the Full Business Case (FBC) and supporting Estates Annex. The programme remains focussed on maintaining delivery momentum, actively managing risks and ensuring robust governance as the South-East Hub progresses through formal approval stages.

South-East Radiopharmacy
Construction of the South-East Radiopharmacy facility is complete, with all equipment successfully installed. Qualification activities and NWSSP commissioning remain underway, with increasing focus on system validation and operational readiness.

Extensive testing continues across the facility, with a particular focus upon pressure balancing, maintaining pressures and environmental validation, to ensure full compliance with regulatory standards and long-term operational resilience. Some delay has been experienced to the commissioning timeline due to fluctuating pressures alongside the hot weather conditions which are being investigated. Discussions are ongoing with key stakeholders regarding updated timelines, with Swansea Bay University Health Board (SBUHB) continuing to support service continuity arrangements to ensure resilience during transition.

South-East Hub
Significant progress has been made over the reporting period, with the South-East Hub Full Business Case (FBC) now fully developed and formally circulated to all relevant organisations for review, supported by a comprehensive Estates Annex and a set of Frequently Asked Questions (FAQs) to aid engagement and understanding.

The FBC has now been approved at both the South-East Hub Project Board and the TrAMS Programme Board, confirming that the proposal aligns with the agreed scope of the TrAMS Programme and can be escalated to the next stage of governance.

A structured governance pathway is now in progress, with the FBC due to be presented to SSPC for approval on 16 July 2026.

A feedback loop remains open, enabling all organisations to submit queries. These are being collated and shared via weekly question and answer circulars with Programme Board members. The TrAMS Programme Team continues to respond at pace to ensure that outstanding queries are addressed promptly and do not impact the governance timeline.

South-West Hub
The South-West Hub programme continues to progress through site selection and due diligence activity. Further responses have been provided to Welsh Government following initial feedback on the submitted business case to Sandringham Park. The project team has undertaken detailed site engagement activity, including in-depth visits with SBUHB and Hywel Dda University Health Board (HDUHB), to fully understand current service models and ensure that the 'as-is' baseline is accurately captured. This will support a robust and evidence-based approach to service design and future business case development.

North Hub
The North Hub programme continues to mobilise positively, with ongoing stakeholder engagement to inform service model development.

During the period, the South-East Hub FBC has been presented to Betsi Cadwaladr University Health Board (BCUHB) to support alignment, build familiarity with the proposed model national principles, and ensure consistency of approach across the TrAMS Programme and this has been well received.

Work is finalising to define the proposed product range for the North Hub production, with further detail scheduled to be presented at the North Hub Project Board on 1 July 2026. Baseline development and 'as-is' service mapping activities also continue in collaboration with BCUHB and wider stakeholders.

Digital
The TrAMS Digital project remains rated green, preparatory work continues to ensure readiness for mobilisation, subject to confirmation of funding approval. The programme maintains close alignment between digital, workforce and hub developments to support an integrated service model.

Overall Position
The programme continues to demonstrate strong progress across all workstreams. The successful development, circulation and initial approval of the South-East Hub FBC represents a significant milestone, positioning the programme for progression through final governance and funding approval. Focus remains on maintaining momentum through governance pathways, responding proactively to stakeholder feedback, and ensuring operational readiness across Radiopharmacy and Hub services.

**Future Workforce Solution**

The programme has progressed into the foundational readiness phase, with NWSSP working in close partnership with NHSBSA as a key delivery partner to support a consistent, all-Wales approach. Early adopter organisations are engaged to validate the implementation approach, with strong levels of engagement and evolving governance arrangements in place to support delivery. Initial scoping activity is underway to establish agreed scope, resources and governance ahead of implementation, alongside the development of a centrally hosted NHS Wales Change Team to support delivery across early adopters and future waves. Next steps focus on finalising readiness outputs, mobilising the Change Team and progressing engagement with subsequent organisations.

I have proactively written to the Chief Executive Officer of the NHS Business Services Authority (NHSBSA) to highlight a number of concerns regarding the programme from an NHS Wales perspective. While reaffirming our ongoing commitment as an early adopter, the correspondence reflects that current uncertainties are impacting confidence, planning and assurance, and emphasises the need for strengthened senior-level engagement to support clarity and alignment as the programme progresses.

**Implementation of the New Resident Doctors Contract in Wales**

A comprehensive deep-dive update on the most recent position regarding the implementation of the new Resident Doctors' contract in NHS Wales was presented at

the SSPC meeting on 14 May. Implementation across NHS Wales remains a dynamic and evolving programme of work. Ongoing engagement with key stakeholders, including Health Boards and the British Medical Association (BMA), continues to inform the approach and requirements as arrangements develop. An Implementation Board meeting is scheduled for 2 July 2026, following further discussions at the Medical Directors Governance Board, to review progress, consider emerging issues, and support the ongoing development of the approach, with outputs informing subsequent reporting through SSPC, in line with its forward cycle of business.

**Single Lead Employer Model**

Further to the Audit Committee meeting on 28 April 2026, where the Internal Audit review of the Single Lead Employer (SLE) model was considered, Members noted that the overall reasonable assurance opinion was driven by findings relating to sickness absence management, reflecting the complexity of shared responsibilities between NWSSP and host Health Boards. The key assurance message was the need for strengthened local ownership and system-wide accountability to support improvement. This matter was subsequently discussed at the Shared Services Partnership Committee (SSPC) on 14 May 2026. A more detailed deep dive into SLE arrangements is scheduled for a future SSPC meeting during the 2026–27 cycle of business, to provide further assurance on progress.

**Laundry Service**

As previously reported, capital investment within the Laundry Service continues to progress positively. The installation of a sheet picker at Church Village Laundry will help reduce manual handling risks, while the new ironer and feeder line installed in North Wales Laundry will further strengthen operational resilience. The Service has now fully recovered from the major disruption referenced in the previous report, and there have been no recent major plant outages.

A range of measures have been put in place by the laundry senior team to support staff welfare during recent periods of hot weather. There has been no impact on service delivery as a result of the interventions.

**Extreme Weather Conditions**

During the recent period of exceptionally high temperatures, NWSSP demonstrated a proactive and compassionate approach to supporting staff across all service areas. Recognising the operational and personal challenges posed by the heatwave, services implemented a range of practical measures to safeguard staff wellbeing while maintaining service continuity. This included the introduction of local flexibility in working arrangements where operationally feasible, adjustments to shift patterns, and the provision of additional rest breaks in line with health and safety guidance.

Estates and Facilities teams worked closely to optimise building environments, including monitoring ventilation, deploying cooling equipment where available, and ensuring access to hydration.

Clear and timely communications were circulated to all staff, reinforcing guidance on heat-related risks, personal wellbeing, and available support mechanisms. In addition, line managers were encouraged to maintain regular contact with their teams to provide support, identify any concerns early, and take responsive action as required.

Collectively, these actions reflect NWSSP's continued commitment to prioritising staff wellbeing, demonstrating organisational agility and a strong duty of care during periods of increased environmental and operational pressure.

**Decarbonisation and Adaptation**

Following approval by WG of the business case for investment in the roof overlay at IP5 in mid-December 2025, work commenced on site in February 2026 and is on track to complete in mid July 2026. Work has already started to examine the optimal level of investment in roof mounted photovoltaic (PV) to address projected loads from planned future investment in electric vehicle (EV) charging facilities and the IP5 TrAMS scheme.

In relation to the updated Strategic Delivery Plan for Decarbonisation (November 2025), work continues to discharge tasks at an organisational level and tasks where we are leading for NHS Wales. Examples of work at a national level include development of guidance for developing net zero estate projects under the value of £20m (published last month, and now being examined by NHS England with a view to adopting it as well), and development of an NHS Wales Waste Strategy (due for publication in July 2026).

During the course of this year, our team have worked across the breadth of our operations to explore and appraise the options for responses to climate change risks. We anticipate completion of this workstream within the WG target of December 2026.

**Neil Frow OBE**
**Managing Director, NWSSP**
**June 2026**

**Date issued:** 30 June 2026

# Audit Wales update for the NWSSP Audit Committee – July 2026

## Introduction

1 This document provides the NWSSP Audit Committee with an update on current and planned Audit Wales work, together with information on the Auditor General's recent publications together with the work of our Good Practice Exchange (GPX).

## Audit & Assurance work update

2 Our assurance work for 2025-26, to support NHS external audits, is complete and we were able to provide positive assurances to auditors. Our findings will be formally communicated to NWSSP over the coming weeks, ready for the October Audit Committee meeting.

3 Members of the NWSSP finance team also made significant contributions to our 2025-26 final accounts audit work of Velindre University NHS Trust which were issued with an unqualified opinion by the Auditor General on 26 June.

4 We are very grateful for the support and engagement of NWSSP in helping us complete both of these pieces of work.

## General Audit Wales Update

5 Other areas of Audit Wales activity of potential interest are outlined below for your information.

6 For latest news and updates you can also **subscribe to our newsletter.**

### Good practice events and products

7 We continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research. Up to date details of future events are available on our GPX webpages.

**Recent Audit Wales Publications**

8 There has been one national report published since the last update paper - NHS urgent and emergency care (June 2026).

**Other**

9 The term of office of the current Audit General ends shortly and Catherine Mealing Jones will fill the role from 21 July 2026.

# NHS WALES SHARED SERVICES PARTNERSHIP

## Audit Committee

## July 2026

# Audit & Assurance Services
# Internal Audit Progress Report

**CONTENTS** Page

## 1. Introduction

The purpose of this report is to highlight the progress with the delivery of Internal Audit Plan to the Audit Committee and outcomes from reports finalised audit since the previous meeting.

## 2. Outcomes from Finalised Audits

One Internal Audit report has been finalised since the previous meeting of the Committee – this is highlighted in the table below along with the allocated assurance rating. The full report is included on the agenda as a separate item.

| ASSIGNMENT | ASSURANCE RATING |
|---|---|
| Medical Examiner Service |  Reasonable |

## 3. Delivery and Planning Update

The remaining audit from the previous year's plan, Medical Examiner Service, has now been concluded with reasonable assurance.

The audit status schedule highlighting the Internal Audit Plan for 26/27 is shown in Appendix A.

On-going planning discussions with management have identified delays with the ESR Replacement Project and as such the planned audit work has been requested to be deferred to a later stage.

The work with Primary Care will be undertaken in two parts, each with a separate output. The main audit will focus as usual on a sample of contractor payments, with a separate advisory piece relating to the management of smartcard access for electronic prescribing.

## 4. Other Internal Audit Activity & Engagement

Ongoing liaison and planning meetings have continued to take place in this period, including with the Assistant Director of Corporate Services and Director of Finance & Corporate Services. Meetings with other directors and senior managers have taken place as part of the planning and delivery of individual audits.

## Appendix A: NWSSP Assignment Status - 2026/27 Internal Audit Plan

| Audit | Status | Assurance Rating | Matters Arising | | Timing | Audit Committee |
|---|---|---|---|---|---|---|
| | | | H | M | | |
| Primary Care Services- Electronic Prescribing System (Advisory) | Planning | | | | Q1/2 | |
| Primary Care Services Contractor Payments | | | | | Q2 | |
| Accounts Payable | Planning | | | | Q1/2 | |
| Financial Management - Grip and Control Assessment | | | | | Q1/2 | |
| Cyber Follow Up | | | | | Q2/3 | |
| Student Streamlining | Planning | | | | Q3 | |
| Procurement Services | Planning | | | | Q2/3 | |
| Payroll Services | Planning | | | | Q2/3 | |
| Regulatory Compliance | | | | | Q3 | |
| Control of Contractors | | | | | Q2/3 | |
| Legal & Risk System | | | | | Q2/3 | |
| Governance Arrangements | | | | | Q3/4 | |

| Audit | Status | Assurance Rating | Matters Arising | | Timing | Audit Committee |
|---|---|---|---|---|---|---|
| | | | H | M | | |
| Laundry Services | | | | | Q3 | |
| Business Continuity and Emergency Planning | | | | | Q3/4 | |
| Information Governance | | | | | Q3/4 | |
| Agreed Action Follow up & Tracking | WIP | | | | | |
| ESR replacement | Defer | | | | | |

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# Medical Examiner Service

## Final Internal Audit Report

## 2025/26

## NHS Wales Shared Services Partnership

Reasonable Assurance

**Contents**



| | |
|---|---|
| **Review Reference** | SSP-2526-07 |
| **Fieldwork** | April – June 2026 |
| **Executive Sign Off** | June 2026 |
| **Audit Committee** | July 2026 |
| **Executive Lead** | Nicola Phillips, Director of Primary Care and Medical Examiner Service |
| **Audit Team** | James Johns, Head of Internal Audit<br>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

To test compliance with a range of system controls along with key aspects of risk management and governance within the service.

The all-Wales Medical Examiner Service (MES) has been operating as a fully statutory national service since the introduction of the Death Certification Reforms in September 2024 under the Coroners and Justice Act 2009. The service provides independent, consistent scrutiny of all non-coronial deaths across acute, community, and primary care settings in Wales.

## Overview

The service has robust mechanisms in place for operational performance oversight and monitoring to ensure that deaths are reviewed promptly, with effective use of business intelligence tools to enable early identification of pressure points. Sample testing identified some minor exceptions in the accurate recording of Medical Certificate of Cause of Death on Datix. Existing quality management system arrangements are in place to identify and such instances through an internal audit programme, although currently this is not fully operating as intended (see below). The service operates at full establishment and Medical Examiners and Medical Examiner Officers are professionally registered (where appropriate) and trained. We have concluded **Reasonable** assurance overall, with three findings for management attention:

1. The service has a comprehensive suite of SOPs however 20% of these are overdue for review.
2. We identified instances where staff leavers still had access to the Datix system used for case management.
3. The service has an ambitious audit programme but has struggled to deliver the planned coverage.

Full details of matters arising are detailed within the Findings & Agreed Action Plan on page 3.

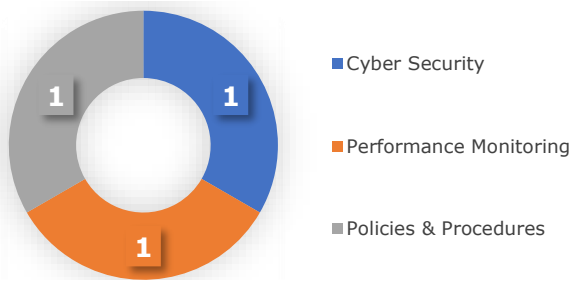
## Scope & Assurance Summary

| | 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 ensures prompt review of deaths in line with agreed processes and timescales | 1, 2, 3 | **Reasonable** |
| 2 | Medical Examiners & Medical Examiner Officers are professionally registered, subject to revalidation (where required) and compliant with mandatory training and continuing professional development activities relevant to their roles | 3 | **Substantial** |
| 3 | Appropriate governance and risk management arrangements have been established for oversight of operational performance of the Service, including performance monitoring and reporting | - | **Substantial** |

## Management Actions

| 0 | 3 |
|---|---|
| High Priority | Medium Priority |

## Themes




## Risk Types

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Public Perception & Reputational Risk

# Findings & Agreed Action Plan

| Objective 1: The Service ensures prompt review of deaths in line with agreed processes and timescales | Reasonable |
|---|---|

A Quality Manual, Quality Management System and processes aligned to relevant national legislative and regulatory frameworks, has been developed to support the consistent, safe and effective operation of the Medical Examiner Service (MES). A comprehensive suite of Standard Operating Procedures (SOPs) is maintained and accessible via Microsoft Loop. However, the service is not currently meeting its planned review schedule, with approximately 20% of SOPs classified as "under revision," some of which have remained outstanding since 2023. **[Finding 1]**

The service operates 364 days a year and is at full establishment with clearly defined roles and responsibilities. Cases are documented and managed via the Datix system. We identified four individuals who have left the service but remain within NWSSP and still have access to Datix. **[Finding 2]**

The *Medical Examiners Regulations 2024* do not prescribe specific KPIs or timescales for the completion of case scrutiny although national guidance and the wider death certification framework require that scrutiny is undertaken without unreasonable delay and prior to death registration. During 2025/26, 28,389 cases were subject to Medical Examiner scrutiny. The average time from notification of death to ME scrutiny was two days and there was same day submission of MCCD to the Register office, in line with internal KPIs. We also noted that performance is generally consistent across all teams.

The Medical Certificate of Cause of Death (MCCD) is the statutory document completed by the qualified attending practitioner (QAP) to certify the cause of death, which is subject to independent scrutiny by a Medical Examiner prior to death registration. Incomplete and erroneous MCCDs must be returned to the QAP for correction, contributing to delays in the death certification process. MCCD returns are monitored via the dashboard – the return rate for 2025/26 was 18%, broadly consistent across all health boards.

Sample testing demonstrated that MCCDs are returned to the QAP for correction where appropriate, demonstrating appropriate review and scrutiny to ensure accuracy of the final MCCD for submission to the Register Office. However, we found a small number of instances where details from the MCCD had not been completely or accurately captured on Datix. **[Finding 3]**

The service has established a comprehensive internal audit programme to assess compliance and quality. Developed at service inception, the programme includes a range of audit types, including vertical (end-to-end case review), horizontal (process-specific across multiple cases), deep dive, training and SOP compliance audits. However, the programme appears ambitious in scope, and the service has not achieved its planned coverage. **[Finding 3]**

We verified that discussions with bereaved families and any concerns are documented and saw evidence that trends or issues identified are shared internally within MES. We observed examples of concerns being fed back to care providers who are accountable for investigating patterns and implementing improvements.

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 1 | **SOPs**<br>Review of SOPs identified 13 of 62 which were categorised as under review but were beyond their revision dates with some dating back to 2023. We were advised that some reviews have been delayed due to operational pressures, particularly during winter periods when this work is deprioritised. | Potential risk of inconsistent process execution, non-compliance with policies and regulatory requirements. | **Agreed Action:**<br>Develop and implement a plan with realistic timescales to complete the review of SOPs that are beyond their scheduled revision dates, prioritising those most overdue or known to require updating to reflect current practice.<br>Future SOP review cycles will be scheduled with consideration of known periods of increased operational pressure.<br>**Expected Evidence of Implementation:** |

| | | | |
|---|---|---|---|
| | | | Plan for completing SOP reviews. Updated/reviewed SOPs. |
| | | **Medium Priority** | **Officer:** Daisy Shale, Lead Medical Examiner Officer<br>**Target Implementation Date:** 30 September 2026 |
| | **Theme:** Policies & Procedures | Control Operation | |
| 2 | **Datix Access**<br>We reviewed the current list of users and identified nine staff who have left the service however their accounts have not been deactivated. Five individuals had left NWSSP and we sighted evidence of the request to IT to deactivate the NADEX account, which would prevent access to Datix. The remaining four relate to bank staff who have left MES but remain employed by NWSSP and have retained the NADEX account linked to their Datix access. | Inappropriate system access posing a potential risk to data confidentiality and integrity. | **Agreed Action:**<br>Datix profiles for the identified staff members have been changed to 'leavers' profile to remove their system access but retain associated records/audit trail within Datix.<br>A leavers checklist has been adopted and includes the requirement to ensure that the Once for Wales Team is notified when a member of staff leaves the service. |
| | | | **Expected Evidence of Implementation:**<br>Datix report demonstrating that the identified individuals have a 'leavers' profile.<br>Leaver's checklist. |
| | | **Medium Priority** | **Officer:** Daisy Shale, Lead Medical Examiner Officer<br>**Target Implementation Date:** Completed |
| | **Theme:** Cyber Security | Control Operation | |
| 3 | **Audit Programme – Design & Delivery**<br>Sample testing identified instances where information from the MCCD had not been completely or accurately captured in Datix:<br>• One instance where the age of the deceased was incorrectly recorded on the MCCD by the QAP (but was correct in Datix) however the error was not detected by the ME prior to forwarding to the Registrar<br>• One instance where QAP cause of death 1a in Datix did not match the MCCD verbatim (the cause of death on the MCCD was correct)<br>• One instance where Cause of Death 1b was not recorded on Datix<br>• One instance where 'MCCD completed by' field was not populated on Datix (Forename, surname and GMC number) | Errors could result in unreasonable delay in the death certification process | **Agreed Action:**<br>The audit programme will be reviewed and refined to ensure that it is appropriately focused on priority areas and is achievable within existing service capacity.<br>Consider incorporating audit programme delivery into the business intelligence dashboard. |
| | | | **Expected Evidence of Implementation:**<br>Updated audit programme. |

| | | | |
|---|---|---|---|
| | • One instance where the GMC number of the ME was not recorded on the MCCD<br><br>The service has established an internal audit programme to identify issues such as these. However, the programme appears ambitious in scope, and the service has not achieved its planned coverage with only 8 of the 30 scheduled audits completed during 2025/26. | **Medium Priority** | **Officer:** Daisy Shale, Lead Medical Examiner Officer<br><br>**Target Implementation Date:** 30 September 2026 |
| | **Theme:** Performance Monitoring | Control Operation | |

| **Objective 2: Medical Examiners & Medical Examiner Officers are professionally registered, subject to revalidation (where required) and compliant with mandatory training and continuing professional development activities relevant to their roles** | **Substantial** |
|---|---|

The service utilises Microsoft Loop as a central source of information for staff, with easy access to guidance, training, CPD resources, SOPs and service updates.

Medical Examiners (MEs) must be fully registered medical practitioners holding a licence to practise with the General Medical Council, with a minimum of five years post-registration clinical experience. They are required to complete nationally mandated training consisting of core e-learning modules and virtual and face-to-face training provided by the Royal College of Pathologists (RCPath). There is no statutory training requirement for Medical Examiner Officers (MEOs) although it is advised that they should complete the same core e-learning sessions and RCPath training. Sample testing demonstrated compliance with the requirements for both MEs and MEOs.

The MES Audit Programme includes five training related audits although only two had been completed at the time of our review. As highlighted in objective 1, the service has struggled to achieve its planned coverage during 2025/26. **[Finding 3]**

Statutory and mandatory ESR training compliance for the MES was 92.56% at the end of April 2026 and PADR compliance was 87.37% for the same period. IG mandatory ESR module training was also green at 90.43% at the end of April 2026. MEs and MEOs are also required to complete MES-specific face-to-face internal information governance training in addition to the statutory ESR module. All sampled MEOs were confirmed as compliant; however, completion could not be verified for two of the sampled MEs. These isolated instances, one of which relates to staff absence have been highlighted to management during the audit – no finding is raised.

Compliance with revalidation, appraisal and CPD requirements for MEs is reviewed as part of annual one-to-one meetings with the Lead Medical Examiner. All MEs have a 1:1 date recorded within the last year, and verification of supporting documentation for a sample of MEs identified no issues. All MEOs have a PADR date recorded within the last year, although we were not provided with requested supporting documentation for our sample.

## Objective 3: Appropriate governance and risk management arrangements have been established for oversight of operational performance of the Service, including performance monitoring and reporting — Substantial

### Performance Monitoring & Oversight

Service activity and performance monitoring is via a Power BI dashboard linked to Datix, providing oversight of the end-to-end death certification process with team and health board-level analysis to identify and understand delays. The dashboard includes the KPIs stipulated within the IMTP, and daily traffic-light indicators to highlight pressure points within the process and enable early action and escalation to external partners where delays sit outside the service. The dashboard is monitored daily and at the monthly Senior Management Group meetings.

As highlighted in Objective 1, the service has established a comprehensive internal audit programme to assess compliance and quality although planned coverage has not been fully achieved as the programme may be over-ambitious and requires refinement. **[Finding 3]** Review of eight completed audits confirmed that each has an action plan and evidence of implementation progress documented on Microsoft Loop.

MES participates in the organisations quarterly review process which focuses on IMTP progress, risks and issues, KPI's, financial performance, people and organisational development workforce matters, and complaints/compliments, key achievements and forward actions. Externally, MES submits quarterly activity dashboards to the National Medical Examiner and Welsh Government with regular review meetings used to monitor performance and address emerging issues.

### Risk

MES maintains an operational risk register aligned to the organisations risk management framework. At the outset of our review the register contained two amber risks relating to plans to retender for the Datix system and access to EMIS web licences. Mitigating actions and review dates have been identified and are subject to ongoing monitoring through the formal Senior Management Group meetings and the SSP quarterly review process.

The current workforce model exceeds Department of Health and Social Care (DHSC) guidance based solely on caseload, recognising the wider national role that the service has in supporting learning. The service is funded by the DHSC via Welsh Government and agreed annually. Following discussion with management at the outset of the review, a risk relating to the sustainability of the current UK staff funding model not supporting operational activities or the maturing expectations of the service has been added to the operational risk register, with formal review of the funding model planned for 26/27.

At a corporate level, MES was previously included with a reputational risk related to stakeholder misunderstanding of the MES role in the death certification process. This was noted as mitigated through ongoing stakeholder engagement, performance monitoring, winter surge planning and additional sessional capacity and the risk has since been removed.

# Appendix A

## Assurance Opinion

| | | |
|---|---|---|
|  | **Substantial** | Few matters require attention and are compliance or advisory in nature.<br>**Low impact** on residual risk exposure. |
|  | **Reasonable** | Some matters require management attention in control design or compliance.<br>**Low to moderate impact** on residual risk exposure until resolved. |
|  | **Limited** | More significant matters require management attention.<br>**Moderate impact** on residual risk exposure until resolved. |
|  | **Unsatisfactory** | Action is required to address the whole control framework in this area.<br>**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.<br>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 NHS Wales Shared Services Partnership 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 NHS Wales Shared Services Partnership. 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]

# NHS WALES
# Shared Services Partnership (NWSSP)

# Counter Fraud Annual Report 01/04/2025 – 31/03/2026

**Mark Weston**
**Local Counter Fraud Manager**
**NHS Wales Shared Services Partnership**
**30 June 2026**

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## 1. Introduction

NHS bodies in Wales must implement anti-fraud, bribery and corruption measures in accordance with Welsh Government Directions on Counter Fraud Measures and the service agreement under section 83 of the Government of Wales Act 2006, and in compliance with Government Functional Standard – GovS 013: Counter Fraud. This report provides details of the work carried out by the NHS Wales Shared Services Partnership (NWSSP) Local Counter Fraud Manager for NWSSP for the financial year 1 April 2025 to 31 March 2026.

The report's format has been adopted, in consultation with the Director of Finance and Corporate Services, to update the Velindre University NHS Trust Audit Committee for NWSSP (the Audit Committee) about counter fraud activity including fraud awareness, risks, proactive work, referrals, investigations, recoveries and other operational issues.

The Counter Fraud Annual Plan 2025/2026 was completed jointly by the NWSSP LCFS Manager and approved by the Director of Finance and Corporate Services and Audit Committee on **13 May 2025**.

NWSSP continues to employ a Local Counter Fraud Manager to provide Local Counter Fraud Services for NWSSP. As at 31 March 2026, all 211 days of counter fraud work had been completed against the agreed 210 days in the Counter Fraud Annual Work Plan for the 2025/26 financial year.

The breakdown of these days, including costs and on-costs, is as follows:

| TYPE | **Days Planned** | **Days Actual** | **+/-** | **Costs** |
|---|---|---|---|---|
| Proactive | 140 | 115 | -25 | £38,749.55 |
| Reactive | 70 | 96 | +26 | £32,347.45 |
| Total | **210** | **211** | **+1** | **£71,097** |

## 2. Progress

### Infrastructure/Annual Plan outcomes

The Counter Fraud Plan's objectives for 2025/2026 were fully aligned to the NHS Counter Fraud Authority (NHS CFA) requirements, as stipulated in Government Functional Standard 13 (GovS 013). The plan set out the proposed delivery throughout the year and has been updated to outline the outcomes delivered against each objective set by NWSSP's Local Counter Fraud Manager during the reporting period from 1 April 2025 to 31 March 2026, as reported in the Functional Standards Return authorised by the Audit Chair and Director of Finance and Corporate Services.

It is pleasing to state that all but one of the functional standards have been rated as Green and can be summarised as follows.

| Ref | Objective / Functional Standard | Rating |
|---|---|---|
| 1 | Accountable individual | GREEN |
| 1b | Counter Fraud Champion, Audit Chair and Board Level Reporting | GREEN |
| 2 | Counter fraud bribery and corruption strategy | GREEN |
| 3 | Fraud bribery and corruption risk assessment | AMBER |
| 4 | Policy and Response Plan | GREEN |
| 5 | Annual action plan | GREEN |
| 6 | Outcome-based metrics | GREEN |
| 7 | Reporting routes for staff, contractors and members of the public | GREEN |
| 8 | Report identified loss | GREEN |
| 9 | Access to trained investigators | GREEN |
| 10 | Undertake detection activity | GREEN |
| 11 | Access to and completion of training | GREEN |
| 12 | Policies and registers for gifts and hospitality and COI. | GREEN |

At the end of 2025/2026, NWSSP arranged with SBUHB to provide 12 days of specialist additional resource to assist with risk assessments, effective from 1 April 2026.

In addition to the Annual Plan objectives, which are aligned to the Government Functional Standards, a summary is also provided of the traditional core actions, as follows:

- Fraud Awareness to develop an Anti-Fraud Culture.
- Prevention and Detection of Fraud.
- Investigation.
- Sanctions and Financial Recoveries.

## Fraud Awareness

The development of an anti-fraud culture and improved fraud awareness within each organisation is an essential part of combatting economic crime in NHS Wales. The NWSSP LCFS Manager provides fraud awareness in a number of ways. A summary table of activity is provided below, followed by further details on each method used.

*Summary of Activity*

| Fraud Awareness interactions 2025/2026 | Total Staff 2025/2026 | Total Staff 2024/2025 For comparison |
|---|---|---|
| **New Starter Fraud Awareness** (x 9) | 166 | 149 |
| **Fraud Awareness Session** (x11) | 242 | 186 |
| **e-Learning** | 309 | 1,098 |
| **Newsletters, emails, SharePoint Blogs & other media** (using Sways and Linkedin) (x15) | 5,618 | 124 |
| **Social Media Posts - "X"** (Formerly Twitter) impressions (NWSSP no longer uses "X") | | 693 |
| **Total** | **6,335** | **2,250** |

*Fraud Awareness Presentations*

From 1 April 2025 to 31 March 2026, a total of **11** fraud awareness sessions were delivered to **242** NWSSP staff. Groups and divisions included Primary Care Services, Specialist Estates, Surgical Materials Testing Laboratory (SMTL), Accounts Payable, People and Organisational Development. Fraud awareness sessions were also provided to Finance and Corporate Services and Heads of Procurement Services on the new Failure to Prevent Fraud offence introduced by the Economic Crime and Corporate Transparency Act 2023 (ECCT).

Since November 2023, NWSSP's new employees have been invited to attend fraud awareness sessions, which are now conducted monthly via MS Teams. **166** new staff attended **9** sessions in 2025/2026.

Staff during each session were very engaging, with feedback forms that were issued following most sessions providing very supportive and positive feedback.

Fraud awareness is also now signposted in the NWSSP induction toolkit presented to new staff at the "Welcome Session" which is delivered virtually.

*All Wales E-Learning Fraud Awareness Module*

The NWSSP LCFS Manager collaborated with NHS CFS Wales and NWSSP Learning and Development to produce a new Fraud Awareness e-Learning module, which was launched in April 2023 and made available to all NHS Wales staff. A manual version has also been produced for staff with restricted access to computers. The module is also now available in Welsh.

Although NWSSP has not made the fraud e-learning module mandatory, with the support of the Director of Finance and Corporate Services, selected divisional staff are currently required to complete the module. This produced excellent progress, with **1,098** staff completing the module in 2024/2025 and a further **309** in 2025/2026. A push to increase participation further will take place in the forthcoming financial year, using improved data to encourage areas of lower participation.

### *Newsletters*

Several bilingual media articles relating to cases and risks were posted on the SharePoint/Intranet page to promote fraud awareness.

Bilingual newsletters and LinkedIn posts were also issued to coincide with International Fraud Awareness Week during November 2025. The newsletters reached 868 people, and LinkedIn posts, which included short videos highlighting common fraud themes against NHS Wales, reached 3,872 people through a combination of impressions and video views.

The combined engagement throughout the year using various methods from presentations to Sharepoint and media platforms such as Linkedin to promote fraud awareness was accessed by over 6,300 people as presented in the table above.

### *Counter Fraud Videos*

The NWSSP LCFS Manager previously collaborated with the NWSSP Communications Team to produce five videos to improve fraud awareness. Each video was also translated into Welsh. The videos continue to be promoted and are available on the NWSSP intranet/internet sites via a YouTube link and have been disseminated to staff by email and social media. The videos were also made available to all health bodies in NHS Wales to help raise fraud awareness.

### *Counter Fraud App*

The NWSSP LCFS Manager previously collaborated with the NWSSP Communications Team to produce a Counter Fraud Mobile App. Despite this innovative approach, uptake has remained low; however, the NWSSP LCFS Manager continues to promote it in all fraud awareness presentations and communications.

### *Failure to Prevent Fraud - The Economic Crime and Corporate Transparency Act 2023*

The new criminal offence of Failure to Prevent Fraud under the Economic Crime and Corporate Transparency Act 2023 (the Act) became effective from 1st September 2025. The genesis of the Act is fraud in the commercial sector, but it does also cover large public sector organisations.

The LCFM and Assistant Director of Corporate Services attended Counter Fraud Authority training on the Act in July 2025. The LCFM has liaised with the Director of Finance and Corporate Services and Assistant Director of Corporate Services to review whether NWSSP has reasonable procedures in place to prevent fraud, as

required by the Act. This was also considered by the Senior Leadership Group, which supported further work on risk assessments.

The LCFM delivered awareness sessions explaining the details and requirements of the Act to the NWSSP Senior Leadership Group, the Procurement Senior Leadership Group and all Accounts Payable staff. Details of the new offence are also included in all fraud awareness sessions.

The Act centres on an organisation benefiting from fraud perpetrated by an employee or agent. Case history in NHS Wales does not appear to include any cases that would have come under the Act had it been in place at the time. Compared with other sectors, the NHS has well-developed counter fraud arrangements. The annual review and submission of the Counter Fraud Authority Functional Standards Return, together with reporting to Audit Committees, ensures that arrangements to prevent and detect fraud are in place and operating effectively.

The only area in the most recent NWSSP Return which was 'amber' rated was risk assessment which had been planned to be addressed during 2025-26 and the Act has provided further focus to this area.

The LCFM continues to work with the Assistant Director of Corporate Services to develop and enhance the recording of fraud risks and fraud risk assessments at NWSSP.

The implications of the Act are also being discussed at an all-Wales level in the Counter Fraud Steering Group and the Counter Fraud Liaison Group in order to ensure a consistent approach.

## Fraud Prevention and Detection Activity

Fraud prevention is another key component in minimising the risk of fraud. Work is undertaken both reactively and proactively.

Once a fraud risk or system weakness is identified it is important to mitigate those risks by improving processes and systems to help prevent fraud from occurring in the first place.

The NWSSP LCFS Manager receives Fraud Prevention Notices (FPNs) and Intelligence Bulletins (IBURNs) from the NHS Counter Fraud Authority (NHS CFA). These alerts are often collated from specific fraud risks identified by NHS CFA, other health bodies in England and Wales, and NHS Scotland.

Where fraud cannot be prevented, it is also important to consider ways to detect fraud at the earliest opportunity to minimise the risk of further loss. NHS CFS Wales and LCFS colleagues in NHS Wales collaborate to ensure that systems and processes are robust and that staff awareness, system checks, controls and data analytics are used to detect and report fraud without delay.

The NWSSP LCFS Manager also conducts proactive work to prevent and detect fraud. All work is logged on the Clue Case Management System in accordance with NHS CFA procedures, which are followed within NHS Wales by all LCFS colleagues and NHS CFS Wales. A summary of actions taken is set out below.

### *Summary 2025/2026*

| | | |
|---|---|---|
| ***Advice on Fraud Related Matters*** | *Number of contacts (emails / calls) where the LCFS has given advice on fraud related queries* | *101* |
| ***No of Fraud Prevention Activities*** | *Actions undertaken to directly change procedures identified as being at risk to fraud, or actions to implement a structured prevention process e.g. fraud proofing, LPEs, Risk reviews* | *16* |

### *Fraud Prevention Notices (FPN'S) and Intelligence Bulletins / Alerts (IBURN's)*

The NHS CFA issues Fraud Prevention Notices and Fraud Bulletins from risks identified throughout the wider NHS Counter Fraud Community. All information received is reviewed, risk assessed and actioned according to the nature of issue identified.

Where appropriate FPN's and IBURN's are also actioned by NWSSP's LCFS Manager centrally and outcomes disseminated to all Lead LCFS in NHS Wales to avoid duplication which previously existed in verifying similar alerts.

All FPN's and IBURN's are recorded and actioned on the CLUE 2 database in accordance with NHS CFA requirements. In 2025/2026 the following Notices and Alerts were received and actioned.

- An FPN issued by NHS CFA was disseminated to relevant staff on 2 April 2025 for awareness in relation to the management of risks associated with agency staff timesheet fraud.
- FPN's were also issued and dealt with in relation to Corporate Impersonation Fraud, Business Email Compromise and Asset Management.
- An IBURN Intelligence Alert was issued by the NHS CFA Intelligence Unit regarding concerns about an individual using a false identity while seeking employment, often via a nursing agency. Checks were made with recruitment on an all-Wales basis, with no concerns identified.
- A Fraud Alert was issued by an NHS Wales health board following concerns regarding a potential scam involving fake emails arranging refunds and purporting to be from the Home Office UK Visas and Immigration (UKVI) and Immigration Skills Charge (ISC). The information was disseminated to Recruitment and Finance teams for awareness, and checks confirmed that no emails had been received by NWSSP.
- Several Fraud Prevention Notices and alerts were issued to relevant staff on payment diversion fraud/mandate fraud. A fraud risk assessment was undertaken on the processes relating to the management of creditor bank amendments and the risks associated with mandate fraud. Although a comprehensive range of preventative and detective controls is in place and

operating effectively, it will be difficult to reduce the risk score further due to the inherent nature of mandate fraud and the prevalence of evolving external threats. Ongoing monitoring therefore focuses on maintaining the effectiveness of controls, staff awareness and timely escalation of emerging risks in this area, rather than further reducing the current risk score. The LCFM liaises frequently with the Accounts Payable Supplier Maintenance Team, which manages bank amendments, particularly when potential risks arise.

A review of the bank mandate processes within Primary Care Services was also undertaken by the LCFM. Recommendations were made to align the processes with the Accounts Payable Supplier Maintenance Team to provide more robust controls to prevent mandate fraud. The recommendations were accepted and changes to the processes were implemented.

A further local risk was also identified in relation to the management of maternity leave within the Single Lead Employer (SLE). Additional controls were advised, and a review will be carried out towards the end of the year to measure the effectiveness of those controls.

The LCFM liaises regularly with Internal Audit and also continues to liaise with the Cyber Security Team on Phishing and Spam email concerns.

The LCFM meets regularly with The CFS Wales Team and Lead LCFS Colleagues at the Counter Fraud Liaison Group.

The NWSSP LCFM also assists and advises other NHS staff, LCFS colleagues and NHS CFS Wales with queries on fraud-related matters. Data is now requested by NHS CFS Wales on the volume of queries and advice received in relation to fraud matters; as such, a record is logged and maintained on queries and assistance provided.

During 2025/2026, the NWSSP LCFM received 101 queries on a wide range of topics, including several mandate fraud checks, NFI checks, recovery of salary overpayments and various system queries. The LCFM has also liaised with NHS CFS Wales and advised Workforce on the All-Wales Social Media Policy and the All-Wales Disciplinary Policy regarding sections relating to fraud. The LCFM has also liaised with NHS CFS Wales and Welsh Government on the inclusion of NHS Wales organisations in the Digital Economy Act, which will assist with sharing information to prevent and detect fraud and may assist in the recovery of salary overpayments.

LCFM has also provided feedback on the proposed new Welsh Government Directions on Counter Fraud.

*National Fraud Initiative*

Payroll data has been uploaded; analysis has commenced and is ongoing. Some anomalies have been detected and are being examined further with relevant staff at other health bodies. Matches are considered on a risk basis. The majority of payroll-to-payroll matches relate to NWSSP Single Lead Employer doctors who may have changed employers, worked additional shifts or undertaken bank shifts at other health boards. This is permissible and common, with all such cases closed with no issues so far. A significant volume was checked during Q4 and many were closed with no further action, with responses awaited on others.

The summary can be seen as follows;

**Report 68.1 Payroll to Payroll phone number**

Only one match was identified, which was closed as no risk following confirmation that a recording error had occurred.

**Report 78 Payroll to Pensions**

All 26 matches were closed with no issues, as the majority related to staff who had retired and returned.

**Payroll to Payroll Report**

Out of 364 matches:

- 312 matches have now been closed with no issues found;
- 41 have been opened and are awaiting a response and/or further checks or investigation;
- 11 not yet opened.

**A total of 339 out of 391 matches have been closed.**

The LCFM also attended a webinar on 24 March 2026 on the NFI feature “App Check”, which is a real-time, secure web-based tool designed to help public sector organisations prevent fraud at the application stage. It has mainly been used by local government to validate applicants, such as for housing and employment. Access will be arranged by Audit Wales and the Cabinet Office during Q1 2026/2027. NWSSP LCFS and LCFS colleagues, together with CFS Wales, are due to meet further with Audit Wales and the Cabinet Office to discuss this in more detail and consider the use of App Check in NHS Wales.

## Referrals/Enquiries/Investigations

*Summary 1 April 2025 – 31 March 2026*

The table below shows a summary of the number of cases investigated, together with values of Fraud Prevented, Fraud Recovered and Sanctions in 2025/2026.

| | **Caseload** | **2025/26 Total** |
|---|---|---|
| A | Cases b/f at 1 April 2025 | 1 |
| B | Add: New cases opened | 14 |
| D | Less: Cases closed or transferred | 11 |
| E | Cases open at 31 March 2026 | **3** |
| | Fraud Prevented | **£0** |
| | Fraud Recovered | **£1,200** |
| | Total Prevented / Recovered | **£1,200** |
| | Number of sanctions | **1** |

The financial recovery of £1,200 related to an investigation where IT equipment was not returned on termination of employment. Following intervention by the LCFM, the equipment was recovered to safeguard NWSSP assets.

Other cases investigated and closed during 2025/2026 resulted in no further action. Some cases related to matters that were more appropriate for recovery by Payroll and the NWSSP Finance Team, including working while on sick leave.

## 3. Conclusion

NWSSP Counter Fraud provision has demonstrated compliance with the requirements of the Welsh Government Directions to NHS Bodies on Counter Fraud Measures and the Government Functional Standard – GovS 013: Counter Fraud, with an overall Green rating as shown in the Counter Fraud Functional Standards Summary and Return (Appendix 1). This demonstrates the continued efforts of the NWSSP LCFS Manager in working innovatively to achieve a balance of both reactive and proactive work to meet the NHS Counter Fraud Authority's Standards and the Government Functional Standards on Counter Fraud.

The NWSSP LCFS Manager can demonstrate a continued trajectory of improvement across the service, with continued success shown across key measures. Key areas of work for next year include developing work associated with

Prevent and Deter, building on fraud risk analysis, identifying specific fraud-risk-based proactive exercises and recording outcomes on Clue3 against Government Functional Standard 013 – Counter Fraud and NHS requirements. The LCFM will continue to maintain focus on Inform and Involve, continuing to raise awareness of fraud, bribery and corruption and further embedding an anti-fraud culture within NWSSP.

NWSSP Counter Fraud provision has demonstrated compliance with the requirements of the Welsh Government Directions to NHS Bodies on Counter Fraud Measures.

**Mark Weston**
**Local Counter Fraud Manager**
**NHS Wales Shared Service Partnership**
**30 June 2026**

# NHS WALES
# Shared Services Partnership
# (NWSSP)

# Counter Fraud Progress Report Q1
# 01/04/2026 – 30/06/2026

**Mark Weston**
**Local Counter Fraud Manager**
**NHS Wales Shared Services Partnership**

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## 1. Introduction

In compliance with the Secretary of State for Health's Directions on Countering Fraud in the NHS, this report provides details of the work carried out by the NHS Wales Shared Services Partnership (NWSSP) Local Counter Fraud Manager (LCFM).

The report's format has been adopted, in consultation with the Director of Finance and Corporate Services, to update the Audit Committee about counter fraud referrals, investigations, activity and operational issues.

## 2. Summary

The Counter Fraud Annual Plan 2026/2027 was completed and approved by the Director of Finance and Corporate Services and approved by the Audit Committee on 28 April 2026.

NWSSP continues to employ 1.0 WTE Local Counter Fraud Manager (LCFM) to provide Local Counter Fraud Services. Additionally, NWSSP has sought support from Swansea Bay University Health Board (SBUHB) to provide an additional 12 days annually in respect of fraud risk assessment expertise. This arrangement commenced on 1 January 2026, with equivalent pro rata days provided to date, and will continue in the 2026/2027 financial year.

As at 30 June 2026, 48 days of counter fraud work had been completed against the agreed 212 days in the Counter Fraud Annual Work Plan for the 2026/27 financial year.

The breakdown of these days is as follows:

| **Type** | **Q1** |
|---|---|
| Proactive | 33 |
| Reactive | 8.25 |
| Training | 6.75 |
| **Total** | **48** |

In summary, the reactive days have been utilised in conducting six fraud investigations, including three new fraud referrals received during the last quarter. Two cases were closed, leaving four investigations ongoing at the end of the quarter.

Three fraud awareness sessions were delivered to 21 staff during Q1. Due to the timing of this report, e-learning data is not yet available and will be presented in the next quarterly update report. However, fraud e-learning benchmarking data is provided later in this report.

The NWSSP LCFM has continued to liaise with Internal Audit under the Joint working protocol in place.

The Counter Fraud Plan for 2026-2027 is aligned fully to the NHSCFA requirements as stipulated in Government Standard 13. The Plan states proposed actions throughout the year. In tandem with investigation work required, the focus of the LCFM during the first quarter is set out in more detail below.

## 3. Fraud Awareness Activity

The NWSSP Local Counter Fraud Service intranet page has continued to be updated with assistance from the NWSSP Communications Team.

E-learning Module – Participation in the All-Wales e-learning module is not mandatory for NWSSP. However, support from Directors and Managers has generally been very positive over the last two years which has been reflected in good participation from staff.

A review of divisional participation was undertaken on 10 June 2026. Contact was made with all Directors/Heads of Service whose staff showed a participation rate below 80%. All were very supportive and agreed to encourage staff to complete the counter fraud e-learning on ESR. However, it is accepted that some staff, e.g. Laundry, may have limited access to computers, so alternative arrangements will be made to ensure that staff receive fraud awareness training. The data at 10 June is presented in the table below, with the aim of demonstrating an increase in Q2.

| Division | Headcount | Completed | Completed % |
|---|---|---|---|
| Counter Fraud Division | 7 | 7 | 100.00% |
| Accounts Payable Division | 155 | 147 | 94.84% |
| Surgical Materials Testing (SMTL) Division | 26 | 24 | 92.31% |
| Employment Division | 351 | 308 | 91.39% |
| E-Business Central Team Division | 20 | 17 | 89.47% |
| Digital Workforce Division | 27 | 24 | 88.89% |
| Finance Division | 29 | 24 | 85.71% |
| Corporate Division | 26 | 21 | 80.77% |
| Audit & Assurance Division | 57 | 39 | 68.42% |
| Primary Care Division | 305 | 201 | 65.90% |
| Planning, Performance and Informatics Division | 50 | 28 | 56.00% |
| Procurement Division | 829 | 401 | 48.55% |
| People & OD Division | 48 | 20 | 41.67% |
| Pharmacy Technical Services Division | 57 | 13 | 22.81% |
| Legal & Risk Division | 206 | 39 | 19.90% |
| Medical Examiner Division | 98 | 16 | 16.49% |
| Welsh Employers Unit Division | 7 | 1 | 14.29% |
| Specialist Estates Division | 54 | 4 | 7.27% |
| Medical Workforce Division | 21 | 1 | 4.76% |
| Laundry Division | 203 | 8 | 3.50% |
| Finance Academy Division | 8 | 0 | 0.00% |
| **TOTALS** | **2584** | **1343** | **52.05%** |

## All Wales e-Learning participation

For comparison, I have also included the e-learning participation figures for each NHS Wales health body for 2025/2026. NWSSP is “mid table”; five of the organisations above NWSSP have made their e-learning mandatory, namely BCUHB, HDUHB, WAST, ABUHB and Velindre.

It is also worth noting that NWSSP participation in 2024/2025 was much higher at 1,098, as shown in the table above as there was a large uptake following a promotional email.

| | | Q1 | Q2 | Q3 | Q4 | TOTAL 2025/26 | TOTAL 2023/24 | TOTAL 2024/25 |
|---|---|---|---|---|---|---|---|---|
| 1 | **BCU** | 1047 | 1342 | 966 | 938 | 4293 | 4334 | 9727 |
| 2 | **ABUHB** | 798 | 1248 | 686 | 578 | 3310 | 5646 | 6620 |
| 3 | **HDUHB** | 609 | 989 | 522 | 492 | 2612 | 2299 | 4289 |
| 4 | **VELINDRE** | 891 | 534 | 190 | 117 | 1732 | 32 | 4 |
| 5 | **WAST** | 245 | 317 | 245 | 205 | 1012 | 3451 | 1009 |
| 6 | **SBUHB** | 103 | 146 | 73 | 33 | 355 | 325 | 214 |
| **7** | **NWSSP** | **73** | **105** | **73** | **58** | **309** | **119** | **1098** |
| 8 | **DHCW** | 3 | 24 | 37 | 38 | 102 | 962 | 340 |
| 9 | **PHW** | 7 | 16 | 7 | 7 | 37 | 69 | 46 |
| 10 | **CTM** | 5 | 16 | 6 | 7 | 34 | 27 | 39 |
| 11 | **POWYS** | 0 | 1 | 4 | 14 | 19 | 4 | 2 |
| 12 | **CVUHB** | 5 | 6 | 2 | 2 | 15 | 56 | 23 |
| 13 | **HEIW** | 0 | 3 | 0 | 0 | 3 | 19 | 7 |
| | **TOTALS** | 3786 | 4747 | 2811 | 2489 | 13833 | 17343 | 23393 |

In addition, Fraud Awareness sessions were delivered via TEAMS to:

- 21 NWSSP staff attending 3 new-starter Fraud Awareness sessions in April, May and June.

Fraud awareness is also signposted in the induction toolkit presented to new staff at the "Welcome Session" which is delivered virtually.

## 4. Referrals/Enquiries/Investigations

During this quarter the NWSSP LCFM received three new referrals for investigation and two cases were closed. A summary of the investigation caseload is as follows:

| | Caseload | Q1 (2026/27) |
|---|---|---|
| **A** | Cases brought forward | 3 |
| **B** | **Add** number of new cases opened | 3 |
| **C** | **Total** caseload during Q1 (A+B) | 6 |
| **D** | **Less** cases closed or transferred during Q1 | 2 |

| | | | |
|---|---|---|---|
| **E** | Cases open at end of Q1 (C-D) | **4** | |
| | **Fraud Prevented or Recovered** | **Q1 (2026/27) £** | **Year Total 2025/2026 for comparison £** |
| | Financial Recoveries | **0** | **£1,200** |
| | Total Prevented / Recovered | **0** | **£11,474.88** |
| | Number of sanctions | **0** | **3** |

## 5. Local Proactive Exercises

As part of the Government Functional Standards, LCFS are required to conduct Local Proactive Exercises (LPEs) and fraud risk assessments and record them on the CLUE case management system. LPEs should be conducted using a local risk-based approach, can be directed by NHS CFA, or pursued as a result of an action point, e.g. from an investigation, a Fraud Prevention Notice (FPN) or a wider nationally driven exercise.

The NWSSP LCFM also assists and advises other NWSSP/NHS staff, LCFS colleagues and NHS CFS Wales with queries on fraud-related matters. Data is now requested by NHS CFS Wales on the volume of queries and advice received in relation to fraud matters; as such, a record is logged and maintained of queries and assistance provided on such matters.

The NWSSP LCFM received 23 queries during Q1 on a wide range of topics, including several mandate fraud checks, National Fraud Initiative (NFI) checks, recovery of salary overpayments, systems queries, and support on investigations and fraud referrals.

The LCFM meets regularly with the CFS Wales Team and lead LCFS colleagues at the Counter Fraud Liaison Group.

The LCFM also continues to liaise with the Cyber Security Team on cyber threats, such as phishing and spam email concerns, and more recently on fraud risks arising from the use of artificial intelligence.

## 6. Fraud Prevention Notices (FPNs) and IBURNs (Intelligence Bulletins)

No FPNs or IBURNs were issued by NHS CFA during Q1 2026/2027.

## 7. Other

The LCFM continues to work with the Assistant Director of Corporate Services to develop and enhance recording of fraud risks and fraud risk assessments at NWSSP.

**National Fraud Initiative**

Payroll data has been uploaded; analysis has commenced and is ongoing. Some anomalies have been detected and are being examined further with relevant staff at other health bodies. Matches are considered on a risk basis. The majority of payroll-to-payroll matches relate to NWSSP Single Lead Employer doctors who may have changed employers or may work additional shifts or bank shifts at other health boards. This is permissible and quite commonplace, with all such cases being closed with no issues so far. A significant volume was checked during Q1 and many were closed with no further action, with responses awaited on others.

The summary can be seen as follows;

**Report 68.1 Payroll to Payroll phone number**

Only one match was identified, which was closed as no risk was identified and the issue related to a recording error.

**Report 78 Payroll to Pensions**

All 26 matches were closed with no issues, as the majority of matches related to staff who had retired and returned.

**Payroll to Payroll Report**

Out of 364 matches:

- 321 matches have now been closed with no issues found;
- 32 have been opened and are awaiting a response and/or further checks or investigation; and
- 11 not yet opened.

**A total of 348 out of 391 matches have been closed.**

The LCFM also attended a webinar on 24 March 2026 on the NFI feature “App Check”, which is a real-time, secure, web-based tool designed to help public sector organisations prevent fraud at the application stage. It has mainly been used by local government to validate applicants, such as for housing and employment. Access will be arranged by Audit Wales and the Cabinet Office during Q1 2026/2027. NWSSP LCFS and LCFS colleagues, along with CFS Wales, are due to meet further with Audit Wales and the Cabinet Office to discuss this in more depth and consider the use of App Check in NHS Wales.

Mark Weston, NWSSP Local Counter Fraud Manager 30 June 2026

# NWSSP Grip & Control Review June 2026

*Delivering Value, Innovation and Excellence through Partnership*

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Shared Services Partnership

# Grip & Control - Introduction

NHS Planning & Improvement have developed a Grip & Control Framework covering a range of areas with a specific focus on the financial impacts. This is to be used by all Welsh NHS bodies to review the control environment within each organisation.

This has been developed as a result of the increasing cost pressures across the wider NHS to demonstrate that the financial governance and financial control environment mechanisms are robust, and sufficient assurance is received on their effectiveness.

NWSSP has previously undertaken similar exercises in 2022 & 2024 to review our grip and control processes.

# Grip & Control - Overview

NHS Planning & Performance Template with a focus on financial control on a number of areas including:

1. Framework & Guidance
2. Establishment & Vacancies
3. Sickness & Leave Management
4. Rostering, Rotas & Job Planning
5. Temporary Staffing
6. Other Staff Payments
7. Procurement
8. Other items including VAT, Income, Stock etc

# Grip & Control – Process of review

During May and June, discussions took place with Finance, Workforce, TMO, Estates, Supply Chain and Procurement leads across NWSSP to review the current Grip & Control Framework against the key assessment areas.

Professional leads had time to consider the template and provide responses in a number of areas including:

- Controls / Processes currently in place.
- Assurance that these processes are operational.

These responses were reviewed and recommendations were developed and RAG rated for importance and impact.

The following slides highlight key areas of current process as well as RAG rated recommendations.

# Grip & Control – Summary of outcomes

| Area of review | Green Actions | Amber Actions | Red Actions |
|---|---|---|---|
| Framework & Guidance | - | 9 | 2 |
| Establishment & Vacancies | 2 | 4 | - |
| Sickness & Leave Management | - | 2 | - |
| Rostering, Rotas & Job Planning | 1 | - | - |
| Temporary Staffing | - | - | - |
| Other Staff Payments | 1 | 1 | - |
| Procurement | 2 | 6 | - |
| Other items including VAT, Income & Stock etc | 4 | 3 | 3 |
| **Total Actions** | **10** | **25** | **5** |

Although there are a number of actions across a range of areas, none of these have a critical impact to NWSSP's Financial Control Framework.

As a self assessment against the framework, **reasonable assurance** should be taken.
A move to substantial assurance can be taken once the red and Amber actions are implemented.

# 1. Framework & Guidance

- Clear and Up to Date Standing Financial Instructions and guidance.
- Clear procedures & process notes.
- Budget holders and all financial administrators have received up to date training on their roles & responsibilities.
- Delegation letters issued and signed.

**Controls / Assurance / Improvements**

- SFIs & FCPs are up to date pending creation of FCP3 – Capital Management.
  - Further develop Finance SharePoint Page with links to SFIs, FCPs, approval limits etc.
  - Development of FCP3 – Capital Programmes.
  - Develop formal induction plan and pack for new Finance Staff which includes link to SharePoint Site.
- Budget Holder Training has been delivered to budget holders including Qliksense budget holder dashboard.
  - Develop central training record for all Finance Staff & Budget Holders.
  - Ensure quarterly budget holder training sessions are diarised for new starters/refresh training.
- Budget Delegation letters have been sent to budget holders and returned for the 2026/27 financial year.
  - Update future years letters to include links to SFIs / FCPs via the updated SharePoint page.
  - Include explicit cost reduction expectations in future letters.
  - Central repository of all signed budget holder letters to be created including a record showing receipt of these letters.

# 1. Framework & Guidance (2)

- Clear governance process for new investment.
- Internal Escalation process in place.

**Controls / Assurance / Improvements**

- There is a clear process for the management of business cases with standard templates and support through the TMO.
- Potential for Business cases to be developed locally within Services using TMO templates and good practice without full TMO support.
  - Utilise existing Business Partner networks into divisional SLGs to enforce and use Finance and TMO sessions to triangulate and coordinate the approach.
- There is a clear committee structure with regular communication in terms of timescales for submissions to them.
  - Consider mechanism for approval of revenue investment bids prior to SLG.
- Any initiatives delivered by the TMO include a project closure review within six months of closure. Projects not delivered by the TMO may not include a formal project closure review.
  - Consider how to review existing organisational activity to identify any areas of work which could be disinvested from.
- A Benefit and Value Realisation group is being established to compliment Capital Prioritisation Group.
  - Value and benefits need to be mapped to new and existing areas of activity with substantial work required in this area.
- TMO involvement ensures projects are managed within a framework.

# 2. Establishment & Vacancies

- Ensure robust budgeted establishments are in place and regularly reviewed and reconciled.
- Regular vacancy control panel (VCP).
- Automated weekly head count tracker.

## Controls / Assurance / Improvements

- The IMTP budget setting process is clear which includes links between Finance & POD, however these links need to be strengthened to develop a formal establishment control process and ensure budget setting matches the outcome of workforce planning.
- There is no agency spend.
- All divisions have fully implemented workforce plans with second stage, 2-year planning cycle now underway.
  - Further develop links between Finance and POD to develop a joint establishment control process.
  - Ensure all vacant posts are reviewed on a regular basis to ensure any that are vacant for an extended period are still required.
- An establishment control panel is in place which ensures all requests for vacancies and bank resource are reviewed on a weekly basis requiring finance approval before being considered.
  - Update VCP process to confirm that any posts not backfilled for more than 6 months will require explanation.
  - Consider the requirement to establish a process to review any posts vacant for 6 months or longer.

# 2. Establishment & Vacancies (2)

- Ensure managers notify HR of leaving dates.
- Review all current vacancies with a view to remove or freeze posts.
- Ensure processes are in place to reduce the risk of salary overpayments.

**Controls / Assurance / Improvements**

- There are a range of policies including in place including Annual Leave, Special Leave, Managing Attendance at Work etc. both All Wales and Velindre specific, which are all regularly reviewed and updated.
- People Business Partner support is available to managers and staff in relation to policies, procedures and associated training.
- An all-Wales policy is in place in relation to Managing Attendance at work.
  - Consider sign off levels from more senior staff, where appropriate for sick leave noting that there is an all-Wales policy in place.
- Policies are in place to ensure that leavers are appropriately managed to reduce the risk of salary overpayments.
  - Consider the potential to develop an internal app for one point of contact for managers for Starters, Leavers and Staff changes to notify POD, Finance, IT etc.

# 3. Sickness & Leave Management

- Enforce compliance with the All-Wales Sickness policy.
- Adherence to the requirements of agreed attendance at work policies and the all-Wales Occupational Health minimum service levels.
- Monitor absence and sickness on individual, service line, divisional and organisation level.
- Monitor medical annual leave.
- Policies to limit carry forward of significant leave balances.

**Controls / Assurance / Improvements**

- The POD Business partnering teams utilise monthly dashboards and Business Intelligence data to engage with managers for targeted support.
- SMTs have access to monthly reporting dashboards with key metrics reported at divisional SMT meetings and in Quarterly Performance Reviews.
- Staff compliance with policies is limited in assurance as it is dependent on managers undertaking a suitable local induction.
  - Review compliance levels across NWSSP to consider what actions are required to increase if necessary.
- A review of the carry over of annual leave policy is being undertaken.
  - Consider if the right to automatic rollover of annual leave remains appropriate.

# 4. Rostering, Rotas & Job Planning

- E-rostering fully deployed.
- Rosters approved 12 weeks in advance (as per the Agency workforce reduction programme and control framework).
- Contracted hours to be fully rostered.
- Job planning policy implemented with > 90% of all Consultants having an agreed job plan in place at all times; and alignment of rota to job capacity plans.

## Controls / Assurance / Improvements

- E-rostering is fully deployed to specific areas across NWSSP.
- Digital Workforce & Productivity Solutions (DWPS) sign off compliance with the 12-week roster sign-off deadlines.
- Monthly audits are undertaken and circulated to the relevant SMTs and flagged to SLG as necessary.
- NWSSP does not have nursing rotas.
- A new Medical Examiner contract was launched in 2025, where Medical Examiners work for more than one NHS employer, a lead employer will be designated and a single integrated job plan agreed.
- Job planning rates are captured by recording of annual appraisal via ESR.
- SLE rosters and job planning does not fall within the responsibility of NWSSP.
- No monitoring of details of job planning process currently takes place for Medical Examiners (13.4 WTE) or Primary Care Medical Advisors (1.75 WTE).
  - Consider the need to monitor job planning for MEs / PCMAs.

# 5. Temporary Staffing

- Temporary Staffing Policy in place.
- Clear process for booking, and compliance with process.
- Review bank and agency authorisation levels – seniority and consistency across sites.
- No off-contract agency & locum.
- Auto enrolment for new starters onto the bank.
- Review pay rates and consider weekly pay for bank as an incentive.
- Ensure appropriate deduction for agency staff breaks.

**Controls / Assurance / Improvements**

- The establishment control panel is in place to review any requests for staffing regardless of engagement type.
- There is currently no use of agency staff across NWSSP.
- Significant control measures are in place in relation to bank usage.

# 6. Other Staff Payments

- Implement prior approval for overtime and enhanced payments.
- A monthly 'audit' of the highest overtime earners and expenses claimants.
- Non-clinical overtime controls in place.
- Enhanced authorisation process for Waiting List Incentives with clear demonstration that existing Programmed Activities (PAs) have been utilised before WLIs awarded.
- Review process in place for additional sessions allocated.

**Controls / Assurance / Improvements**

- The POD Business partnering team undertake focused review within specific services where appropriate.
  - Develop a report to show the top 10 highest overtime earners by division.
- There is an overtime app which required advance approval for any overtime to be undertaken.
- There is a clear policy which outlines what can and cannot be claimed through expenses. The expense system is set up to flag any expenses not within this policy requiring claimants and managers to provide justification for payment of any expenses outside the policy.
  - Develop monthly report showing 10 highest expense claimants by division.
  - Consider the need for a report on any expenses paid outside of the expenses policy.
- There are no Waiting List Initiatives in NWSSP.

# 7. Procurement

- Monitor use of Single Tender Waivers.
- Consolidate a list of supplier discounts.
- Robust contract management processes in place.

**Controls / Assurance / Improvements**

- SFIs detail roles and responsibilities of budget holders, divisions, and Procurement Services within the procurement process.
- Only contracts awarded following a formal request for approval (RFA) in line with SFIs are awarded.
  - Consider how to communicate to and influence divisions within NWSSP to move to the All-Wales standardised catalogue.
  - Undertake analysis of late payment penalties by division and supplier to review if any additional measures need to be taken to reduce these payments.
  - Ensure all contracts are captured in the NWSSP contract register.
- SQA/STA only endorsed by Procurement Services where it is demonstrated only the one supplier can deliver the requirement in line with the SFIs.
- Early payment managed through the Priority Supplier Programme.

# 7. Procurement (2)

- Enforce the ‘No PO No Pay’ policy.
- Review and reduce those able to requisition and order.
- Ensure the number and use of purchasing cards is right-fitted.
- Targeted approach for clinical preference variation (as identified by V&S procurement group).

**Controls / Assurance / Improvements**

- NWSSP fully aligned to the AW NPNP Policy.
  - Regularly review categories of spend to see if any holds on specific types of expenditure are required.
- Retrospective POs are reported as breaches to Audit Committee.
  - Consider more action against the use of retrospective POs.
- Purchase orders are receipted when goods or services are received. This accounts for the expenditure at this point via an accrual which remains until an invoice is matched to the PO and paid.
  - An annual review of all open purchase orders to be undertaken in order to ensure any that are not required can be closed.
- Invoices that fail three-way match are not rejected and returned, they are placed on hold until they pass matching or are released.
  - Continue to report on invoice numbers and values which remain on hold.
  - Develop an action plan for NWSSP to reduce the number of invoices on hold.
- There are currently a number of Purchasing Cards in use across NWSSP (19). Mostly issued to PAs & Administrators.
  - Undertake review of all purchasing card holders and limits to ensure limits are right fitted.
- Employment services have created an automated approval process for purchase card expenditure.
  - Review automation within employment services to see if this approach can be used for all purchasing cards.

# 8. Other Items

- Review and ensure all eligible VAT is being reclaimed.
- Income management policies to minimise bad debt costs.

**Controls / Assurance / Improvements**

- Process to review VAT is recorded and expenditure is reviewed on a quarterly basis by external VAT experts to ensure maximum appropriate reclaims.
  - Formalise process in standard SOP with VUNHST.
  - Review training for all NWSSP Finance Staff to ensure everyone is clear on responsibilities.
- There is a bad debt process in place lead by VUNHST, however salary overpayments are managed by NWSSP.
- Outstanding NHS Debt over 10 weeks is reported within the MMR and all debtors are included in budget holder Qliksense dashboards.
- There is a process for salary overpayments with write offs low at £10,754 over the past three years however these are not formalised.
  - Develop formal SOP for write offs and debt management with VUNHST.
- There is a clear stock rotation process to ensure wastage is minimalised with current documentation and procedures being reviewed.
  - Complete review of current documentation and procedures.

# 8. Other Items (2)

- Stock management policies to minimise wastage.
- Management of Estates

## Controls / Assurance / Improvements

- Stock levels are regularly reviewed and reported to Inventory Operational Manager Groups including reviews of slow-moving stock. Any write off's go through Velindre Board and audit committee.
- Annual review of NWSSP estates which include identification of energy usage and overall running costs.
- Condition appraisal undertaken in March 2026 along with the development of a database of all estate assets.
- Regular H&S Audits undertaken to ensure compliance with H&S requirements.
- Estate rationalisation undertaken resulting in reduction of estate requirement such as Companies House reduced from 1.5 floors to 0.5 floors as well as the reassignment of Samlet Road to WAST moving HCS to Matrix House.
    - Continue to review usage of desk space at Companies House, Nantgarw HQ & Alder house to see if further efficiencies can be obtained.
- Capital Prioritisation Group is in place to ensure appropriate governance for capital funding requests.

# 8. Other Items (3)

- Review all credit balances on the Balance sheet for potential over accrual.
- Journals are based on latest relevant data and assumptions.

## Controls / Assurance / Improvements

- An annual exercise is undertaken in October to validate fixed assets which are recorded in the RAM fixed asset register managed by Velindre.
- The Capital Prioritisation Group has been setup to review any new requests for capital funding.
  - Review CPG's ToR to ensure it captures appropriate Value for Money and Benefits considerations.
  - Ensure that capital programmes capture current metrics to be able to evidence VfM and Benefits once implemented.
- Monthly balance sheet reconciliations are undertaken; however, these are not regularly reviewed by senior finance team members for accuracy and completeness.
  - Setup clear Standard Operating Procedures for balance sheet entries and monthly reviews.
  - Setup and deliver training to all finance staff on a standard process to review balance sheet entries.
  - Ensure balance sheet entries are at a level and age that is appropriate.

# Summary Action Plan

| Lead | Action | Target Date |
|---|---|---|
| Head of Finance Business Partnering / Head of Financial Resources, Systems and Planning | Develop SharePoint site for SFIs, FCPs & Approval Limits.<br>Update budget holder letters to include links to SharePoint site, details of cost reduction expectations and a central repository of all letters.<br>Develop formal induction plan and pack for new Finance Staff.<br>Undertake analysis of late payment penalties by directorate and supplier to review if any additional measures need to be taken to reduce these payments.<br>An annual review of all open purchase orders to be undertaken in order to ensure any that are not required can be closed.<br>Undertake review of all purchasing card holders and limits to ensure limits are right fitted.<br>Review automation within employment services to see if this approach about be used for all purchasing cards.<br>Develop formal SOP for write offs and debt management with VUNHST.<br>Setup clear Standard Operating Procedures for balance sheet entries and monthly reviews.<br>Setup and deliver training to all finance staff on a standard process to review balance sheet entries.<br>Ensure balance sheet entries are at a level and age that is appropriate. | End of Q2 26/27<br>End of Q3 26/27<br>End of Q2 26/27<br>End of Q2 26/27<br>End of Q3 26/27<br>End of Q4 26/27<br>End of Q4 26/27<br>End of Q3 26/27<br>End of Q2 26/27<br>End of Q2 26/27<br>End of Q2 26/27 |
| Assistant Director of Transformation Management Office | Consider mechanism for approval of revenue investment bids prior to SLG.<br>Consider how to review existing organisational activity to identify areas of which could be disinvested from.<br>Value and benefits need to be mapped to new and existing areas of activity.<br>Consider the need for an NWSSP app for one point of contact for any Starters, Leavers and changes to notify POD, Finance, IT etc.<br>Review CPG's ToR to ensure it captures appropriate Value for Money and Benefits considerations.<br>Ensure that capital programmes capture current metrics to be able to evidence VfM and Benefits once implemented. | End of Q3 26/27<br>End of Q3 26/27<br>End of Q2 26/27<br>End of Q4 26/27<br>End of Q3 26/27 |

# Summary Action Plan (2)

| Lead | Action | Target Date |
|---|---|---|
| Deputy Director of People & OD | Ensure all vacant posts are reviewed on a regular basis to assess any that have been held for an extended period of time can be disestablished.<br>Review compliance levels of sickness management across NWSSP to consider what actions are necessary.<br>Consider if the right to automatic rollover of annual leave remains appropriate.<br>Consider the need to monitor job planning for MEs / PCMA's. | End of Q3 26/27<br><br>End of Q3 26/27<br><br>End of Q4 26/27 |
| Deputy Director of Procurement | Consider how to communicate to and influence directorate within NWSSP to move to the All-Wales standardised catalogue.<br>Regularly review categories of spend to see if any holds on specific types of expenditure are required.<br>Consider more action against the use of retrospective POs.<br>Complete review of current documentation and procedures in relation to stock rotation. | End of Q3 26/27<br><br>Ongoing<br>End of Q2 26/27<br>End of Q2 26/27 |
| Head of Accounts Payable & E-enablement | Continue to report on invoice numbers and values which remain on hold. | Ongoing |
| Head of Resources Capital | Formalise process in standard SOP with VUNHST in relation to VAT.<br>Review training for all NWSSP Finance Staff in relation to VAT to ensure everyone is clear on responsibilities. | End of Q3 26/27<br>End of Q3 26/27 |

# Summary Action Plan (3)

| Lead | Action | Target Date |
|---|---|---|
| Head of Estates | Continue to review usage of desk space at Companies House, Nantgarw HQ & Alder house to see if further efficiencies can be obtained. | Ongoing |
| Deputy Director of Finance & Corporate Services | Develop FCP3 – Capital Programmes. | End of Q2 26/27 |

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# Financial Grip and Control measures across NHS Wales

### Financial Planning and Delivery Directorate

**Objective:**

To provide organisations with a consolidated schedule setting out the core financial, workforce and procurement grip and control measures to safeguard financial stability during periods of significant financial pressure.

**Background:**

At M09 2025/26 six health boards in Wales report deficits totalling £206m, (1.9% of the reported Revenue Resource Limit).

Given the scale of the pressure, it is essential that the NHS Wales Finance Function can demonstrate that the financial governance and financial control environment mechanisms are robust and sufficient assurance is received on their effectiveness.

**Scope:**

The tool is designed to help organisations assess their financial grip and control. It is not an exhaustive list but is predicated on common themes and areas of risk identified through NHS Wales.

The key focus for the grip and control schedule is the practical controls, processes and actions that should be in place in year to avoid excessive or inappropriately approved financial commitments; reduce waste; and improve in year expenditure run-rates. The tool will help organisations to strengthen the underpinning financial governance and control measures that support improved financial performance.

As a first step, the focus has been placed on core financial, workforce and procurement processes and systems. There is more limited literature available on best practice grip and control within specific expenditure areas such as commissioning, CHC and prescribing systems and processes.

**Preparation approach:**

The schedule has been prepared by Financial Planning and Delivery by examining and consolidating examples from various sources including:-

- Grip and Control presentation report (Financial Planning and Delivery May 2022)
- Financial Grip and Control Checklist (NHS England December 2022)
- Establishment Control (HFMA May 2025)
- Budgetary Framework and Grip and Control Discussions (Directors of Finance Forum July 2024)

**Structure of the document:**

The schedule includes both **financial controls (in black)** that organisations should have in place and **grip actions (in blue)** that will support the reduction of expenditure run rates.

The financial grip and control measures are categorised across eight themes:- Framework and Guidance, Vacancies, Sickness and Leave, Rostering and Rotas, Bank and Agency, Other Staff Payments, Procurement and Other items.

The document includes both a summary schedule and a detailed schedule. The summary schedule identifies key thematics and the highest impact actions from the detailed schedule.

**Other financial governance reference documents:**

The checklist may be used in conjunction with:

- HFMA's "Improving NHS financial sustainability: are you getting the basics right?" checklist tool Improving NHS financial sustainability: are you getting the basics right? (hfma.org.uk) – focus on key overarching financial processes such as planning, budget setting, reporting, financial governance, training and development
- Financial Management Maturity Model (NAO January 2010)
- Model Standing Orders, Reservation and Delegation of Powers and Model Standing Financial Instructions – NHS Wales (issued by Welsh Government)
- The Finance Academy's 'Financial Control Procedures Governance Best Practice Principles Guide' - available on the learning and development platform

All are valuable tools to support organisations to consider if they have the controls and processes in place to achieve best value for money.

**Completion and next steps: -**

Complete the checklist to consider whether the relevant policy or process exists and secondly to consider operational delivery and compliance. This may require input from representatives from several areas; workforce, procurement, efficiency, finance and audit.

Agree priority issues and how proposed actions to address the issues identified will be taken forward. This may require assembling a working group including representatives from workforce, procurement, efficiency, finance.

Key findings from the exercise to be shared through the Director of Finance forum to identify any national areas of focus.

| 1. Framework and Guidance | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG Status |
|---|---|---|---|---|
| **Clear and Up to Date Standing Financial Instructions**<br>• SFIs are up to date and readily accessible to all relevant officers. | Evidence of SFIs & FCPs for NWSSP & VUNHST | NWSSP FCPs<br>Velindre FCPs<br>Velindre SFIs | Develop the NWSSP Finance SharePoint site further to include NWSSP and VUNHST SFIs and FCPs. | |
| Clear Process Notes<br>• All Financial Control Procedures are up to date, accessible and minimum provision aligns with the Finance Academy best practice guide. (e.g. month end close down processes, financial reforecasts).<br>• All Financial Control Procedures are widely available to all relevant team members.<br>• Adequate training is provided to all relevant staff members to ensure awareness and understanding of relevant financial control procedures. | Lack of clear links to SFIs and FCPs for NWSSP & VUNHST.<br><br>FCP 3 – Capital Programmes needs to be developed.<br><br>Training has been delivered to budget holders and finance staff; however, clear records are not currently maintained to confirm who has received training. | SFIs and FCPs are accessible; however, a single access point is required to provide the finance team and budget holders with easier access. | Develop FCP 3 – Capital Programmes.<br><br>Develop central training record for all Finance Staff & Budget Holders.<br><br>Ensure quarterly budget holder training sessions are diarised for new starters/refresh training. | |
| **Roles and Responsibilities**<br>• Roles and responsibilities of budget holders clearly defined and clearly communicated, including responsibilities with respect to core budgets, cost reduction element of their budgets and procurement.<br>• Delegation letters have been issued and have been signed.<br>• All budget holders have objectives supporting the delivery of financial objectives in Performance appraisal process.<br>• Budget holders receive training on their roles responsibilities and objectives at reasonable intervals and monitoring of this can be demonstrated. | Budget holders have annual budget holder letters which reference the Financial Control Procedures, specifically the budgetary control procedure which outlines their responsibilities.<br><br>These include recurrent budgets which include any cost improvement target but don't specifically reference cost reduction elements. | Budget holder letter templates are saved centrally, however there is currently no central record of when signed letters have been returned.<br><br>Evidence of budget holder training slides including Qliksense budget holder dashboard.<br><br>Specific financial slides are within the Quarterly | Update future years letters to include links to SFIs / FCPs and or updated SharePoint page.<br><br>Include explicit cost reduction expectations in future letters.<br><br>Establish a central repository for all signed budget holder letters, including a record showing receipt. | |

| 1. Framework and Guidance | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG Status |
|---|---|---|---|---|
| • Consider whether the number of budget holders is appropriate - reduced budget holders can improve control over expenditure. | | performance review slide templates to be discussed on a quarterly basis. | | |
| **Investments and Business Cases**<br>• Clear Business Case review procedures for reviewing and approving any new projects across the organisation.<br>• The above includes a relevant committee structure where robust review and challenge takes place.<br>• Post implementation benefit realisation reviews process in place.<br>• Establish list of ongoing and planned projects and determine what can be ceased or delayed. | There is a clear process for managing business cases, with standard templates and support provided through the TMO.<br><br>The structure for reviews and approvals for capital business cases is clear depending on the value, however there is no formal group to review revenue investment bids.<br><br>Establishment of a Benefits & Value Realisation Group is underway. | TMO maintains a Teams list of business cases, with allocated Finance and TMO support.<br><br>Finance staff have access to Verto system which manages projects.<br><br>TMO and Finance have regular meetings to discuss existing and future business cases. | Use existing Business Partner networks with divisional SMTs to reinforce the approach and use Finance and TMO sessions to triangulate and coordinate activity.<br><br>Consider mechanism for approval of revenue investment bids prior to SLG.<br><br>Consider how to review existing organisational activity to identify any areas of work which could be disinvested from. | |
| • Review previous 12 months of business cases to ensure savings/benefits realisation | | | Map value and benefits to new and existing areas of activity, recognising that substantial work is required in this area. | |
| **Internal Escalation**<br>• Clear internal escalation processes in place for service areas that are not delivering their financial plans with appropriate financial or non-financial controls or remedial actions applied. | There are quarterly review meetings which are chaired by the Planning & Performance team to capture performance in a range of areas including financial position. | Evidence of the completion of quarterly performance reviews for Q4 2025/26 which include standard templates. | Continue quarterly performance meetings as planned.<br><br>Review the timing of all divisional QPRs to consider increasing or decreasing their regularity. | |

| 2. People Costs – Establishment and Vacancies | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG Status |
|---|---|---|---|---|
| **Policy and Procedure**<br>• Criteria in place for annual and other leave (e.g. study and parental leave) to be notified to the organisation and signed off (where applicable) with sufficient notice to minimise impact on rotas.<br>• Processes in place to ensure compliance with the All Wales Sickness policy - Rigorous sickness policy and procedure is in place and communicated to minimise absences (inc. return to work meeting).<br>• Consider increasing sign off levels for sick leave to ensure transparency. | **AL Policy (Velindre)**<br>**Study Leave Procedure (NWSSP)**<br>**Shared Parental Leave Policy (Velindre)**<br>Special Leave Policy (All Wales)<br>**MAAW Policy (All Wales)**<br>**Documents including RTW**<br>**In-House Training - MAAW Policies into Practice**<br><br>Aligned to the MAAW Policy. | Business Partnering support is available to managers in relation to policies, procedures, and associated training.<br><br>Communications are disseminated through the newsletter to ensure timely updates on any changes to policies. There is a continued focus on enhancing employees' ability to access support from the POD team in relation to policies and procedures.<br><br>Sign-off levels for sickness absence are aligned to the MAAW Policy, which is an All Wales Policy. It may therefore be difficult to operate outside the scope of this policy. | Consider sign-off levels for sick leave, noting that an All Wales Policy is in place in this area. | |

| 2. People Costs – Establishment and Vacancies | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG Status |
|---|---|---|---|---|
| **Establishment (Establishment control \| HFMA)**<br>• Workforce plans are in place, are of a sufficiently granular level of detail (for example, by service, workforce type and substantive/ temporary); and align to approved establishment levels and budget.<br>• Workforce plans are regularly reviewed by service and divisional leads to ensure compliance with or action to move to compliance against both establishment and budget.<br>• Reconciliation process in place to ensure that WTEs per financial and HR systems reconcile. | **Workforce Planning NWSSP)** (WFPN)<br>• 2-year review completed & signed off at Jan 26 SLG<br>• SLG review - July 26<br><br>Workforce Planning – SLG papers and Aligned with QR in 26/27 IMTP cycles<br><br>**Reconciliation process**<br>Out of P&OD control at present.<br><br>DWPS<br>**Rostering Monthly Finance Meetings in place.**<br><br>**Rostering Efficiency Audit in place –**<br>Monitoring included in these | **WFPN -** Reasonable Assurance<br>All divisions now have fully implemented workforce plans, with second stage, 2-year planning cycle now underway across 2026 – 2028 with implementation timeline in place.<br><br>All divisions now have fully implemented workforce plans, with second stage, 2-year planning cycle now underway across 2026 – 2028 with implementation timeline in place. Scrutiny undertaken at Divisional Quarterly Reviews and SLG.<br><br>Reconciliation<br>Rostering monthly finance meetings and efficiency audits analyse overtime and bank costs by reviewing relevant periods alongside site rosters and comparing them to actual staffing patterns. This helps identify opportunities to optimise scheduling and reduce unnecessary staffing expenses.<br>Further input from Finance is required. P&OD has completed the necessary work, but further discussion and agreement with the finance team is required to align with new FWS requirements. | Further develop links between Finance and POD to develop a joint establishment control process.<br><br>Include regular reviews of vacant posts and close working during IMTP budget setting to ensure pay budgets align with workforce plan outcomes. | |

| 2. People Costs – Establishment and Vacancies | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG Status |
|---|---|---|---|---|
| **Vacancy Review (Establishment control \| HFMA)**<br>• Establish a regular vacancy control panel (VCP) or equivalent to check and challenge recruitment to ensure all vacancies remain within authorised budgetary limits.<br>• Ensure the VCP terms of reference enable flexibility to avoid operationally delaying opportunities for savings and considering clinical need.<br>• Implement an automated weekly head count tracker (temporary and substantive).<br>• Assess the recruitment process and remove blockers/ bottle necks that may lead to higher agency & locum costs.<br>• Review all current vacancies with a view to remove or freeze posts.<br>• Focus on long term/ 6-month vacant posts – can these be removed or re-engineered?<br>• Review the establishment to remove partial posts not required and identify unfunded posts.<br>• Implement non-clinical recruitment freeze unless it can be evidenced that role is business critical or key for financial/ quality and safety improvement. | **NWSSP Resourcing Framework**<br><br>**NWSSP Resourcing Control Framework**<br><br>**NWSSP Agency Reduction Plan - Q2 2024 Submission.docx**<br><br>**NWSSP Agency Reduction Plan.docx**<br><br>**Establishment control/Reconciliation work in progress with Finance and DWPS** | **Vacancy Review**<br>**Substantial Assurance**<br>**Audit of P&OD** recruitment measures took place in April - May 2026 with notes to confirm "Audit concluded substantial assurance with no findings."<br><br>Establishment control/Reconciliation<br>Linked to narrative above – establishment control and reporting elements not met and require action for 26/27.<br><br>DWPS<br>Rostering Budget Alignment: Roster schedules are being aligned with budgets across all service areas. So far, 31 services have completed this alignment. This process is helping to identify where unavailability and relief percentages are not being allocated appropriately.<br><br>Monitoring is included in the Rostering Efficiency Audit.<br><br>Further input from Finance is required. P&OD has completed the necessary work, but further discussion and agreement with the finance team is required to align with new FWS requirements. | Continue work on establishment controls to completion as establishment control is key to ensuring a clear approved establishment of posts across the organisation.<br><br>Establish a formal process to review any posts vacant for 6 months or longer. | |

| 2. People Costs – Establishment and Vacancies | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG Status |
|---|---|---|---|---|
| **Leavers**<br>• Processes in place to ensure line managers notify HR of leaving dates and any other pay-impacting staff changes in a timely manner to reduce risk of overpayments. | Managers complete an SMA or use ESR Self Service to terminate employment or make payroll-impacting changes. P&OD is not involved in this process.<br><br>**Managers Guide to Leavers Process**<br><br>**Staff Movement App**<br><br>DWPS<br>**Weekly audits** undertaken. | **Leavers / Pay Impacting Changes**<br>POD is unable to provide assurance, as this process is not owned by POD. Policies are available to support and signpost managers. Payroll flags overpayments through the overpayments dashboard. Each division should review overpayment reasons through internal SMTs and/or quarterly performance reviews.<br><br>DWPS<br>Weekly audits include monitoring whether termination dates in ESR align with annual leave balances. | Consider the development of a NWSSP Leavers, Joiners, Changes app for single point of contact to include notifications to POD, Finance, IT etc in line with HEIW's internal app.<br><br>Consider each division reviewing overpayments reasons at their internal SMTs and/or their quarterly performance reviews. | |
| **Workforce management monitoring (Establishment control \| HFMA)**<br>• Process in place to review levels of poorly performing staff and consider options for more rapid improvement and/ or staff exit.<br>• Periodical review of actual temporary staff rates against rates charged to identify and address issues (specific and themes). | The All-Wales Improving Performance at Work Policy is available on the intranet to all managers.<br><br>All Wales Improving Performance at Work Policy FINAL | Reasonable assurance – The Business Partnering team is available to support managers with the application of policies and processes, as well as the provision of training. However, this remains dependent on managers actively undertaking and effectively managing these scenarios.<br><br>Temporary staff are charged against the band applied. This process is scrutinised by the Vacancy Control Panel. | None identified. | |

| 3. People Costs – Sickness and Leave Management | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG Status |
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| **Monitoring and Reporting**<br>• Monitor adherence to the requirements of agreed attendance at work policies and the all-Wales Occupational Health minimum service levels.<br>• Monitor absence and sickness on individual, service line, divisional and organisation level.<br>• Sickness is regularly reviewed at the board level, and problem areas identified and examined.<br>• There is a set % target for staff off sick at any time and performance is measured against this target.<br>• There is a set % target for staff on leave at any time and performance is measured against this target.<br>• Monitor staff compliance with core organisational HR policies (e.g. annual leave requests, sickness absence) and ensure outliers are identified and addressed through appropriate routes.<br>• Monitor medical annual leave.<br>• Limits to the amount of annual leave, training and other influenceable absences that can be taken at any time.<br>• Global policies for the management of leave to prevent excessive use of annual leave at the end of the year or carry forward of significant balances. | The Business Partnering team utilises information from monthly dashboards and Business Intelligence data to perform analysis and engage with managers to provide targeted support. The team also delivers a range of training, including corporate programmes and ad hoc sessions. Sickness absence data and trends are reported monthly to Senior Management Teams and through quarterly review processes.<br><br>Reporting – Monthly reporting dashboard set up for Senior Management Teams to access in NWSSP<br>NWSSP Monthly Reporting - Power BI<br>2026 updated targets – SLG paper<br>Sickness Absence Targets<br><br>Staff understanding of policy – signposted at Induction and compliance rates are flagged at SLG by division.<br><br>P&D Carry Over paper due for SLG review in July 2026 | Reasonable assurance – The Business Partnering team is undertaking targeted sickness absence deep-dive analyses within identified hotspot areas to ensure cases are being managed in line with policy. This approach also supports the identification of any additional interventions or support requirements.<br><br>Sickness Target – Substantial<br>Full review of NWSSP absence targets undertaken in Jan 2026, approved by SLG and implemented for new financial year April 2026.<br><br>Staff compliance with policy is limited assurance. Overarching signposting at Induction is then dependent on managers undertaking a suitable local induction and contact from managers when they are uncertain about the use of organisational policies.<br><br>% Limits<br>Limited assurance as divisions implement their own approach due to operational requirements.<br><br>Annual Leave Carry Over 26-27<br>If agreed, this proposes removing mandatory carry over and implements a new annual leave policy to include % limits of leave aligned to other orgs in Wales. | Review compliance levels with policy and consider what is required to increase compliance in these areas.<br><br>Consider whether the automatic rollover of annual leave remains appropriate. | |

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| 4. Rostering, Rotas and Job Planning | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG Status |
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| **General rostering and rotas**<br>• E-rostering is fully deployed<br>• Rosters are approved 12 weeks in advance (as per the Agency workforce reduction programme and control framework), and minimal changes to rosters once approved, for all staff grades.<br>• Processes to ensure contracted hours are fully rostered.<br>• Clear timeline for submission of rotas. | DWPS<br>**Roster Sign-Off Compliance**:<br>eRostering<br>NWSSP Health Roster Policy v18 Approved.docx<br>Reporting below by P&OD:-<br>12 weeks rota – SLG Report January 2026<br>12 week rotas SMT report – May 2026 | This process is not owned by People and OD.<br>DWPS roster sign-off compliance depends on engagement with services to meet the 12-week roster sign-off deadline. Monthly audits are undertaken, circulated to relevant SMTs and flagged at SLG where necessary.<br>Monitoring is included in the **Rostering Efficiency Audit**. | None identified. | |

| 4. Rostering, Rotas and Job Planning | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG Status |
|---|---|---|---|---|
| **Robust Nursing Rota Management**<br>• Staff levels are matched to patient demand patterns to avoid waits and avoidable admissions.<br>• Weekly monitoring for shift requests vs. shift fill rate and any associated care and safety issues.<br>• Review staffing levels against patient ratios vs current guidelines (inc. safer staffing tools) and provide constructive challenge to clinical leads on achieving efficiency while maintaining quality.<br>• Review specialing policy, approvals, and tracking process to ensure standardised approach linked to patient need/acuity.<br>• Review nursing agency & locum use before, during and after school holiday periods (tests the strength of rota planning).<br>• Review options for:<br>  ○ reduced handover periods;<br>  ○ back-to the ward for nursing management staff for a number of shifts per week; and<br>  ○ specialist nurses to provide a number of clinical shifts on wards to reduce agency & locum bill, cover vacancies, and improve staff rotation. | N/A | N/A | N/A | N/A |

| 4. Rostering, Rotas and Job Planning | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG Status |
|---|---|---|---|---|
| **Robust Medical Job Planning Management**<br>• Job planning policy implemented with > 90% of all Consultants having an agreed job plan in place at all times.<br>• Process in place to ensure alignment of rota to job plans.<br>• Monitoring in place to support Medical Director leadership track medical productivity for example:-<br>  ○ job plan delivery (individual and then team job plans);<br>  ○ PAs over 12;<br>  ○ % Direct Clinical Care; and<br>  ○ theatre/clinic throughput.<br>• Review consultant job planning compliance (assess current level of rollout) to identify opportunities for greater productivity (review of low and high Professional Activity "PA" staff).<br>• Improve transparency of medical workforce holiday planning to core planning teams, linking to theatre and clinic planning.<br>• Review on-call run rate for utilisation trends. | A new Medical Examiner contract was launched in 2025 this was developed in partnership with the BMA and agreed by NHS Employers.<br><br>Where Medical Examiners work for more than one NHS employer, a lead employer will be designated and an integrated single job plan agreed. Typically, this will be the substantive employer. Where NWSSP is the lead employer job planning will be completed with the Lead Medical Examiner for Wales and will relate to the Medical Examiner role only.<br><br>Primary Care Medical Advisors are issued with a consultant contract which refers to job planning being required. | Job planning compliance rates are captured by recording of annual appraisal via ESR.<br><br>No monitoring of details of job planning process taking place for Medical Examiners or Primary Care Medical Advisors employed directly by NWSSP. | Consider the need to monitor job planning for MEs and Primary Care Medical Advisors. | |

| 4. Rostering, Rotas and Job Planning | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG Status |
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| **Other Clinical Staff**<br>• Review compliance with / introduce Clinical Nurse Specialist and Allied Health Professional job planning process to identify opportunities for greater productivity. | There is currently no requirement for job planning to take place in relation to pharmacy roles. In terms of opening of the new Radiopharmacy unit on 6th July 2026 there are rota arrangements in place for the two shift patterns required, allocation of staff will be based on completed training and competence level in the first instance and will be reviewed regularly.<br><br>There are discussions in relation to implementation of health roster to provide shift patterns to staff in a timely way and in line with Roster Policy. | This process is not owned by People and OD.<br><br>DWPS roster sign-off compliance depends on engagement with services to meet the 12-week roster sign-off deadline. Monthly audits are undertaken, circulated to relevant SMTs and flagged at SLG where necessary.<br><br>Monitoring is included in the Rostering Efficiency Audit. | None identified. | |

| 5. People Costs – Temporary staffing including Bank and Agency & Locum | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG status |
|---|---|---|---|---|
| **Policy, procedures, roles and responsibilities**<br>• An organisation wide temporary Staffing Policy in place and up to date.<br>• There is a clearly communicated process in place for bank / agency & locum booking.<br>• Monitoring controls in place to monitor compliance with the process for bank / agency & locum booking.<br>• Governance process exists to oversee temporary staffing with clear ToR (either at overall level or by key staffing group e.g. nursing, medical, corporate).<br>• Limit who can authorise bank and agency & locum staff to increase transparency; follow up on all short notice use.<br>• Review consistency of authorisation levels and approach across sites. | Vacancy / Establishment control<br><br>NWSSP Resource Bank & Agency<br><br>NWSSP Resourcing Framework<br><br>NWSSP Resourcing Control Framework<br><br>NWSSP Agency Reduction Plan - Q2 2024 Submission.docx<br><br>NWSSP Agency Reduction Plan.docx<br><br>The All Wales Terms of Reference are used. | Substantial assurance is supported by significant control measures, reduced temporary staffing and agency spend remaining at or close to £0 on a sustained basis.<br><br>All requests go through VCP regardless of what type of engagement/employment term is being requested. | None identified. | |

| 5. People Costs – Temporary staffing including Bank and Agency & Locum | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG status |
|---|---|---|---|---|
| **Bank utilisation**<br>• All relevant staff groups are auto enrolled on the bank.<br>• Review actual temporary staff rates against rates charged periodically to identify and address issues.<br>• Implemented and promoted a medical bank; and an Administration and Clerical bank.<br>• Promote bank staff as an alternative to agency & locum.<br>• Review pay rates and consider financial incentives for bank staff to increase bank usage, for example consider weekly pay as an incentive. | NWSSP operates only a clerical Bank. We do not auto enrol as not relevant for organisational needs. Agency requests will not be considered unless Bank has been explored.<br><br>**NWSSP Resource Bank & Agency**<br><br>**Bank Process Map**<br><br>**All Wales Terms of Engagement**<br><br>**NWSSP Resourcing Control Framework** | **Substantial**<br>Based on significant control measures in place and significant reduction in temp staffing and agency spend has remained at or close to £0 on a sustained basis.<br><br>All requests go through VCP regardless of what type of engagement/employment term is being requested. | None identified. | |

| 5. People Costs – Temporary staffing including Bank and Agency & Locum | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG status |
|---|---|---|---|---|
| **Agency and Locum controls**<br>• Robust controls over agency & locum usage for example:-<br>  ○ self-imposed cap on agency & locum expenditure;<br>  ○ senior sign off of agency & locum expenditure;<br>  ○ senior sign off of off-framework expenditure;<br>  ○ clear Board accountability defined and communicated across organisation;<br>  ○ improved communication of planned clinic cancellations to agency/bank teams; and<br>  ○ no direct approach for agency.<br>• Process in place to ensure non-framework or off-contract agency staff are not engaged.<br>• An organisation process in place for long term agency & locum use.<br>• Seek local agreement of agency & locum pay rates with surrounding trusts / explore use of a collaborative bank.<br>• Evaluate opportunities for moving from use of agency & locum to internal organisation resource and / or bank. | NWSSP has been on £0 agency spend for several months. Procurement team will not permit Agency contract without approval from VCP<br><br>NWSSP Resourcing Framework<br><br>NWSSP Resourcing Control Framework<br><br>NWSSP Agency Reduction Plan - Q2 2024 Submission.docx<br><br>NWSSP Agency Reduction Plan.docx<br>Agency Expression of Interest Form | Substantial<br>Based on significant control measures in place and significant reduction in temp staffing and agency spend has remained at or close to £0 on a sustained basis. | None identified. | |

| 5. People Costs – Temporary staffing including Bank and Agency & Locum | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG status |
|---|---|---|---|---|
| **Timesheet and expenses management**<br>• Ensure breaks and hours claimed are accounted for correctly in timesheets (i.e. agency workers are only paid for time worked, in accordance with HB policies).<br>• Ensure appropriate deduction for agency & locum staff breaks (lunch).<br>• Ensure mileage claims are only for required intra-site travel. | POD / DWS for timesheets – Managed via managerial placement for Bank staff and Health roster team<br><br>**Bank Managers Pack**<br><br>An expenses policy is in place which outlines what can and cannot be claimed. In addition, the expenses system has safeguards built into the approval process.<br>There are currently no reports run showing the highest mileage and expense claimants on a monthly basis. | **No P&OD involvement –** see bank workers pack, managers to verify and approve locally<br><br>Internal audit report from April 2020 in relation to expenses process. | None identified. | |
| **Restrictions on non-clinical temporary staff**<br>• Review and implement exit strategies for all non-clinical temporary workers.<br>• Temporary ban on usage of non-clinical agency staff, with exceptions authorised by executive director. | 2024/2025 exercise completed to end all Agency Workers.<br><br>**Resourcing Control Framework** | Substantial<br>Based on significant control measures in place and significant reduction in temp staffing and agency spend has remained at or close to £0 on a sustained basis. | None identified. | |

| 5. People Costs – Temporary staffing including Bank and Agency & Locum | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG status |
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| **Effective monitoring**<br>• Senior leads monitor weekly dashboard summaries of temporary staff usage, cost and trends to provide early warning signs and demonstrate progress with issues arising.<br>• Track number of interims, termination dates, delivery of objectives, and daily rates. Focus on reducing number and costs. Consider options for contract terms that enables the organisation to offer substantive role after x months use:- e.g. offer locums a suitable package to convert from locum to substantive contracts.<br>• Identify medical rotas with the highest use of temporary and bank staff and set out a plan to address<br>• Hold weekly agency & locum meetings across all staffing groups with agency & locum overspends, attended by finance and key stakeholders, to review and control agency & locum expenditure. | Monthly reports<br><br>Flexible Recruitment Principles<br><br>NWSSP Resourcing Control Framework<br><br>NWSSP Agency Reduction Plan - Q2 2024 Submission.docx<br><br>NWSSP Agency Reduction Plan.docx | **Substantial**<br>Based on significant control measures in place and significant reduction in temp staffing and agency spend has remained at or close to £0 on a sustained basis. | None identified. | |

| 6. People Costs – Other Staff Payments | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG Status |
|---|---|---|---|---|
| Overtime and enhanced payments controls<br>• Ensure breaks and hours claimed are accounted for correctly in timesheets.<br>• Perform a monthly 'audit' of the top 10 highest overtime earners by division.<br>• Implement prior approval for overtime and enhanced payments - monitor and reduce.<br>• For non-clinical staff - implement non-clinical overtime controls to limit expenditure in this area (e.g. Exec director authorisation required). | The Working Time Regulations (Velindre) Policy is available on the intranet to provide guidance to managers.<br>WF44 Working Time Regulations Policy v3 Combined<br><br>The Business Partnering Team works closely with Health Roster to support compliance with roster requirements and statutory rest breaks. For services utilising Health Roster, compliance is monitored and reported through monthly Senior Management Team meetings.<br><br>In addition, a new overtime system has been implemented to strengthen the approval process and enhance the ease and accuracy of reporting on overtime activity.<br><br>POD / DWS re timesheets & overtime control<br><br>Finance re top 10 overtime.<br><br>DWPS undertake Weekly audits | The Business Partnering Team has undertaken a focused review within the laundry service, where particularly high levels of overtime have been identified. This work is ongoing, with the team working closely with the service to understand the underlying causes of the increased overtime, as well as any associated risks or concerns. The intention is for this approach to be further developed and, where appropriate, rolled out across other services.<br><br>DWPS Weekly audits include bank holiday and overtime allocation. Use of overtime against negative TOIL balances. Exploring an O/T API with Rostering re: approval | Develop a report within finance to show the top 10 highest overtime earners by division.<br><br>Consider the need for a report on any expenses paid outside of the expenses policy. | |

| 6. People Costs – Other Staff Payments | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG Status |
|---|---|---|---|---|
| Expenses Monitoring<br>• Monthly monitoring of the highest mileage and expenses claimants. | An expenses policy is in place which outlines what can and cannot be claimed. In addition, the expenses system has safeguards built into the approval process.<br>There are currently no reports run showing the highest mileage and expense claimants monthly. | Internal audit report from April 2020. | Develop monthly report showing highest mileage and expenses claimants per service. | |
| Waiting List Initiatives (WLIs) controls<br>• Ensure consistent process across organisation including compliance with the WLI rate across the organisation.<br>• Appropriate review process in place for additional sessions allocated.<br>• Enhanced authorisation process for WLIs, with checks are undertaken before WLIs are awarded to ensure that :-<br>o WLIs offer financial benefit or are operationally critical before approving, and<br>o existing Programmed Activities (PAs) have been utilised.<br>• Benchmark WLI rate against other Health Boards. | N/A | N/A | N/A | |

| 7. Procurement | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG Status |
|---|---|---|---|---|
| **Procurement – Clarity of Roles** | SFIs detail the roles and responsibilities of budget holders, divisions and Procurement Services within the procurement process. | Minimal breaches of procurement rules are | None identified. | |

| 7. Procurement | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG Status |
|---|---|---|---|---|
| • Clear documentation and communication of roles between local managers, the procurement function and Shared Services. | Procurement Services stakeholder training has been provided to all divisions to communicate roles and responsibilities in ensuring effective procurement and value for money, from planning through to delivery and management. | reported to the Audit Committee.<br>Audits demonstrate that procurement rules have been followed and contracts have been effectively delivered. | | |
| **Procurement - Tender process**<br>• Approval limits are periodically and regularly reviewed where appropriate. | -Approval limits are regularly reviewed and when new staff join or there are leavers.<br>Only two NWSSP Finance staff are authorised to make changes. | -Change request forms are saved centrally | None identified. | |
| • All new contracts awarded in compliance with Statutory Regulations and SFIs. | -Only contracts awarded following a formal request for approval (RFA) in line with SFIs are awarded.<br>RFAs are only approved by Procurement Services for issue to NWSSP once all procurement legislation and SFI requirements have been met. | -Demonstrated through audits. | Ensure all contracts are captured in the NWSSP contract register. | |
| • All new contracts (including agency & locum staff) are procured via appropriate tendering procedures to ensure best value for money is attained. | All procurements are tendered where possible. Where a direct award under a framework is required due to urgency or other justified reasons, a value for money test is undertaken to confirm that the route is cost-effective and provides best value for NWSSP. | -Demonstrated through procurement outcome reports and RFAs. | None identified. | |
| • Single Tender Waivers controlled to minimise use. | SQA/STAs are only endorsed by Procurement Services where it is demonstrated that only one supplier can deliver the requirement in line with SFIs. | -Demonstrated through audits, and the number of SQA/STAs reported in the NWSSP Audit Committee Report. | None identified. | |

| 7. Procurement | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG Status |
|---|---|---|---|---|
| • Whole Life Costings are applied to evaluate tenders.<br>• Appropriate SLAs and T&Cs are applied to ALL contracts to enable appropriate and effective contract management.<br>• Breaches are reported to the relevant Executive Director and included in financial performance monitoring arrangements. | -Any procurements over the value of the Find a Tender Service threshold are not progressed as STAs to ensure the requirements of the Procurement Act are met.<br>-All procurements costed based on the whole contract life cost, or in the case of equipment the whole life cost.<br>-All capital should be costed based on capital cost and revenue tail costs at the point of procurement.<br>-In line with SFIs all contracts will be issued with standard T&Cs which will include as a minimum standard contractual requirement, specification, DPAs where appropriate, performance metrics and service credits where appropriate.<br>-Where external framework providers are used call-off contracts would be used which would incorporate the above where appropriate into the agreement.<br>-All breaches are reported to the Director of Finance by Procurement Services and included within the NWSSP Audit Committee report. | -Demonstrated through Procurement Outcome Reports and RFAs, and audit.<br>-Compliance demonstrated through audits.<br>-Audit Committee Report and Procurement Service reporting. | None identified.<br>None identified. | |
| **Procurement – Call Off**<br>• Contract pricing is reviewed annually to attain any further increased banding cost advantages through life of contract. | -Where possible contracts are benchmarked to ensure they continue to deliver value for money and the most cost-effective price for volume/spend is being paid. | -Benchmarking reports. | | |
| • Product catalogues reviewed (both NHS Supply Chain and Local Catalogues) to remove duplicate items on catalogue (e.g. pens) to ensure value for money.<br>• Consolidate a list of supplier discounts and penalties for early / late payments (in | -Duplicate items only made available via the catalogue where there is justification.<br>-NWSSP unable to wholly influence removal of items from the catalogue as they utilise Velindre's iProcurement and catalogue, areas such as stationary aligned to the AW standardised catalogue which reduces duplication.<br>-Early payment managed through the Priority Supplier Programme, PSP isn't aligned to the contract register, but | -Catalogue management processes within Procurement Services.<br>-PSP reporting. | Consider how to communicate to and influence divisions within NWSSP to move to the All-Wales standardised catalogue.<br>Undertake analysis of late payment penalties | |

| 7. Procurement | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG Status |
|---|---|---|---|---|
| alignment with contract register) - set out plans to recover / avoid these and share with accounts payable team to enact. | contracts are linked in the Oxygen Finance Dragonfly portal.<br>-Early payment discounts outside of PSP not captured<br>-Register of late payment penalties is not kept, all suppliers are able to charge interest for late payments in line with the Late Payment of Commercial Debts Act, which is also included within all T&Cs. | -All invoices paid within terms unless they fail matching. | by division and supplier to review if any additional measures need to be taken to reduce these payments. | |
| **Procurement - Contract management** | | | None identified. | |
| • Robust contract management processes are in place, including a complete and up to date contract register. | -Contract Management procedure in place and training rolled out to all divisions.<br>-Contract register held by Procurement Services and shared with all divisions. | -Demonstrated through audit and Contract Management reporting. | | |
| • Regular contract reviews to ensure SLAs are being met - with specific focus on PFI contracts where relevant. | -In line with Contract Management Procedure, contracts are required to be reviewed at least bi-annually. | -Demonstrated through audit and Contract Management reporting. | None identified. | |
| • When contracts expire, these are retendered in accordance with the statutory regulations rather than rolled over, and explore options for efficiencies/price reduction. | -No contracts would be rolled over and only re-procured in line SFIs and procurement legislation.<br>-Contracts only extended where there is provision/in line with procurement legislation. | -Procurement Outcome Reports, RFAs, and audits. | None identified. | |
| • Contract terms are relative and proportionate to the contract matter and that there is a clear understanding of the risks transferred. | -Reviewed at the pre-procurement stage to ensure terms and specification are proportionate and relative to the required, and at the evaluation and award stages to ensure it remains proportionate to the requirements.<br>-Risk reviewed and highlighted at procurement briefing and outcome report stages. | -Procurement Briefing Papers and Procurement Outcome Reports. | None identified. | |
| • Service specifications are reviewed and ensure SLAs are being achieved or amend where suitable and do not directly affect patient care (e.g. reduce frequency of window cleaning etc.) | -Service specifications reviewed at pre-procurement and award stages to ensure they continue to remain appropriate.<br>-Reviewed as part of management processes to ensure they are being met. | -Procurement Briefing Papers and Procurement Outcome Reports.<br>-Contract Management process. | None identified. | |

| 7. Procurement | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG Status |
|---|---|---|---|---|
| | -Where changes are requested they are agreed by all parties via Contract Change Notice.<br>-All specifications reviewed again at renewal to ensure appropriateness moving forward, and question if still required. | | | |
| **Procurement – Purchase to Pay**<br>• Establish a robust purchase ordering (PO) system to enable the implementation of a 'no PO no payment' rule and no retrospective POs , in collaboration with Accounts Payable, to help control expenditure. | -NWSSP fully aligned to the AW NPNP Policy.<br>-Retrospective POs reported as breaches to Audit Committee.<br>There are currently no sanctions for retrospective POs<br>-All divisions aware of requirement to liaise with procurement and raise a requisition to allow a PO to be approved prior to instructing suppliers | -NPNP reporting for NWSSP<br>-Audits<br>-Audit committee report | Consider more action against the use of retrospective POs. | |
| • Invoices that fail three way match (PO, goods receipt, invoice) are rejected and returned. Source of error are identified and contract managed appropriately. | -NWSSP fully aligned to the AW NPNP Policy.<br>-Retrospective POs reported as breaches to Audit Committee.<br>-All divisions aware of requirement to liaise with procurement and raise a requisition to allow a PO to be approved prior to instructing suppliers<br>- Invoices that fail three-way match are not rejected and returned, they are placed on hold until they pass matching or are released<br>- Invoices failing three-way match will go on hold. Hold report is shared with organisations | -Invoices that fail 3-way match are placed on hold and are disputed with the supplier.<br>-Reports from Accounts Payable showing numbers and values of invoices on hold by organisation and supplier<br>-Reports from NWSSP to all organisations showing numbers and value of invoices on hold | Continue to report on invoice numbers and values which remain on hold.<br><br>Develop an action plan for NWSSP to reduce the number of invoices on hold. | |
| • Payments are only processed following sign off from the appropriate level. | -Invoices matched to a PO would only be paid when they pass matching.<br>-All PO's raised require a requisition to be approved in line with the scheme of delegation prior to procurement approving the PO.<br>-There is a workflow approval process for manual invoices in line with oracle approval hierarchy | -Requisition and PO approvals.<br>-Invoicing process.<br>-Invoice on hold process. | None identified. | |

| 7. Procurement | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG Status |
|---|---|---|---|---|
| • Sample audit batches for any possible out of policy expenditure. | -Spend reviewed by Procurement Services and reviewed with divisions.<br>-POs only raised with a fully approved requisition in line with the scheme of delegation, where spend is over £5k, this would be in line with a contract that has received approval within NWSSP.<br>-An annual audit is undertaken within AP to review out of policy expenditure. | -Spend reviews. | None identified. | |
| • Continuous review of all open purchase orders that feed the monthly goods received not invoiced (GRNI) accrual for accuracy and appropriateness, ensuring any no longer valid items are removed/closed. | -Open PO's issued by eEnablement to Procurement Services monthly, orders reviewed and closed where appropriate.<br>-Finance undertake reviews of POs that have been receipted but not invoiced and close where appropriate | -Open PO reports. | Undertake an annual review of all open purchase orders to ensure any that are no longer required are closed. | |
| • Consider limiting and refining approval limits of requisitioners where appropriate. | -Requisitioners do not have any approval limits | | None identified. | |
| **Procurement - Other**<br>• Process in place to identify any "off contract" and consultancy expenditure. A strategy in place to review and market test costs to ensure best value. | -Spend reviews undertaken by Procurement Services and reviewed with divisions.<br>-Value for money test undertaken as a minimum on all spend above £5k with suppliers. | -Spend reviews. | None identified. | |
| • Contract pipeline clearly identified (and shared with NWSSP) to enable economies of scale. | -Contract programme maintained by Procurement Services on behalf of NWSSP and shared with all divisions.<br>-Lines are reviewed by Procurement Services to identify economies of scale across NWSSP and across other organisations. | -Spend reviews.<br>-Contracts register.<br>-AW Contract Programme. | None identified. | |

| 7. Procurement | Controls / Processes in place | Assurance that processes are operational | Actions Required | RAG Status |
|---|---|---|---|---|
| • Ensure the number of purchasing cards in the organisation is right-fitted and balances the process efficiencies against the risk that the use of these bypasses procurement processes. | There are currently 19 Purchasing Cards in use across NWSSP. Mostly issued to PAs & Administrators.<br><br>These cards have fixed limits which can be increased with appropriate authorisation for larger purchases of required.<br><br>Within Employment Services, there are a few cards with high limits which are limited to purchases through government supply specifically for Certificates of Sponsorship expenditure.<br><br>Employment services have setup an automated approval process for purchase card expenditure. | | Undertake review of all purchasing card holders and limits to ensure limits are right fitted.<br><br>Review automation within employment services to see if this approach about be used for all purchasing card holders across NWSSP. | |
| • Targeted approach for clinical preference variation (as identified by V&S procurement group). | -Clinical preference areas not applicable to NWSSP.<br>-Limited number of medical devices purchased by NWSSP have been rationalised to ensure VFM. | -Spend reviews. | None identified. | |
| **Procurement – Signalling**<br>• Organisation has considered placing a hold on certain items (e.g. external venue hire). Although the savings will be low, can act as a signalling mechanism. | There has historically been a hold on agency staffing, however with agency usage now eradicated there are no holds on a specific item at this time. | | Review categories of spend regularly to determine whether any holds on specific types of expenditure are required. | |

| 8. Other Items | Controls / Processes in place | Assurance that processes are operational | Action Required | RAG Status |
|---|---|---|---|---|
| **VAT recovery management**<br>• Review latest contracted out services guidance to ensure all eligible VAT is being reclaimed. | Monthly reviews by Management Accountants so ensure correct accounting for VAT.<br><br>Velindre also review transactions in addition to EY undertaking a review of all Velindre's transactions to ensure appropriate VAT reclaims. | Process notes for NWSSP VAT accountant which captures the process; however this could be formalised.<br><br>Recoveries evidenced through the work of EY on an annual basis.<br><br>EY offer webinars appropriate for finance staff. | Standardise SOP for NWSSP processes in relation to VAT recovery.<br><br>Ensure bi-annual training is delivered to NWSSP finance staff to ensure knowledge is kept up to date. | |

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|---|---|---|---|---|
| **Income and Debt management**<br>• A NHS visitor and migrant cost recovery programme in place.<br>• Bad debt cost management process in place e.g.:-<br>○ Ensure debtors categorised logically (e.g. NHS, Non-NHS, Private Patients, Overseas, Salary Sacrifice, Prescriptions, Salary Overpayments, etc.) with agreed risk based, proportionate approach to collection for each category.<br>○ Identify strategy for key debtors, and set collection targets for team members.<br>○ Review processes in place to ensure invoices are issued in real time or as soon as possible.<br>○ Consider payment in advance/on delivery where appropriate or the use of pro forma invoices in areas such as private patients backed with settlement facilities available at point of delivery.<br>○ Identify and address internal issues that are preventing timely collections i.e. unresponsive / untimely resolution of queries by divisions.<br>○ Scrutinise requests to write-off salary overpayments (if historic practice shows these are material).<br>○ Ensure prompt referral to external debt recovery agencies where necessary. | NWSSP does not have any visitor and migrant cost recoveries.<br><br>The debtor process is led by VUNHST.<br><br>NWSSP report on any NHS Debt which is older than 11 and 17 weeks to Welsh Government for which there is a formal process in place.<br><br>Consideration is made of any non-NHS aged debt monthly. Where appropriate debt is passed to debt recovery agencies.<br><br>DoF of NWSSP and DoF of Velindre required to sign off salary write offs. | All Wales Overpayment Policy<br><br>Monthly reports are included in Qliksense Budget Holder Dashboards<br><br>NWSSP reports to Welsh Government on any aged NHS Debt through the MMR.<br><br>Any non-NHS debt linked to stores will have their accounts put on stop and have debt passed to collection agencies where appropriate. | Develop FCP in relation to debt collection including debt management. | |

| 8. Other Items | Controls / Processes in place | Assurance that processes are operational | Action Required | RAG Status |
|---|---|---|---|---|
| **Stock Management**<br>• Ensure appropriate stock rotation processes are in place and being followed to minimise wastage. Agree process with suppliers to swap out short shelf life items or use consignment.<br>• Review stock level minimum and maximum thresholds in line with current usage to minimise wastage.<br>• Review delivery charges, triggers and schedules and implement changes to reduce any carriage charges where possible (e.g. standing orders, minimum order values, 3 day delivery rather than next day).<br>• Review controls on consignment stock. | The Oracle Warehouse Management System (WMS) replenishment process uses the oldest Licence Pallet Number (LPN) from BULK storage.<br><br>When replenishment is triggered to move items into PICK locations, the system automatically selects and transfers the oldest stock first, supporting effective stock rotation and inventory control.<br><br>Automated Min/Max reports generate Purchase Orders for stock replenishment from suppliers when inventory levels fall below the defined minimum threshold.<br><br>NWSSP does not hold any consignment stock. | Evidence that the level of stock write off is low. | None identified. | |

| 8. Other Items | Controls / Processes in place | Assurance that processes are operational | Action Required | RAG Status |
|---|---|---|---|---|
| **Estates**<br>• Review outliers identified from benchmarking overall running costs for facilities and estates (inc. estates footprint use) (see the VAULT).<br>• Ensure appropriate maintenance schedules in place to ensure asset kept in good working order.<br>• Ensure an estates strategy is in place and regularly reviewed, to include estate rationalisation consideration to determine where savings might be delivered.<br>• Establish list of ongoing and planned estates and maintenance projects and ensure it has been prioritised and has Board approval. | Annual review of estates performance management which was undertaken in 2024/25 for the first time which feeds into the Vault system.<br><br>Energy performance monitoring through the tracking of consumptions across all sites.<br><br>Following a condition appraisal of all sites in March 2026, a central database has been created to maintain records of maintenance requirements.<br><br>An annual review of leases is undertaken to ensure estate remains fit for purpose. Estate rationalisation undertaken resulting in reduction of estate requirement such as Companies House reduced from 1.5 floors to 0.5 floors as well as the reassignment of Samlet Road to WAST moving HCS to Matrix House.<br><br>Software is used to analyse desk usage within Companies House. | Annual reporting using Estates & Facilities Management Reporting System. Documentation provided on data definitions and completion notes. In addition, report on energy generation and usage for IP5 provided along with evidence of Qliksense expenditure review.<br><br>Links to risk register to understand the condition status and required investments to ensure estate remains fit for purpose. | None identified. | |

| 8. Other Items | Controls / Processes in place | Assurance that processes are operational | Action Required | RAG Status |
|---|---|---|---|---|
| **Journal Approvals**<br>• Internal journal review process in place and regular accruals and prepayments have been reviewed to ensure they remain current and the method of calculation is based on up to date assumptions.<br>• Controls over journals are appropriate including posting authorisation levels, review and sign off process. | Balance sheet reconciliations are completed monthly by Management Accountants, however there is no central review of appropriateness of entries including reversing vs transfer journals, ages of provisions, accruals and prepayments and assumptions. | Evidence that Balance Sheet Reconciliations are being done monthly, however limited assurance that entries on the balance sheet are regularly reviewed by senior finance team members for accuracy and completeness | Develop a clear SOP in relation to journals and accruals and pre-payments.<br><br>Design and deliver training to all finance staff on the SOP for journals, accruals, prepayment and the use of balance sheet.<br><br>Review requirement for journal posting authorisation. | |
| **Fixed Assets and Capital**<br>• Fixed asset register is in place and regularly updated including a fixed asset verification exercise.<br>• Review capital programme for subsequent revenue affordability, deferring, reducing or stopping schemes as appropriate.<br>• Asset lives regularly reviewed to ensure appropriate and that depreciation is consistent with consumption.<br>• Consider reprioritising the capital programme to prioritise spend-to-save projects.<br>• Review assets held on SoFP (buildings, equipment etc) and dispose of any no longer in use or needed.<br>• Consider VfM of ownership options such as lease v purchase. | An annual exercise is undertaken, led by VUNHST using the RAM fixed asset register. Emails are sent to service leads for them to review all assets. Service leads are required to report back on any required disposals or write offs.<br><br>A Capital Prioritisation Group has been setup to create a structure for capital requests during the year. This group has a clear Terms of reference to consider. | Confirmation of asset verification within RAM which is subject to external audit annually.<br><br>Evidence of Capital Prioritisation Group meetings.<br><br>Velindre use bar coding where as NWSSP use manual review of fixed assets. | Review CPG ToR to ensure that the prioritisation of spend-to-save projects. | |

| 8. Other Items | Controls / Processes in place | Assurance that processes are operational | Action Required | RAG Status |
|---|---|---|---|---|
| **Balance Sheet Review**<br>• Ensure all balance sheets are reconciled at appropriate intervals and action is taken to address historical balances.<br>• Monthly assessment of existing provisions to determine whether these can be released during year as opposed to later in the year/year end.<br>• Review all credit balances on the Balance sheet for potential over accrual (e.g. Annual Leave Accrual or GRNI balances). | Monthly balance sheet reconciliations are undertaken by Senior Finance officers or Management Accountants; however, the current process is focused on confirming balances rather than reviewing the appropriateness of transactions. | | Develop clear Standard Operating Procedures for balance sheet entries and monthly reviews.<br><br>Develop and deliver training to all finance staff on the standard process for reviewing balance sheet entries.<br><br>Ensure balance sheet entries are at a level and age that is appropriate. | |

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| **MEETING** | Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership |
| **DATE** | 07 July 2026 |
| **PREPARED BY** | Carly Wilce, Corporate Services Manager |
| **PRESENTED BY** | James Quance, Assistant Director of Corporate Services |
| **RESPONSIBLE HEAD OF SERVICE** | Alison Ramsey, Director of Finance & Corporate Services |

**TITLE OF REPORT**

NWSSP Annual Report on Conflict-of-Interest Declarations and Gifts, Hospitality & Sponsorship for 2025-26.

**PURPOSE OF REPORT**

The purpose of this report is to provide the NWSSP Audit Committee with a record of Directors' interests and a summary of completion rates for each service for Conflict of Interest declarations, as at 18 June 2026. This paper also includes a summary of the Gifts, Hospitality and Sponsorship declarations received during the reporting period, 1 April 2025 to 31 March 2026.

## NWSSP Annual Report on Conflict of Interest Declarations and Gifts, Hospitality & Sponsorship for 2025-26

### 1. BACKGROUND

The Velindre University NHS Trust Standards of Behaviour Framework outlines arrangements within the organisation to ensure that staff comply with requirements, including recording and declaring potential conflicts of interest. It is imperative that any private interests do not conflict with NHS duties.

The Nolan Principles on Public Life were established in 1994 and have been extended to define public office as applying to all those involved in the delivery of public services. The seven principles are as follows:

1. ***Selflessness*** *- You should take decisions solely in terms of the public interest. You must not act in order to gain financial or other material benefit for family or friends;*
2. ***Integrity*** *- You should not place yourself under any financial or other obligation to any individual or organisation that might reasonably be thought to influence you in the performance of your duties;*
3. ***Objectivity*** *- You must make decisions solely on merit when carrying out public business (including the awarding of contracts);*
4. ***Accountability*** *- You are accountable for your decisions and actions to the public. Consider issues on their merits, taking account of the views of others and ensure the organisation uses resources prudently and in accordance with the law;*
5. ***Openness*** *- You should be as open as possible about all decisions and actions, giving reasons for your decisions and restricting information only when the wider public interest demands;*
6. ***Honesty*** *- You have a duty to act honestly. Declare private interests relating to public duties and take steps to resolve any conflicts arising in a way that protects the public interest*
7. ***Leadership*** *- Holders of public office should promote and support the foregoing principles by leadership and example.*

It is the responsibility of all individuals to ensure that they are familiar with the requirements of the Nolan Principles. Every public body should develop Codes of Conduct for staff and Independent Members which reflect these principles and its shared values. The guidance in terms of disclosing potential conflicts of interest is to err on the side of caution and disclose more rather than less. What is important is whether a relationship could be perceived as a conflict of interest, whether or not it actually is. Guidance has been revised to require staff to highlight any family or close personal relationships in their declarations, in accordance with our Managing Personal Relationships at Work Protocol.

## 2. DECLARING CONFLICTS OF INTEREST

All employees, regardless of band, are required to declare any conflicts of interest or submit a nil return. This approach aligns with best practice and supports improved compliance, as part of the implementation of lifetime declarations for all staff across NWSSP.

Members of the Senior Leadership Group will continue to confirm their annual declaration, the details of which will be published on the NWSSP website (Appendix A – List of Declarations for SLG Members). Once a declaration has been submitted, staff are only required to update their submission should their circumstances change.

Declarations of interest for NWSSP Audit Committee and Shared Services Partnership Committee members are recorded within a central register held and maintained by NWSSP Corporate Governance Team and supporting appropriate oversight, transparency and accountability. NWSSP publishes its declarations for its Senior Leadership Group (SLG) members and Chair, and NWSSP is reliant upon NHS Wales organisational publication of declarations relating to Committee Members and Independent Members, through their own publication route.

In addition, declarations of interest are requested as a standing item at each SLG and Committee meeting, providing members with a regular opportunity to declare any actual, potential or perceived interests in relation to the business under consideration. This provides a further assurance mechanism by ensuring that interests are considered at the point of decision-making and that any necessary mitigating actions can be identified and managed appropriately.

Declarations are to be completed via the ESR Self-Service Portal. For staff without access to the system, a hard copy form may be used; however, this must be authorised by the relevant Director of Service before submission to Corporate Services for recording. This is an exception to the rule, as all staff with access to a computer are expected to complete declarations via ESR to ensure consistency and maintain a single, central register. This requirement includes Laundry Services.

Guidance on completing a declaration via ESR is available via a dedicated staff intranet page for Conflicts of Interest. Managers requiring further support may contact the Corporate Governance Team for assistance. New starters are also required to complete a declaration via ESR as part of the onboarding and induction process, as included within the Welcome Toolkit and associated declaration of compliance.

It is the responsibility of all individuals to ensure that they are familiar with the requirements of the Standards of Behaviour Framework and that they duly complete a declaration of any potential or perceived conflicts of interest. Where potential or perceived conflicts require mitigating action, an action plan must be developed. It is also important to note that further declarations are required in procurement processes and that individuals are excluded from the exercise where a conflict of interest is deemed to exist.

The table below records the current position regarding completion across the organisation, as at 18 June 2026. Figures are based on ESR and paper records. Procurement includes drivers and stores staff, and not solely staff involved in procurement exercises.

| Directorate | Headcount | Percentage Completion | Outstanding Declarations |
|---|---|---|---|
| **Audit & Assurance Services** | 58 | 98% | 1* |
| **Finance & Corporate Services** | | | |
| ○ Corporate Services | 25 | 100% | 0 |
| ○ Finance Services | 28 | 100% | 0 |
| ○ Accounts Payable | 159 | 94% | 10 |
| ○ Counter Fraud | 7 | 100% | 0 |
| ○ E-Business Central Team Services | 20 | 95% | 1* |
| **Legal & Risk and Welsh Risk Pool Services** | 198 | 90% | 19 |
| **People and Organisational Development** | | | |
| ○ Digital Workforce | 27 | 92% | 2 |
| ○ Medical Workforce Team | 23 | 95% | 1* |
| ○ People and OD | 48 | 100% | 0 |
| **Employment Services** | | | |
| ○ Employment Services | 337 | 99% | 1 |
| **Planning, Performance & Informatics** | 77 | 96% | 3 |

| | | | |
|---|---|---|---|
| **Primary Care and Medical Examiner Services** | | | |
| ○ Medical Examiner Service | 98 | 88% | 12 |
| ○ Primary Care Services | 307 | 99% | 2 |
| **Procurement, Supply Chain and Laundry Services** | | | |
| ○ Laundry Services | 205 | 64% | 73 |
| ○ Procurement Services, including supply chain and Health Courier Services | 845 | 93% | 57 |
| **Specialist Estates Services** | 54 | 98% | 1 |
| **Surgical Materials Testing Laboratory** | 45 | 98% | 1 |
| **Pharmacy Technical Services** | 59 | 93% | 4 |
| **Total** | **2,620** | **93%** | **185** |

**A small number of outstanding declarations relate to staff who are currently absent from work. These will be followed up through local management arrangements when individuals return.*

Directors are responsible for developing local action plans for the management of potential conflicts. A summary of declarations received for each directorate will be shared with the relevant Directors to support follow-up on outstanding declarations, following presentation of this paper to the Committee, together with template action plans for completion and return.

Of the 57 outstanding declarations within Procurement, Supply Chain and Laundry Services, the majority relate to Band 2 and 3 staff, primarily drivers, where the perceived risk of conflicts of interest is considered lower. This reflects the nature of these roles, which are operational in focus and do not ordinarily involve budgetary decision-making, contract award, supplier selection or direct influence over procurement decisions. The outstanding declarations are therefore assessed as presenting a lower overall risk to the organisation, while still remaining subject to the same declaration requirements and follow-up arrangements as all other staff groups. The Corporate Governance Team will, however, continue to monitor compliance and identify opportunities for improvement.

In comparison with the previous year, overall compliance within the Service has improved significantly, reflecting the transition from paper-based forms to electronic submission via ESR. This represents a substantial improvement in the overall completion position and provides assurance that the revised process is strengthening visibility, consistency and central oversight of declarations across the Service. This approach has recently been implemented within Laundry Services by management, and a similar improvement in ESR compliance is anticipated during the forthcoming cycle.

Notwithstanding the current level of compliance within Laundry Services, hard copy declarations submitted in previous years remain on record in the form of existing lifetime declarations. These confirm that no declarations have been identified which present a risk to NWSSP, and that no mitigating action has previously been required.

## 3. GIFTS, HOSPITALITY & SPONSORSHIP

All employees of NWSSP should consider the implications very carefully before accepting any personal gifts or offers of hospitality during, or outside of, office hours. They should avoid placing themselves in a position where acceptance of such gifts or hospitality might be perceived to influence their decision in respect of purchasing goods or services, awarding contracts, or making appointments. Anyone found to be in breach of this procedure could face disciplinary action.

If staff receive any offer over the value of £25, or several small gifts with a cumulative value over £100 from the same or closely related source in a 12-month period, whether accepted or declined, these are required to be recorded in the Gifts and Hospitality Register held by the Corporate Services Manager. A summary of declarations received is presented to the NWSSP Audit Committee at each meeting.

Summary of declarations received during 2025-26

The following declarations were received during 2025/26 and have been reported to previous meetings of the NWSSP Audit Committee:

| Department | Type of sponsorship | Source of hospitality | Description | Value | Accepted or declined |
|---|---|---|---|---|---|
| Legal and Risk Services (LaRS) | Hospitality | Andrew Post KC (previously of Hailsham Chambers but now retired). | Lunch for four members of LaRS staff. | £80 | **Declined:** by the Managing Director. Given the nature of LaRs' business and the relationship with the former KC, it was determined that a potential conflict of interest could arise and the request was therefore declined. |
| Specialist Estates Services (SES) | Hospitality | The Institute of Healthcare Engineering and Estate Management (IHEEM). | Attendance for nine members of staff at the Joint IHEEM / NWSSP SES Wales Regional Conference 2025 at the International Convention Centre Wales in Newport. The lead speaker was Judith Paget, Chief Executive Officer of NHS Wales.<br><br>IHEEM stands for the Institute of Healthcare Engineering & Estate Management.<br><br>IHEEM is a registered charity (257133) and arranges similar events across the UK and Ireland. | Total: £2,285 | **Accepted:** The Institute of Healthcare Engineering and Estate Management (IHEEM) and NWSSP SES jointly hosted a conference in Cardiff, to which delegates were invited to hear speakers, including Judith Paget, covering a range of engineering and estate management issues.<br><br>This is a repeat of annual events jointly staged in previous years. In essence, IHEEM pays the costs of the event through private company sponsorships and delegate admission fees. In |

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| | | | | | return, NWSSP provides administration, technical support and speakers on subjects relating to the NHS in Wales.<br><br>In summary, the nature of benefits for those attending comprises:<br>a) Admission to the event over 2 days (including refreshments and food)<br>b) Overnight hotel and breakfast<br>c) Admission to the Gala awards dinner (at which I will be assisting in presenting awards)<br><br>Up to nine employees attended the event. |
| Finance & Corporate Services (FCS) | Hospitality | Fiscal Tec, Reading. | The service was allocated four tickets to attend the annual EMPOWER Conference in Reading on 25 and 26 September, involving an overnight stay. Fiscal Tec is NWSSP's service provider for Duplicate Payment and Statement Reconciliation software. Historically, the service has only been offered two tickets but, in recognition of the input made by NHS Wales in developing its Statement Reconciliation software, | £1,560.00 | **Accepted:** This was a repeat of annual events jointly staged in previous years. Four of the six tickets offered were approved. |

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| | | | the service was allocated four tickets. The two-day event was facilitated by Fiscal Tec and included several guest speakers, including from the NHS. It provided an opportunity for the team to meet software leads and network. Travel was funded by NWSSP. | | |
| Specialist Estates Services | Hospitality | Joint IHEEM Healthcare Estates Conference Manchester. IHEEM stands for the Institute of Healthcare Engineering & Estate Management. | The Director of Specialist Estates was invited to attend the event as a speaker and panellist to represent NHS Wales at the conference. They were also invited, as a guest of the IHEEM President, to attend the Gala Awards Dinner.<br><br>IHEEM is a registered charity (257133) and arranges similar events across the UK and Ireland.<br><br>Travel has been funded by NWSSP. | £390.00 approximately | **Accepted:** This is a repeat of annual events arranged in previous years.<br><br>IHEEM is a registered charity (257133) and arranges similar events across the UK and Ireland. |
| Finance & Corporate Services | Hospitality | Joint IHEEM Healthcare Estates Conference Manchester. IHEEM stands for the Institute of Healthcare Engineering & Estate Management. | Joint IHEEM Healthcare Estates Conference Manchester.<br><br>The Head of Estates was invited to attend the event as a delegate. There were no costs to the NHS, and the individual did not attend the Gala Dinner.<br><br>Travel has been funded by NWSSP. | £0 | **Accepted:** This is a repeat of annual events arranged in previous years. |

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| Finance & Corporate Services | Hospitality | Oracle Enterprise Performance Management (EPM) – Shaping the Future of Decision Making – accelerating reporting cycles and unlocking AI-powered insights; Oracle Office London. Oracle and Version 1 (managed service provider). | Presentation by the supplier on the latest system developments and case studies from other customers, sharing learning from system change and implementation.<br><br>Lunch and refreshments were provided by the supplier.<br>Travel by train funded by NWSSP. | £20 approximately | **Accepted:** lower than the specified threshold. |
| Welsh Risk Pool | Sponsorship | RLDatix: 1 Church Rd, London TW9 2QE. | Funding from RLDatix to NWSSP to facilitate members of the Welsh Risk Pool Safety & Learning Pool to attend the event, which is a national event. The funding is effectively free places (at a full cost of £429 per person). Eight places have been provided as NHS Wales is presenting at the event. The organiser has also negotiated half price accommodation for those attending (which represents a £50 | £3,353.00 | **Accepted:** Sponsorship accepted to support NWSSP representation and participation at a national event where NHS Wales was presenting, providing clear organisational benefit, with funding considered proportionate, non-influential, and appropriately declared in line with policy. |

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| | | | saving per person) – which applies to all attendees who book early. | | |
| Finance & Corporate Services | Hospitality | Vector Consumer. | Offer of lunch or dinner. | Unknown | **Declined** by the Finance Business Partner. |
| Finance & Corporate Services | Gift | Mrs Bucket Cleaning Company. | Small gift box of Gower Cottage Brownies received via post. | £20 | **Accepted:** lower than the specified threshold. |
| Legal and Risk Services | Hospitality | Lisa Jones The Medical and Legal Experts Practice (TMLEP). | Lunch at Leonardo Hotel Cardiff. | Unknown | **Declined:** The Director of Finance acknowledged that such arrangements are common practice within the private sector; however, in light of the potential public perception associated with a high-end restaurant setting hosted by a client, it was determined that a more formal and appropriate venue should be used. |
| Finance & Corporate Services | Gift | Welsh Infected Blood Support Scheme (WIBSS) beneficiary. | 6 bottles of wine, box of chocolates and bunch of flowers. | £80 to 100 | **Accepted in part:** The beneficiary was informed of the policy, which states that managers are not permitted to accept gifts following an offer of money. Despite this, the individual had left the gifts at Companies House. In accordance with security procedures, the items needed to be collected; the flowers and chocolates were therefore shared with the WIBSS team, and the six bottles of wine will |

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| | | | | | be donated for inclusion in a charity raffle. |
| Legal and Risk Services | Gift | Simon Hilton – Counsel at Kings Chambers. | Bottle of prosecco. | £20 approximately | **Declined:** The gift was cancelled by the sender after being informed by the recipient that they were unable to accept it in line with policy. |
| Legal and Risk Services | Hospitality | St Johns Chambers | Lunch to discuss customer service/barristers' availability. | £45 approximately | **Declined:** After considering the potential wider public perception, the member of staff was advised that business-related matters should be discussed in a more formal setting. |
| Primary Care Services | Gift | Nasreen Ali of Welchem Ltd (Pharmacy chain). | Lindt luxury chocolates. | £20 approximately | **Declined:** The chocolates were donated to the Macmillan Coffee Morning taking place at Matrix House in Swansea. |

All accepted declarations detailed above were reported to the NWSSP Audit Committee during the period, as a matter of course.

## 4. RECOMMENDATION

The NWSSP Audit Committee is asked to:

- **NOTE** the progress made in relation to Conflicts of Interest declared to date;
- **NOTE** the summary of Gifts, Hospitality and Sponsorship declared for the 2025-26 period; and
- **NOTE** the Senior Leadership Group and Chair Declarations in **Appendix A.**

## Appendix A – List of Declarations for SLG and Chair, 2025-2026, as at May 2026

| Name | Job Title | Disclosure |
|---|---|---|
| Neil Frow, OBE | Managing Director of NWSSP | • Observer Life Science Hub Board - Attend Board Meetings, Non-Paid.<br>• Spouse employed by Cwm Taf Morgannwg University Health Board. |
| Simon Cookson | Director of Audit and Assurance Services | • Owner and Director of S Cookson Consulting Ltd (formed in 2013). Company has been dormant since 2014. |
| Stuart Douglas | Director of Specialist Estates Services | • Inactive Director of Chadwick Holdings Limited – receipt of dividend income only.<br>• Shareholder in Chadwick Enterprises Limited – receipt of dividend income only.<br>• Shareholder in Newminster House Bristol Limited – receipt of dividend income only.<br>o Mace are tenants at the Newminster House offices. They have been on successive Building for Wales frameworks over the years (including the current one). I was not active in the bid review process.<br>o The Division has occasionally used Mace, but I have not been directly involved in their selection. This will remain under constant review.<br>• Shareholder in The Exchange Bridgwater Limited – I may receive dividends in future.<br>• Director of Douglas Management Consultants Limited (not trading).<br>• Family members working within NHS Wales, as follows (no professional interaction with them as part of his work):<br>• Son is a Specialist Registrar (Anaesthetics & Critical Care) working with Cardiff & Vale University Health Board at University Hospital of Wales and Aneurin Bevan University Health Board at the Grange (on a training rotation).<br>• Daughter is a Staff Nurse (Paediatrics) working at Princess of Wales Hospital for Cwm Taf Morgannwg University Health Board.<br>• Daughter in Law is registered as a Bank Midwife at UHW for Cardiff and Vale University Health Board. |
| Martin Edwards<br>(*from April 2026*) | Medical Director | • Specialist Application Associate with the General Medical Council (GMC).<br>• Consultant Paediatrician at Cardiff and Vale University Health Board.<br>• Treasurer of a local Scout Group in Cardiff. |

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| | | • Trustee of the Advanced Life Support Group (ALSG). |
| Gareth Hardacre | Director of People & Organisational Development and Employment Services | • Spouse is Director of Nursing and Midwifery at Cwm Taf Morgannwg University Health Board.<br>• Son is an Admin Employee in Cardiff and Vale University Health Board.<br>• Chair of HPMA Cymru - and National Committee Member of HPMA (a Charity for NHS HR Professionals).<br>• Sister is a full-time officer with the Public and Commercial Services (PCS) union.<br>• Niece is employed by a Welsh Government Sponsored Body, the Commission for Tertiary Education and Research (MEDR). |
| Mark Harris | Director of Legal & Risk Services and Welsh Risk Pool | • Spouse is a GP partner in a medical centre in the Aneurin Bevan area. |
| Dr Gavin Hughes | Director of Surgical Materials Testing Laboratory | • American Patent Number 20060140911. *Bacteriophage for the treatment of bacterial biofilms*. 29th June 2006;<br>○ Professor Richard Sharp, Dr Gavin Hughes, Dr James Taggart Walker (Health Protection Agency, Porton Down, Salisbury, Wiltshire, SP4 0JG)<br>○ Professor Anthony Hart (Department of Medical Microbiology and Genitourinary Medicine, Royal Liverpool University Hospital, Liverpool).<br>• Worldwide International Patent Number PCT/GB2004/000073. *Bacteriophage for the treatment of bacterial biofilms*. 27th July 2004;<br>○ Professor Richard Sharp, Dr Gavin Hughes, Dr James Taggart Walker (Health Protection Agency, Porton Down, Salisbury, Wiltshire, SP4 0JG)<br>○ Professor Anthony Hart (Department of Medical Microbiology and Genitourinary Medicine, Royal Liverpool University Hospital, Liverpool).<br>• Honorary Senior Lecturer with Cardiff University School of Medicine. |
| Jonathan Irvine | Director of Procurement, Supply Chain, Logistics, Transport and Laundry Services | No interests to declare. |
| Laura-Jayne Keating<br>(*From March 2026*) | Director of Pharmacy Technical Services | No interests to declare. |
| Rebecca Nelson | Director of Planning Performance and Informatics | • Council Member for CIPFA 2025-2027 – unremunerated. |

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| | | • Independent Member of the Audit Committee for the Representative Body of the Church in Wales – unremunerated.<br>• Spouse of the Member of Parliament for Torfaen, UK Government Paymaster General and Cabinet Office Minister for European Relations. |
| Nicola Phillips | Director of Primary Care Services | • Mother is an Independent Board Member for Swansea Bay University Health Board. |
| Alison Ramsey | Director of Finance & Corporate Services | • Governor on the University of South Wales Board and Chair of the Audit Committee of the University of South Wales until 31 March 2026 when the term came to an end. |
| Tracy Myhill OBE<br>(*Ended 30/06/2026*) | NWSSP Chair | • Non-Executive Director - Ministry of Defence People Committee.<br>• Appeals Board Member - Ministry of Defence LGBT Financial Recognition Scheme<br>• Associate Alumni Global - executive recruitment NHS.<br>• Director and owner of Tracy Myhill Associates Ltd. Management Consultancy providing Organisational Development Support and Mentoring to public, private and third sector including the NHS.<br>• Spouse is Director in Tracy Myhill Associates Ltd. Management Consultancy providing Organisational Development Support and Mentoring to public, private and third sector including the NHS.<br>• Through Tracy Myhill Associates Limited:<br>o Provide consultancy support on Development of Health Education to University of South Wales.<br>o On the HEIW framework for mentoring, coaching and speaking/presentations to aspiring senior leaders.<br>o OD consultant with Association of Ambulance Chief Executives providing mentoring, coaching and Organisational Development support to Ambulance services across the UK and Ireland.<br>o Provision of Organisational Development and mentoring and coaching support to NHS organisations in Wales, England and Scotland.<br>o On Academi Wales Framework for coaching. |

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| **MEETING** | Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership |
| **DATE** | 07 July 2026 |
| **PREPARED BY** | Carly Wilce, Corporate Services Manager, Gemma Roscrow, Procurement Services and Leanne Wright, Procurement Services |
| **PRESENTED BY** | Alison Ramsey, Director of Finance and Corporate Services |
| **TITLE OF REPORT** | Governance Matters - NWSSP Expenditure |
| **PURPOSE**<br>The purpose of this paper is to provide the NWSSP Audit Committee with a brief update on governance developments within NWSSP and details of the contract activity within the period. | |

## 1. STANDING ORDERS AND FINANCIAL INSTRUCTIONS (SOs and SFIs)

There have been two occasions where a contract award was not progressed in accordance with Standing Orders and Standing Financial Instructions.

## 2. CONTRACTS FOR NWSSP

The table below summarises contracting activity undertaken during the period **1 April 2026 to 31 May 2026**. Details of the contract activity for the period are set out in **Appendix A**.

| Description | No. |
|---|---|
| Retrospective Non-Compliant Activity | 2 |
| Contracts value breached/extended at risk as a result of emergency/unforeseen circumstances | 0 |
| Invitation to competitive quote of value between £5,000 and £25,000 (excluding VAT) | 7 |
| Invitation to competitive tender between £25,000 and the relevant procurement threshold | 1 |
| Single Tender Actions | 0 |
| Single Quotation Actions | 2 |
| Direct Call Off against National Framework Agreement | 3 |
| Mini competition against National Framework | 2 |
| Contract Change Notice (CCN) | 4 |
| **Total** | **21** |

## 3. GIFTS, HOSPITALITY & SPONSORSHIP

Following the most recent NWSSP Audit Committee meeting, **eight** declarations concerning Gifts, Hospitality and Sponsorship were made, all of which were accepted or accepted in part. The details are as follows:

| NWSSP Job Title | Dept | Type of Sponsorship | Date of Event | Donated by/Source of Hospitality | Description | Approx Value | Accepted or declined | Date of approval |
|---|---|---|---|---|---|---|---|---|
| Deputy Director of Legal and Risk Services | LaRs | Hospitality | 01/05/2026 | HPMA Cymru (charitable organisation, supports HR teams in NHS) | HR in Wales Awards, representing HPMA Cymru (The Deputy Director of Legal and Risk Services is currently chair of the Wales branch). | £103.38 (ticket price) | **Accepted:** Chair of the Wales HPMA branch. | 23/04/2026 |
| Head of Specialist Estates Services | FCS | Hospitality | 06/05/2026 and 07/05/2026 | Institute of Healthcare Engineering & Estate Management - Registered Charity 257133. | To attend The Institute Of Healthcare Engineering and Estate Management (IHEEM) Healthcare Estate Conference in Manchester 2025. | £105 (ticket price) | **Accepted:** IHEEM is a registered charity and not a supplier of services, and therefore no conflict of interest. | 23/04/2026 |
| Head of Financial Resources, Systems and Planning | FCS | Hospitality | 06/05/2026 and 07/05/2026 | Institute of Healthcare Engineering & Estate Management - Registered Charity 257133. | To attend the Institute Of Healthcare Engineering and Estate Management (IHEEM) Healthcare Estate Conference in ICC Newport. | £105 (ticket price) | **Accepted:** IHEEM is a registered charity and not a supplier of services, and therefore no conflict of interest. | 23/04/2026 |
| Deputy Director of Finance and Corporate Services | FCS | Hospitality | 13/05/2026 | Oracle | To attend the Oracle SaaS Insight Day at Oracle Offices, London, including customer stories, expert sessions and focused breakouts on transformation and innovation across ERP, HCM, EPM and platform services. | No charge for the day – free buffet lunch provided estimated to be <£15 per head. NWSSP covered the | **Accepted:** The Oracle SaaS Insights Day, hosted by Version 1 in partnership with Oracle, is a dedicated event for current and prospective Oracle Cloud Applications users to explore the latest roadmap, AI advancements, and real-world deployment lessons and therefore no perceived conflict of interest. | 11/05/2026 |

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| | | | | | | travel costs to the event. | | |
| Solicitor | LaRs | Gift | 28/04/2026 | GP and defendant in claim | Box of chocolates and a bottle of wine | £20 | **Accepted in part:** Chocolates shared with the team and bottle of wine donated to school PTA for fundraising purposes. | |
| Anaesthetics Trainee, Single Lead Employer (SLE) | POD | Hospitality | 7 and 8 July 2026 | Beckton Dickinson UK, | NIVAS National Conference, Brighton Metropole Hotel, to deliver a keynote speech at the conference during an industry-sponsored session. The company (BD) will cover travel and accommodation costs, as well as conference fees to attend the conference. Study leave form completed. | £900 estimated total. Travel and accommodation - £505; meals/refreshments - £50; conference/ registration fees - £245; other - £100 honorarium fee. | **Accepted:** An honorarium is permitted where it is a one-off, voluntary payment for services such as a conference presentation or external contribution and is modest in value and not comparable to normal pay.<br><br>Honorarium payments made directly to individuals (i.e. outside of payroll) may be subject to tax and National Insurance contributions, depending on individual circumstances such as total income, employment status and receipt of state benefits. It is the responsibility of the recipient to determine any tax liability and ensure that appropriate declarations and payments are made to HM Revenue and Customs (HMRC). This information has been communicated to the member of staff by the Director of Finance. | 29/05/2026 |
| Solicitor | LaRs | Gift | 04/06/2026 | Isca Medical Practice, Caerleon (GP and defendant in claim) | Small bouquet of roses, Scottish shortbread biscuits and thank you card delivered to Companies House in Cardiff | £37.95 (£25 roses and £12.95 biscuits) | **Accepted:** Biscuits shared with the team. | 08/06/2026 |

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| Managing Director | FCS | Hospitality | 16/06/2026 | The Hackett Institute \| The Hackett | | Discount on ticket price to attend the Hackett Group Annual Conference - AI Breakthrough Conference, Convene 22 Bishopsgate. | £2,500 | **Accepted:** This conference provides early access to emerging technologies, trends, and regulatory developments that may not yet be widely published. It will inform organisational strategy and ensure the organisation remains aligned with future service delivery models and digital transformation priorities. | 17/06/2026 |

**LaRs – Legal and Risk Services; FCS – Finance and Corporate Services; POD – People, Organisational Development and Employment Services; SLE – Single Lead Employer.*

## 4. WELSH GOVERNMENT QUARTERLY UPDATE

On a quarterly basis, a letter is issued to the Director General for Health and Social Services at Welsh Government confirming any audit reports that have received limited or no assurance. During the reporting period, one internal audit was assessed as Limited Assurance; this was considered at the NWSSP Extraordinary Audit Committee on 15 June and will subsequently be reported to Welsh Government for Quarter 1 2026, in line with the established reporting process.

## 5. RECOMMENDATION

The Committee is asked to **NOTE** the report.

**APPENDIX A - NWSSP Contracting Activity Undertaken (1 April 2026 to 31 May 2026)**

Retrospective Non-Compliant Activity (2)

This is activity where departments have engaged suppliers directly without seeking Procurement involvement and, therefore, have incurred a direct breach of Standing Financial Instructions (SFIs).

| No. | Division/ Service | Procurement Ref No | Period | SFI Reference/ Compliance | Agreement Title/ Description | Supplier | Anticipated Agreement Value (ex VAT) | Reason/Circumstance/Issue | Procurement Action Required |
|---|---|---|---|---|---|---|---|---|---|
| 1. | Laundry | AC (NWSSP 26-27) 014 | One off 04/06/2026 | Retrospective non-compliant activity | 2 repairs with the same supplier additional costs on both combination total over £5,000 | Hazrem Environmental Ltd | £5,929.00 | Laundry Services commissioned repair works in December 2025, resulting in two invoices with a combined value of £5,928 (exc. VAT). The requirement was progressed without Procurement involvement and exceeded the threshold requiring procurement engagement. The activity took place prior to the Procurement Best Practice and Contract Management training sessions delivered to the division. | Procurement Services reviewed the activity and reminded the division of the applicable Standing Financial Instructions and procurement thresholds. Procurement Best Practice and Contract Management training was delivered to all Laundry on 13/05/2026 to improve awareness of procurement procedures and support future compliance. Guidance was also provided on available framework and contract options for future repair requirements. |
| 2. | Finance and Corporate Services | AC (NWSSP) 26-27) 015 | One off 10/06/2026 | Retrospective non-compliant activity | Re-certification audit | BSI Management Systems | £5,505.00 | A service requirement that historically incurred annual expenditure below £5,000 exceeded the procurement threshold during the reporting period. The services required were agreed with the supplier before a formal quotation was obtained and reviewed, resulting in the final cost only becoming known upon receipt of the invoice. Consequently, | A retrospective audit review was completed, and the end user was reminded of the requirement to obtain and review quotations before confirming services with suppliers. Guidance was provided on procurement engagement thresholds and the need to involve Procurement at the earliest opportunity where |

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| | | | | | | | | Procurement was not engaged prior to the commitment being made. | aggregate spend is expected to exceed £5,000, ensuring appropriate governance and compliance arrangements are in place. |

Please note the planned action regarding retrospective purchase orders (POs):

- The Procurement team will liaise with the relevant stakeholders to ascertain why orders are retrospective and agree the appropriate process, such as adding items to the Oracle catalogue or formalising a contract, to prevent recurrence.
- The Accounts Payable team has refreshed and relaunched the No PO No Pay Policy initiative with Procurement colleagues across the whole of NHS Wales. Letters have been issued from the Directors of Finance and Procurement to Oracle users and suppliers alike.
- The NWSSP Finance team is also reporting NWSSP retrospective POs as part of the monthly finance report to the Senior Leadership Group by division.

Contracts value breached/extended at risk as a result of emergency/unforeseen circumstances (0)

Report of Single Tender/Quotation Actions - Prospective (2)

| No. | Division/ Service | Procurement Ref No | Period | SFI Reference/ Compliance | Agreement Title/ Description | Supplier | Anticipated Agreement Value (ex VAT) | Reason/Circumstance/Issue | Procurement Action Required |
|---|---|---|---|---|---|---|---|---|---|
| 1. | Employment Services | SSP-SQA (2026/27) 5 | 22/06/26 - 21/06/28 | SQA | CIPP - Payroll diplomas | CIPP | £13,580.00 | Employment Services requires appropriately trained and qualified payroll staff to maintain the delivery of a comprehensive payroll service. The required qualification is the Payroll Diploma accredited by the Chartered Institute of Payroll Professionals (CIPP). As CIPP is the sole provider of this accreditation, competition was not possible and a Single Quotation Action (SQA) was approved to enable the training to proceed. | N/A |

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| 2. | Audit and Assurance Services | NWSSP-SQA (26-27) 13 | 29/09/26 - 30/09/26 | SQA | Chartered Institute of Internal Auditors (CIIA) Conference | Chartered Institute of Internal Auditors (CIIA) | £12,567.00 | Audit and Assurance Services require staff attendance at the Chartered Institute of Internal Auditors (IIA) Annual Conference on 29–30 September 2026 to support continuing professional development and maintain awareness of developments within the internal audit profession. A number of attendees are professional members of the Institute, and the event is organised exclusively by the professional body. As no alternative provider could deliver the same conference, a Single Quotation Action (SQA) was approved. | N/A |

Compliant Activity Delivered (17)

| No. | Division/ Service | Procurement Ref No | Period of Agreement | SFI Reference/ Compliance | Agreement Title/ Description | Supplier | Anticipated Agreement Value (ex VAT) | Reason/ Circumstance/ Issue | Procurement Action Required |
|---|---|---|---|---|---|---|---|---|---|
| 1. | Laundry Services | SSP-MIN-61495 | 11/05/26 - 10/05/30 (with the option to extend for a further 12 months) | Mini competition | NWSSP Laundry Linen Products | Interweave Textiles Limited | £3,144,000.00 | Mini Competition via the NHS Supply Chain framework Textiles and Associated Products Reference: 2021/S 163-430013. | N/A |
| 2. | Welsh Translation Services | NWSSP-FTS-59861 | 01/04/26 – 31/03/29 | Open tender | Provision of Translation Software | Phrase | £228,715.20 | Open tender | N/A |
| 3. | Laundry Services | SSP-RFQ-RA357620 | 01/06/26 - 31/08/26 (with the option to extend for a further 3 months) | Quotation | Interim NWSSP Supply of Laundry Services Machinery Parts | Maxi-Press DRM LTD | £24,000.00 | Quotation exercise via Multiquote portal | N/A |
| 4. | Laundry Services | SSP-DCO (26-27) 6 | One-off to be completed by 31/05/26 | Direct award | One Off NWSSP Laundry Linen Products (2) | Interweave Textiles Limited | £85,184.00 | Direct Award via the NHS Supply Chain framework Textiles and Associated Products | N/A |

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| | | | | | | | | Reference: 2021/S 163-430013 | |
| 5. | Pharmacy | SSP-DCO (26-27) 11 | One-off to be completed by 03/05/26 (with option to extend for a further 3 months) | Direct award | One Off Rental of Cleanroom Clothing Garments | Microncleanlimited | £15,000.00 | Direct award via East of England NHS Collaborative Procurement Hub 2022/S 000-008597 framework | N/A |
| 6. | Estates and Facilities | SSP-DCO (25-26) 229 | 14/04/26 -13/04/27 | Direct award | Provision of Insurance for Matrix House | Arthur J. Gallagher Insurance Brokers Limited | £8,624.82 | Direct award via RM6323 framework | N/A |
| 7. | Finance Academy | SSP-RFQ-RA357466 | One-off to be completed by 30/06/26 | Quotation | Finance Academy event June 26 | Venue Cymru | £10,837.00 | Quotation exercise via Multiquote portal | N/A |
| 8. | Supply Chain | SSP-RFQ-RA357748 | 08/06/26 - 07/06/27 (with option to extend for a further 24 months) | Quotation | Picketston Data Loggers Calibration Services | VQS LTD | £13,785.00 | Quotation exercise via Multiquote portal | N/A |
| 9. | Specialist Estates Services | SSP-RFQ-RA356873 | 15/05/26 - 14/05/27 | Quotation | Provision of Historic and Projected Building and FM Cost Indices for the UK Construction Industry | BCIS | £7,475.00 | Quotation exercise via Multiquote portal | N/A |
| 10. | Accounts payable | SSP-RFQ-RA356788 | 05/04/26 - 04/04/28 | Quotation | Bank verification system | Creditsafe | £15,900.00 | Quotation exercise via Multiquote portal | N/A |
| 11. | Planning, performance and informatics | SSP-RFQ-RA357197 | 01/11/26 - 30/11/29 | Quotation | Customer service excellence | Assessment services limited | £13,162.50 | Quotation exercise via Multiquote portal | N/A |
| 12. | Laundry Services | SSP-RFQ-RA358162 | One-off requirement to be completed by 31/08/26 | Quotation | Laundry Apprentice Training | Hayley Group Limited | £6,980.00 | Quotation exercise via Multiquote portal | N/A |
| 13. | Estates and Facilities | NWSSP-MIN-MULTIRA350474 | 08/06/26 - 30/06/26 | CCN | IP5 Sprinkler Servicing | Concept Fire Sprinklers Limited | £24,999.00 | Contract extension | N/A |
| 14. | Health Courier Services | SSP-MIN-62304 | 27/04/26 - 26/04/30 (with option to extend for further 12 months) | Mini competition | Tracking Device System for NWSSP Health Courier Services Vehicles | Terrafix Limited | £200,475.99 | Mini Competition via CCS Framework | N/A |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 15. | Supply Chain | NWSSP-MIN-MULTI RA352436 | 11/08/26 - 10/08/27 | CCN | Ad hoc electrical works (Bridgend) | Amberwell Engineering Services Limited | £24,999.00 | Contract extension | N/A |
| 16. | Legal & Risk | NWSSP – DCO (25-26) 29 | 27/05/26 - 26/05/27 | CCN | Provision of Extra Support for Legal services | Hill Dickinson LLP | £100,000.00 | Contract extension | N/A |
| 17. | Corporate Services | NWSSP-MIN-MULTIRA350474 | 01/05/26 – 22/07/26 | CCN | NWSSP Communications and Engagement Graphic Designer | Four Communications Limited | £9,000.00 | Contract extension | N/A |

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| **MEETING** | Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership |
| **DATE** | 07 July 2026 |
| **PREPARED BY** | Jonathan Irvine, Director of Procurement, Supply Chain, Logistics, Transport and Laundry Services |
| **PRESENTED BY** | Alison Ramsey, Director of Finance and Corporate Services |
| **TITLE OF REPORT** | Governance Matters - All Wales Contracting Activity |

**PURPOSE**

The aim of this paper is to provide the NWSSP Audit Committee with assurance on the governance, approval and oversight arrangements in place for All Wales contracting activity undertaken by NWSSP Procurement Services on behalf of NHS Wales organisations during the reporting period.

The paper also highlights the current position of contracts at briefing, Procurement Outcome Report and extension stages, including associated approval routes and any areas requiring continued monitoring or challenge.

## 1. NWSSP PROCUREMENT SERVICES ALL WALES CONTRACTING ACTIVITY

Since the last report prepared for the NWSSP Audit Committee, and based on the position as at 16 June 2026, **four** new contracts are at briefing stage and **four** have progressed to Procurement Outcome Report stage. In addition, **six** contract extensions have been utilised. This provides assurance that the relevant activity has continued to be progressed through the established governance and approval routes. A summary of the activity for the period is set out in **Appendix A**.

"All Wales" contracting activity, also referred to as national procurement activity, is undertaken by NWSSP Procurement Services on behalf of all participating NHS Wales organisations, including Health Boards, Trusts and Special Health Authorities. For the purposes of "All Wales" procurements, Velindre University NHS Trust is named as the Contracting Authority, reflecting the lead procurement role undertaken by NWSSP Procurement Services in establishing the contract. Approvals for "All Wales" contracts are sought and obtained through each participating NHS Wales organisation's own governance arrangements prior to Welsh Government approval or noting, where required, and the subsequent final award of contract. These local organisational approvals include Velindre University NHS Trust where it is a participant in an "All Wales" contract.

Upon establishment of an "All Wales" contract, each NHS Wales organisation will enter into its own contract with the contractor through a "draw down" contract and/or through the issuing and receipt of purchase orders. This combination of NHS Wales organisational input into the establishment of the "All Wales" contract, and each organisation's role in operating the contract following award, means that operational and delivery risk sits significantly with the participating organisations and the contractor(s) throughout the life of the contract. The "All Wales" contract acts as the vehicle through which NHS Wales organisations access and operate the agreed arrangements.

To provide further clarity, the "Procurement Stage" referred to as "Briefing" within Appendix A is a pre-notification of the intention to commence a procurement in order to establish a contract for the goods or services described. Following approval by the NWSSP Director of Procurement Services, the briefing paper is issued to Welsh Government for noting for contracts valued at £1 million and over.

The "Procurement Stage" referred to as "Procurement Outcome Report" (POR) within Appendix A is the post-procurement stage at which approval is sought for the contract to be awarded. The POR contains details of the procurement process undertaken, in line with the plan outlined in the briefing Paper, and the proposed award details. The POR is approved by the NWSSP Director of Procurement Services, Welsh Government for contracts valued at £500,000 or above, the NWSSP Managing Director for contracts valued at £750,000 and over, and the NWSSP Chair for contracts valued at £1 million and over.

Welsh Government Approval Timescales Update

A slight improvement in the timeliness of Welsh Government approvals has been observed during the reporting period. However, the process continues to exceed the target of 15 working days in a number of cases, with some approvals taking significantly longer. This remains an area for continued monitoring and challenge, particularly where approval delays may affect procurement timelines, contract commencement dates or continuity of supply.

The Committee may wish to note that several high-value items remain awaiting Welsh Government approval, and continued oversight will be required to ensure that any delays do not adversely affect procurement timelines, contract commencement dates or continuity of service.

## 2. RECOMMENDATION

The Committee is asked to **NOTE** the All Wales contracting activity outlined in **Appendix A** and the associated approval routes applied during the reporting period.

**APPENDIX A - All Wales Contracting Activity (01 April 2026 to 16 June 2026)**

The table below provides the current position of contracting activity during the period January 2026 to March 2026 in respect of contracts reported to the previous meeting of the Committee.

| No | Contract Title | Total Value | Proc Services Director approval | WG approval >£500k | NWSSP Managing Director approval >£750k | NWSSP Chair Approval >£1m |
|---|---|---|---|---|---|---|
| **BRIEFINGS** | | | | | | |
| 1. | **AW culture media & associated consumables**<br>Culture media is a primary consumable used extensively in microbiology across Wales, encompassing both clinical laboratories and food, water, and environmental (FWE) testing laboratories. Its purpose is to provide the optimal conditions required for the growth of microorganisms, enabling their identification.<br>*Anticipated contract start: 01/08/2026 – 31/7/2030 (+ 2 years extension)* | £8,809,170 | 09/10/2025 | Sent to Welsh Government 09/10/2025 | N/A at this stage | N/A at this stage |
| 2. | **AW Continence Products**<br>The current contract covers the supply and delivery of disposable and washable (reusable) continence products to Secondary Care and Primary Care patients.<br>*Anticipated contract start: 01/07/2026 (+1 year extension)* | £46,000,000 | 09/10/25 | Sent to Welsh Government 09/10/2025 | N/A at this stage | N/A at this stage |
| 3. | **Enteral Feeding Service**<br>The contract consists of enteral feeding products, ancillaries and consumables along with associated pumps. The service is provided within secondary and community care settings and provides a home delivery service for patients. There is also a need within Welsh Prisons when required for care of inmates.<br>*Anticipated contract start 01/03/2027 – 30/04/2031 (+3 year extension)* | £62,113,772 | 13/10/2025 | Sent to Welsh Government 13/10/2025 | N/A at this stage | N/A at this stage |
| 4. | **Printed Forms**<br>There are currently 39 All-Wales forms available throughout the Health Boards and Trusts, these include consent forms and patient medical charts amongst many other health-related forms. The purpose of the documents is to record patient data, which is a fundamental component to the successful operational services that NHS Wales provide to the wider public.<br>*Anticipated contract start 01/04/2026 – 31/03/2030 (+1 year extension)* | £1,523,168 | 29/10/2025 | 13/05/2026 | N/A at this stage | N/A at this stage |
| 5. | **Supply of Wheelchairs, Associated Parts and Accessories**<br>The framework was separated into lots, powered and non-powered adult wheelchairs, paediatric wheelchairs and buggies, each lot included all associated accessories and spare parts.<br>*Anticipated contract start 01/01/2027 - 31/12/2030 (+2 year extension)* | £27,914,315 | 06/11/2025 | Sent to Welsh Government 06/11/2025 | N/A at this stage | N/A at this stage |
| 6. | **Provision of Part Time Distance Learning Nursing education (Adult, Child, Mental Health, and Learning Disabilities)** | £24,792,480 | 03/12/2025 | sent to WG 4/12/25. | N/A at this stage | N/A at this stage |

| | | | | | | |
|---|---|---|---|---|---|---|
| | To deliver degree-level part-time nursing education for employed NHS Wales staff across all four nursing fields: adult, child, mental health, and learning disabilities. *Anticipated contract start 01/08/2027 – 31/07/2029 (+3 year extension)* | | | | | |
| 7. | **Ustekinumab** Ustekinumab is used for multiple indications across gastroenterology, dermatology and rheumatology and is available as a subcutaneous injection and as an intravenous infusion. Pre-filled pens are available for ease of patient administration, with these being available from the originator manufacturer from 2023 and other manufacturers from 2025. *Anticipated contract start 01/10/2026 – 30/06/2028 (+1 year extension)* | £9,489,300 | 09/12/2025 | sent to WG 9/12/25. | N/A at this stage | N/A at this stage |
| 8. | **AW Endoscopy consumables** to support Endoscopy Units across Wales and promote clinical collaboration and standardisation across services. The NEP have identified standardisation opportunities for the following Endoscopy Consumables: Snares, Forceps, Clips, Needles, Knives and for the following processes: Decontamination Pathways; Procurement Procedures; Capital Expenditure Planning; *Anticipated contract start 01/06/2026 to 31/05/2029 (+2 year extension)* | £30,000,000 | 06/02/2026 | sent to WG 6/2/26. | N/A at this stage | N/A at this stage |
| 9. | **Spinal Implants & Consumables Framework** Covering all spinal products used across Wales, including consumables, biologics, and implants. This approach ensures continuity of supply, comprehensive coverage, compliance with procurement legislation, flexibility for Health Boards, and clinical choice. *Anticipated contract start**:** 01/07/2026 to 30/06/2030* | £20,000,000 | 03/03/2026 | sent to WG 3/3/26. | N/A at this stage | N/A at this stage |
| 10. | **All Wales Digital Cellular Pathology Framework** will comprise scanners, image viewing and reporting software, and image storage. Storage will transition from "hot" rapid-access storage to lower cost "cold" storage after a defined period. All elements will be delivered under a single Managed Service Contract (MSC), with one supplier responsible for all subcontracted components and serving as the single point of contact for Health Boards. *Anticipated contract start: 01/12/2026 – 30/11/2030 (Framework), 01/01/2027 – 31/12/2033 up to 31/12/2035 (Call off Contract per HB)* | £27,000,000 | 04/03/2026 | sent to WG 4/3/26. | N/A at this stage | N/A at this stage |
| **PROCUREMENT OUTCOME REPORTS** | | | | | | |
| 1. | **Printed Forms** Health Boards, Trusts and Special Health Authorities across NHS Wales are reliant on the availability and access of various printed forms which are crucial to maintaining service continuity. There are currently 39 All-Wales forms available *Anticipated contract start; once fully approved (June 2026 )- 31/03/2030 (+1 year extension)* | £1,250,253 | 18/03/2026 | 13/05/2026 | 13/05/2026 | 04/06/2026 |
| 2. | **Laundry Linen Products** the provision, replacement, and procurement of linen products as required. This includes the ongoing replenishment of stock, replacement of damaged or non-compliant items, and the purchase of new linen products to meet evolving service demands across NHS Wales Organisations *Anticipated contract start 01/05/2026 – 23/04/2030 (+1 yr extension)* | £4,716,000 | 30/03/2026 | 27/04/2026 | 28/04/2026 | 29/04/2026 |

The following table shows new contracting activity, not previously reported to the Committee, that occurred during the period 1 April 2026 to 16 June 2026:

## Contract Briefing Papers

| No | Contract Title | Total Value | Proc Services Director approval | WG approval >£500k |
|---|---|---|---|---|
| 1. | **General Medical Consumables**<br>The products that sit within the General Medical Consumables category area have a variety of functions and are used widely within the NHS across a range of departments.<br>*Anticipated contract start – 01/11/2026 – 31/10/2030* | £5,496,256 | 31/03/2026 | Sent to Welsh Government 07/04/2026; awaiting approval |
| 2. | **Transitional Drugs 7**<br>Medicines which are all shortly due to lose their patent exclusivity (or have previously lost their exclusivity) and therefore will have competition available in the UK.<br>*Anticipated contract start – 01/07/2026 – 30/06/2028 (+2 yr extension)* | £53,566,932 | 09/04/2026 | 08/06/2026 |
| 3. | **Collection and Disposal of Clinical Waste**<br>Management of clinical waste from the point of collection at NHS premises through to disposal.<br>*Anticipated contract start – 01/04/2027 – 31/03/2031 (+4 yr extension)* | £71,829,296 | 12/05/2026 | Sent to Welsh Government 12/05/2026; awaiting approval |
| 4. | **AW Independent Mental Capacity Advocacy (IMCA)**<br>Service provides support to individuals who lack capacity to make certain decisions. The IMCA is not limited to a mental health diagnosis or individuals within a hospital setting – its scope is broad and extends across various contexts.<br>*Anticipated contract start – 01/01/2027 – 31/12/2028 (+3 yr extension)* | £8,426,550 | 07/05/2026 | 04/06/2026 |

## Contract Award (Procurement Outcome Report) Papers

| No | Contract Title | Total Value | Proc Services Director approval | WG approval >£500k | NWSSP Managing Director approval | NWSSP Chair Approval |
|---|---|---|---|---|---|---|
| 1. | **Maintenance Of Olympus Endoscopes and Electromedical Equipment**<br>This is a continuation of the current agreement that exists for this requirement, ensuring continued service is provided in line with OEM standards. This award is to be considered a Direct Call Off without competition to the incumbent supplier, Olympus-Keymed Limited via the NHS Supply Chain Framework for Maintenance, Repair and Calibration of Medical Equipment.<br>*Anticipated contract start 20/4/2026 – 31/03/2028* | £5,059,877 | 31/03/2026 | NA Direct Award. | 07/04/2026 | 13/04/2026 |
| 2. | **Fleet Replacement and Conversions**<br>Supply of seventeen (17) Light Commercial Vehicles (LCVs) to support the ongoing Fleet Modernisation Programme using the TPPL Framework – Cars, Light and Medium Commercial Vehicles - Lot 2: Light Commercial Vehicles up to 5t.<br>*Anticipated contract start 01/05/2026 – 31/03/2027* | £991,638 | 17/04/2026 | NA Direct Award. | 28/04/2026 | 29/04/2026 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 3. | **Pre-Registration Nursing Education & Training Services SEW**<br>Delivery of full-time pre-registration adult and mental health nursing education and training (BSc/BN and MSc/PGDip) in the South East Wales region.<br>*Anticipated contract start 01/08/2026 – 31/07/2030 (+2 yr extension)* | £34,461,000 | AS 05/06/26 | Sent to Welsh Government 05/06/2026; awaiting approval | | |
| 4. | **Transitional Drugs 7**<br>Supply of Eculizumab; Ferric Carboxymaltose; Icatibant; Omalizumab; Nintedanib; Tocilizumab medicines which have recently lost patent exclusivity resulting in the availability of generic and biosimilar medicines.<br>*Anticipated contract start 01/07/2026 – 30/06/2028 (+2 yr extension)* | £16,804,001 | CS 08/06/26 | 08/06/2026 | 08/06/2026 | 08/06/2026 |

## Contract Extensions

| No | Contract Title | Total Value | Proc Services Director approval | WG approval >£500k | NWSSP Managing Director approval | NWSSP Chair Approval |
|---|---|---|---|---|---|---|
| 1. | **Occupational Health**<br>Occupational Health software to provide a web-based software solution to manage the Occupational Health services within NHS Wales with the aim of streamlining process, documentation, and management of Occupational Health records across NHS Wales.<br>*Contract term: 21/06/2023 - 20/06/2026 Extension 21/06/2026 - 20/06/2028.* | £945,844 | 08/04/2026 | Original approval applies 23/09/22. | 09/04/2026 | N/A. |
| 2. | **Transitional Drugs 3**<br>medicines which had recently lost exclusivity and had generic or biosimilar competition available for the first time. This contract included: - Eculizumab; Icatibant; Omalizumab; Tocilizumab; Amphotericin Liposomal B; Liraglutide; Natalizumab; Pomalidomide; Thalidomide<br>*Contract Term 01/04/2025 – 30/06/2026 Extension 01/07/2026 – 30/06/2027.* | £8,447,910 | 17/04/2026 | original approval applies 9/4/25. | 17/04/2026 | 21/04/2026 |
| 3. | **Erythropoietin Stimulating Agents & Iv Iron**<br>Erythropoietin Stimulating Agents (ESA) are structurally and biologically similar to naturally occurring protein erythropoietin. Clinicians prescribe ESAs to maintain haemoglobin at the lowest level that both minimises transfusions and best meets individual patient needs. IV iron is necessary to treat iron deficiency in patients who are receiving ESA treatment.<br>*Contract Term – 01/10/2023 to 30/09/2026 Extension – 01/10/2026 – 30/09/2027.* | £20,092,264 | 22/04/2026 | Original approval applies 14/07/2023 | 22/04/2026 | 22/04/2026 |
| 4. | **Junior Doctor E-Rota Monitoring Solution**<br>A cloud-based software solution to assist Health Boards/Trusts in NHS Wales to plan and monitor their Resident Doctors' rotas and rosters in line with the European Working Time Directive (EWTD) and New Deal, supporting exception reporting and including the potential for a self-rostering programme.<br>*Contract Term 01/08/2024 – 31/07/2026 Extension 01/08/2026 – 31/07/2027.* | £800,233 | 06/05/2026 | NA Direct Award (approval 21/7/24). | 06/05/2026 | N/A. |

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|---|---|---|---|---|---|---|
| 5. | **Generic Drugs - Tablets & Capsules**<br>Includes 636 lines across a range of therapy areas such as Chemotherapy, Arthritis, Heart Disease and Analgesics.<br>*Contract Term – 01/02/2024 to 31/01/2027 Extension – 01/02/2027 to 31/01/2028.* | £14,768,878 | 27/05/2026 | Original approval applies 19/12/2023 | 28/05/2026 | 04/06/2026 |
| 6. | **Generic Anti-Infective Drugs**<br>This tender will include antibacterial and antifungal drugs.<br>*Contract Term – 01/02/2024 to 31/01/2027 Extension – 01/02/2027 to 31/01/2028.* | £18,076,714 | 27/05/2026 | Original approval applies 26/01/2024 | 28/05/2026 | 04/06/2026 |

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| **MEETING** | Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership |
| **DATE** | 7 July 2026 |
| **PREPARED BY** | James Quance, Assistant Director of Corporate Services |
| **PRESENTED BY** | James Quance, Assistant Director of Corporate Services |
| **RESPONSIBLE HEAD OF SERVICE** | Alison Ramsey, Director of Finance and Corporate Services |
| **TITLE OF REPORT** | NWSSP Risk Management Protocol |

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| **PURPOSE OF REPORT**<br>To request the Audit Committee to re-approve the Risk Management Protocol. |

## 1. INTRODUCTION

The Risk Management Protocol (the Protocol) is presented at **Appendix 1** for information. The Protocol provides guidance to NWSSP in interpreting and applying the principles of the Velindre University NHS Trust risk management policy. The Protocol requires regular review and biennial approval by the Audit Committee and was last approved at the June 2021 meeting.

## 2. SUMMARY OF AMENDMENTS

The Protocol in Appendix 1 contains tracked changes in order for the Audit Committee to see all amendments following recent review. The amendments can be summarised as:

- updates to titles, updating for current operating arrangements and other minor amendments;
- inclusion of reference to programme/project management arrangements;

- update to include the risk scoring framework in alignment with the Trust policy, tailored for the NWSSP business; and
- inclusion of reference to the approach to risk appetite.

## 3. RECOMMENDATION

The Audit Committee is asked to:

- **APPROVE** the updated Risk Management Protocol.

# RISK MANAGEMENT PROTOCOL

RISK MANAGEMENT PROTOCOL

JulyApril 20264

## STATEMENT OF INTENT

*NWSSP is committed to ensuring that the management of risk throughout the organisation is consistent and effective.*

**NHS Wales Shared Services Partnership (NWSSP) Statement**

NWSSP:

- is committed to achieving and maintaining the highest standards of managerial practices that maximise and progress service benefits.
- recognises that effective risk management is a key component of corporate governance and is critical to achieving the strategic objectives of the organisation.
- continues to embed the risk management process by ensuring staff recognise the principles that "risk management is everyone's business," and encourage them to report any hazards, risks, incidents and near misses within their working activities or environment.
- recognises the importance of continuing to promote a culture of honesty and openness when dealing with a breakdown/failure in a system or individual error/mistake. NWSSP is committed to investigating system failures and or individual errors to establish the underlying causes.
- seeks to ensure that risks and incidents are identified and managed in a positive and constructive manner, so that lessons learned are shared across the organisation.
- acknowledges that effective risk management allows managers and staff to respond to opportunities and to take appropriate risks on behalf of the organisation with greater confidence of a successful outcome.

**Introduction**

NWSSP seeks to integrate the risk management process by having a single clear systematic approach. R~~Therefore r~~isk management is not seen as a separate function but is an integral part of the day-to-day

management activities of the organisation including financial, health and safety and environmental functions.

It is the aim of NWSSP to assess and control the risks which threaten or compromise its ability to fulfil its aims and objectives. Risk Management should be able to provide a suitable framework from within which staff can manage risks potentially facing the organisation in a consistent and meaningful way. This protocol sets out a framework, which identifies the risk management arrangements for the organisation.

**Background**

This protocol is intended to complement the Velindre University NHS Trust strategy by establishing a comparable framework around which NWSSP will manage risks potentially facing the organisation. It is the intention that this will provide a framework which enables NWSSP to define its risk management arrangements.

**Purpose**

The purpose of this protocol is to provide a clear systematic approach to the management of risk within NWSSP. The protocol will define the way in which NWSSP will continue to embed the risk management process across the whole organisation whilst taking note of the various requirements of external agencies and statutory bodies.

**Aims**

NWSSP has a clear commitment to operate high standards of governance and internal control and will aim to minimise and contain any costs or consequences that may arise in the event of an incident occurring. NWSSP is committed to the following aims and objectives:

- A clear commitment to operate to the highest standards of governance and internal control through the adoption of Risk Management Policy and regular reporting of risk management issues to the ~~NWSSPC~~Shared Services Partnership Committee (SSPC);

- Provide evidence that NWSSP is making every effort to meet the objectives set within the protocol and will, in doing so, protect staff, the public and other stakeholders against risks of all kinds;

- To inform the SSPC about significant risks within the organisation for which they are responsible;

- Assist staff and the SSPC to identify risks, determine unacceptable levels of risk, and decide on where best to direct limited resources to eliminate or reduce those risks;

- Promote risk management awareness at all levels of the organisation;

- Develop, establish, and implement an infrastructure and arrangements to ensure that managing risk becomes an integral part of the planning and management processes and general culture of the organisation;

- Ensure that NWSSP adopts best practice and achieves the highest standards of risk management;

- Manage risk in a positive but not punitive way as an opportunity to learn and improve systems in practice;

- Increase public confidence in the quality of service provided with the NHS; and

- Enable NWSSP to effectively meet its key objectives.

**Objectives**

NWSSP will:

- Ensure a safe environment for staff to work in;

- Improve business performance by informing and improving decision making and planning;

- Continue to promote a single consistent approach to risk management across NWSSP;

- Ensure clear lines of accountability and responsibility for risk management exist;

- Ensure adequate risk reporting structures are in place across the whole organisation that provide assurance to the SSPC;

- Develop and promote the risk management escalation process;

- Ensure effective processes are in place to achieve staff compliance with statutory, mandatory, and professional standards;

- Encourage open and honest reporting of hazards, risks, and incidents and near misses;

- Ensure that risks and incidents identified are managed in a positive and constructive manner, so lessons learned are shared;

- Promote a culture where innovation is encouraged; and

- Provide a sound basis for integrated risk management and internal control as components of good corporate governance.

**Organisational Arrangements and Responsibilities**

NWSSP is a large and complex organisation ~~with over 5,000 employees~~. The Managing Director, NWSSP is ~~ultimately~~ accountable for ensuring that ~~risk is managed adequately~~risks to the achievement of the Shared Services objectives and fulfilment of its responsibilities are identified, that the significance is assessed, and that a sound system of internal control is in place to manage them.~~,~~

~~a~~Although there are levels of responsibility throughout the structure to ensure effective risk management. However, day-to-day implementation thereof is delegated to the Director of Finance and Corporate Services of NWSSP, who is assisted in this role by the ~~Head of Finance and Business Development~~Assistant Director of Corporate Services and the Corporate Services Team.

It is the responsibility of each of the Directors, Assistant Directors, and Heads of Service to ensure that risk is addressed at each of the locations relevant to their Directorates and that an effective feedback mechanism operates through NWSSP such that corporate and significant/critical risks are reported and discussed at NWSSP Senior Leadership Group (SLG) meetings.

All employees individually and collectively have a responsibility for risk management with the identification of risks and the reporting of incidents and near misses being encouraged.

Staff should:

- Report risks, incidents and hazards using the appropriate reporting procedure;

- Be aware of their legal duty to take care of their own health and safety and the safety of others affected by their work activities;

- Attend statutory and mandatory training in line with NWSSP requirements;

- Act in accordance with the training and instruction provided by NWSSP; and

- Comply with the Velindre University NHS Trust Risk Management strategy and NWSSP Protocol supporting health and safety policies and procedures.

**~~Head of Finance and Business Development~~Assistant Director of Corporate Services**

The NWSSP ~~Head of Finance and Business Development~~Assistant Director of Corporate Services will provide advice and guidance on risk management related functions across NWSSP. The post holder will also support the development and implementation of a standard overarching risk management framework.~~ This includes the coordination of risk assessments, risk registers, assurance maps and development and maintenance of the risk management system. ~~and its modules.~~

**Third Party Risks**

Hazards and risks may be identified which are not within the ability of NWSSP to control or manage, such as building or facilities management issues which are instead the responsibility of another NHS Wales organisation. The arrangements of NWSSP will be such that it is a requirement on its officers to bring such matters to the attention of the organisation controlling that building or service at the earliest possible opportunity. Such action should always be the subject of a written report to the Director of Finance and Corporate Services of NWSSP.

**Risk Management Framework**

The organisational framework for Risk Management is controlled ~~through the establishment of various Committees~~by the SLG.~~. The Committees~~ SLG members are responsible for ensuring that risks that fall under their remit are reviewed and where significant risks are identified, these are appropriately escalated. Risks are also monitored through programme, project and working groups that provide additional opportunity to discuss, assess and escalate risks accordingly. See Annex 1 for the structure.

**Risk Identification, Assessment & Management**

NWSSP will embed processes to ensure that risk is identified, assessed, and managed.

**Identification of Risks**

NWSSP will identify risks both by proactive and reactive methods. These will be managed proactively on an NWSSP Corporate Risk Register, supported by risk registers in each directorate which will be

maintained by all nominated individuals assessing the risks which exist in their service area.

Corporately, all papers for decision and noting presented to the SSPC, the Velindre University NHS Trust Audit Committee for Shared Services (the Audit Committee) and SLG meetings must contain a section on identified risks contained in the paper presented and how they will be managed. The Director of Finance and Corporate services will be responsible for reviewing the risks raised in papers and ensuring they are added where appropriate to the Corporate Risk Register.

Reactively, risks will become apparent from a number of sources including complaints, claims, losses, and internal and external audit. Adverse incidents are also an important information source. It is crucial that all incidents are reported and investigated through the Incident Reporting Procedure (Datix). Any trends identified will be recorded as risks along with the corresponding actions to mitigate them.

**Risk Assessment Process**

Risk assessment within NWSSP is a structured process used to understand the nature and scale of risks that may impact the delivery of organisational objectives. Once a risk has been identified, it must be clearly described in a consistent format in the required template that sets out the cause, event, and consequence to ensure a shared understanding. The risk is then assessed using the agreed risk matrix by considering both the potential impact (severity) and the likelihood of occurrence, generating an initial (inherent) risk score. This provides a consistent basis for evaluating the significance of risks and prioritising management attention across services.

Following initial assessment, existing controls are identified and evaluated to determine how effectively the risk is currently being managed. This enables a revised (residual) risk score to be calculated, reflecting the level of risk after controls are applied. The risk is then considered against the organisation's risk appetite to determine whether further action is required. Where necessary, additional mitigating actions are identified to reduce the risk to an acceptable level, with a target score assigned to reflect the intended level of control once those actions are complete. All elements of the assessment must be appropriately recorded to support consistency, transparency, and ongoing review.

~~A formal risk assessment is required for all risk assessments that are held on the Datix system. See Annex 2.~~

~~The basic steps within the risk assessment process are:~~

- ~~Identify the hazard(s);~~

- ~~Assess who and what might be affected, and how;~~
- ~~Evaluate the risks and decide whether existing precautions are adequate or should more be done;~~
- ~~Record the findings;~~
- ~~Monitor and review the risks and any resulting further actions; and~~
- ~~Communicate and consult.~~

**Risk Register**s

The Risk Register**s** contain~~s~~ an overview of the identified risks, the controls already in place to manage the risks, and any actions that have been identified to further mitigate the risks. The format for the Risk Register**s** has been agreed by the SLG and the Audit Committee. All risk registers presented to any committee or sub-group will follow this agreed format.~~–~~ It is important that this format is implemented at all levels to ensure consistency is achieved across NWSSP.

Risks are scored within the Register as follows:

- ***Inherent (or Gross) Risk Score*** – evaluation of the risk without consideration of any current or future controls or actions to mitigate it;

- ***Residual (or Current) Risk Score*** – evaluation of the risk as at today (i.e. taking into account current controls and mitigations, but **not** any further actions that are yet to be undertaken); and

- ***Target Risk Score*** – where the risk score should be once planned actions have been completed. (This should be a realistic rather than an aspirational assessment).

All risks identified will be assessed using the following matrices (in accordance with the Velindre University NHS Trust Risk ~~Policy~~Management Policy) which consider the likelihood of the risk occurring and the resulting severity.

Where a risk meets its target score this does not automatically mean that is should be de-escalated and removed from the risk register because there may be the need to take further action to continue to manage the risk at the target level.

**Risk Quantification – MATRIX**

**Simple risk quantification is identified by multiplying the Impact X Likelihood = Risk Rating. This impact matrix below has been developed by the NPSA (National Patient Safety Agency) and is adopted by Velindre University NHS Trust with relevant amendments for NWSSP to recognise that NWSSP does not provide patient care or clinical services to patients.**

| | ~~LIKELIHOOD DESCRIPTION~~ |
|---|---|
| ~~5 Almost Certain~~ | ~~Likely to occur, on many occasions~~ |
| ~~4 Likely~~ | ~~Will probably occur, but is not a persistent issue~~ |
| ~~3 Possible~~ | ~~May occur occasionally~~ |
| ~~2 Unlikely~~ | ~~Not expected it to happen, but may do~~ |
| ~~1 Rare~~ | ~~Can't believe that this will ever happen~~ |

| | **Impact, Consequence score (severity levels) and examples** | | | | |
|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** |
| **Domains** | **Negligible** | **Minor** | **Moderate** | **Major** | **Catastrophic** |
| **Impact on the safety of patients, staff or public (physical/psychological harm)** | Minimal injury requiring no/minimal intervention or treatment.<br><br>No time off work | Minor injury or illness, requiring minor intervention<br><br>Requiring time off work for >3 days | Moderate ~~injury requiring~~injury requiring professional intervention<br>Requiring time off work for 4-14 days<br><br>RIDDOR/agency reportable incident<br>An event which impacts on a small number of patients | Major injury leading to long-term incapacity/disability<br><br>Requiring time off work for >14 days<br><br>Mismanagement of patient care with long-term effects | Incident ~~leading to~~leading to death<br><br>Multiple permanent injuries or irreversible health effects<br><br>An event which impacts on a large number of patients |
| **Quality/complaints/audit** | Peripheral element of treatment or service suboptimal<br><br>Informal complaint/inquiry | Overall treatment or service suboptimal<br><br>Formal complaint (stage 1) Local resolution<br><br>Single failure to meet internal standards<br><br>Minor implications for patient safety if unresolved | Treatment or service has significantly reduced effectiveness<br>Formal complaint (stage 2) complaint<br><br>Local resolution (with potential to go to independent review)<br>Repeated failure to meet internal standards<br>Major patient safety implications if findings are not acted on | Non-compliance with national standards with significant risk to patients if unresolved<br><br>Multiple complaints/ independent review<br><br>Critical report | Totally unacceptable level or quality of treatment/service<br><br>Gross failure of patient safety if findings not acted on<br><br>Inquest/ombudsman inquiry<br><br>Gross failure to meet national standards |
| **Human resources/ organisational development/staffing/ competence** | Short-term low staffing level that temporarily reduces service quality (< 1 day) | Low staffing level that reduces the service quality | Late delivery of key objective/ service due to lack of staff<br><br>Unsafe staffing level or competence (>1 day)<br><br>Low staff morale<br><br>Poor staff attendance for mandatory/key training | Uncertain delivery of key objective/service due to lack of staff<br><br>Unsafe staffing level or competence (>5 days)<br><br>Loss of key staff<br>Very low staff morale<br>No staff attending mandatory/ key training | Non-delivery of key objective/service due to lack of staff<br><br>Ongoing unsafe staffing levels or competence<br><br>Loss of several key staff<br>No staff attending mandatory training /key training on an ongoing basis |
| **Statutory duty/ inspections** | No or minimal impact or breach of guidance/ statutory duty | Breach of statutory legislation<br><br>Reduced performance rating if unresolved | Single breach in statutory duty<br><br>Challenging external recommendations/ improvement notice | Enforcement action<br><br>Multiple breaches in statutory duty<br><br>Improvement notices<br>Critical report | Multiple breaches in statutory duty<br><br>Prosecution<br>Complete systems change required<br>Severely critical report |
| **Adverse publicity/ reputation** | Rumours<br><br>Potential for public concern | Local media coverage – short-term reduction in public confidence<br><br>Elements of public expectation not being met | Local media coverage – long-term reduction in public confidence | National media coverage with <3 days service well below reasonable public expectation | National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)<br>Total loss of public |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | confidence |
| **Business objectives/ projects** | Insignificant cost increase/ schedule slippage | <5 per cent over project budget<br><br>Schedule slippage | 5–10 per cent over project budget<br><br>Schedule slippage | Non-compliance with national 10–25 per cent over project budget<br>Schedule slippage<br>Key objectives not met | Incident leading >25 per cent over project budget<br><br>Schedule slippage<br>Key objectives not met |
| **Finance including claims** | Small loss<br>Risk of claim remote | Loss of 0.1–0.25 per cent of budget<br><br>Claim less than £10,000 | Loss of 0.25–0.5 per cent of budget<br><br>Claim(s) between £10,000 and £100,000 | Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget<br><br>Claim(s) between £100,000 and £1 million | Non-delivery of key objective/ Loss of >1 per cent of budget<br><br>Failure to meet specification/ slippage<br><br>Loss of contract / payment by results<br>Claim(s) >£1 million |
| **Service/business interruption**<br>**Environmental impact** | Loss/interruption of >1 hour<br><br>Minimal or no impact on the environment | Loss/interruption of >8 hours<br><br>Minor impact on environment | Loss/interruption of >1 day<br><br>Moderate impact on environment | Loss/interruption of >1 week<br><br>Major impact on environment | Permanent loss of service or facility<br><br>Catastrophic impact on environment |

## Likelihood – MATRIX

| LIKELIHOOD (*) | | | | | |
|---|---|---|---|---|---|
| LIKELIHOOD SCORE | 1 | 2 | 3 | 4 | 5 |
| DESCRIPTOR | RARE | UNLIKELY | POSSIBLE | PROBABLE | EXPECTED |
| Frequency:<br>How often might it/ does it happen? | Not expected to occur for 10 years | Expected to occur at least annually | Expected to occur at least monthly | Expected to occur at least weekly | Expected to occur at least daily |
| Probability:<br>Will it happen or not? | Less than 0.1% chance | 0.1 - 1% chance | 1 - 10% chance | 10 - 50% chance | Greater than 50% chance |

## Risk Rating Matrix- Impact X Likelihood

| RISK MATRIX | LIKELIHOOD (*) | | | | |
|---|---|---|---|---|---|
| CONSEQUENCE (**) | 1 - Rare | 2 - Unlikely | 3 - Possible | 4 - Probable | 5 - Expected |
| 1 - Negligible | 1 | 2 | 3 | 4 | 5 |
| 2 - Minor | 2 | 4 | 6 | 8 | 10 |
| 3 - Moderate | 3 | 6 | 9 | 12 | 15 |
| 4 - Major | 4 | 8 | 12 | 16 | 20 |
| 5 - Catastrophic | 5 | 10 | 15 | 20 | 25 |

~~**Risk Rating Matrix = Impact x likelihood**~~

| LIKELIHOOD (*) | |
|---|---|
| LIKELIHOOD SCORE | |
| DESCRIPTOR | |
| Frequency: How often might it/ does it happen? | Not occur |
| Probability: Will it happen or not? | Less tha |

| RISK MATRIX | |
|---|---|
| CONSEQUENCE (**) | |
| 1 - Negligible | |
| 2 - Minor | |
| 3 - Moderate | |
| 4 - Major | |
| 5 - Catastrophic | |

~~LIKELIHOOD~~

| ~~IMPACT~~ | ~~Certain~~ ~~5~~ | ~~Likely~~ ~~4~~ | ~~Possible~~ ~~3~~ | ~~Unlikely~~ ~~2~~ | ~~Rare~~ ~~1~~ |
|---|---|---|---|---|---|
| ~~5 Catastrophic~~ | ~~25~~ | ~~20~~ | ~~15~~ | ~~10~~ | ~~5~~ |
| ~~4 Major~~ | ~~20~~ | ~~16~~ | ~~12~~ | ~~8~~ | ~~4~~ |
| ~~3 Moderate~~ | ~~15~~ | ~~12~~ | ~~9~~ | ~~6~~ | ~~3~~ |
| ~~2 Minor~~ | ~~10~~ | ~~8~~ | ~~6~~ | ~~4~~ | ~~2~~ |
| ~~1 Insignificant~~ | ~~5~~ | ~~4~~ | ~~3~~ | ~~2~~ | ~~1~~ |

~~Actions and Treatment Timetable~~

| ~~Risk Score~~ | ~~Risk Level~~ | ~~Action and Timescale~~ |
|---|---|---|
| ~~1-3~~ | ~~LOW~~ | ~~No action required providing adequate controls in place.~~ |
| ~~4-6~~ | ~~MODERATE~~ | ~~Action required to reduce/control risk within 12-month period~~ |
| ~~8-12~~ | ~~SIGNIFICANT~~ | ~~Action required to reduce/control risk within 6-month period~~ |
| ~~15-25~~ | ~~CRITICAL~~ | ~~Immediate action required by Senior Management~~ |

## Management of Risk

### *Roles and Responsibilities*

- **Senior Leadership Group (SLG) -** The SLG is accountable for the systems of internal control, based on an ongoing process designed to identify and prioritise the risks of the organisation, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically. SLG review and update the Corporate Risk Register at their monthly meetings which contains the corporate, significant, and critical risks from across NWSSP including any escalated departmental risks. A SLG lead is assigned to each risk on the register.

- **The Velindre University NHS Trust Audit Committee for Shared Services (NWSSP Audit Committee) -** The NWSSP Audit Committee provides the SSPC and Velindre Trust Board with a means of independent assurance that the systems in place for the management of risk are operating efficiently and effectively. The NWSSP Audit Committee will also provide an objective review of the corporate governance responsibilities, financial systems, financial information and compliance with law, guidance, and codes of conduct. The NWSSP Audit Committee reviews the Corporate Risk Register at each of its meetings.

- **Shared Services Partnership Committee -** The Shared Services Partnership Committee ensures that risk management arrangements are in place, and both receives and provides assurance that appropriate and effective control systems are in place to identify and manage risks. The Shared Services Partnership Committee reviews the Corporate Risk Register at its bi-monthly meetings.

- **Sub/Working Groups -** A wide range of sub/working groups are in place across NWSSP to discuss their departmental/site risks and to ensure that any critical and significant risks are escalated to SLG along with risks which may become corporate. The aim of the working groups is to gather information and where appropriate share the lessons learned across the department.

- **Programme/Project Groups** – These Groups are established to provide oversight of more significant programmes or projects and follow best practice in ensuring that the programme or project has a risk register in place that is maintained up to date and significant risks are escalated to the Corporate Risk Register.

- **NWSSP All Wales Health and Safety Meeting -** The NWSSP All Wales Health and Safety meeting is chaired by the Director of Finance & Corporate Services. Each Service Division will ensure an appropriate representative attends this committee to ensure that their risks and incidents are monitored and discussed and that the lessons learned can be shared across NWSSP. All significant risks regarding Health and Safety are reported to the Velindre University NHS Trust Health and Safety Management Group.

**Directorate Risks**

Directors, Assistant Directors, and Managers should ensure that all risks associated with their directorate are input into ~~the risk management system~~risk registers in the standard format. Any red-rated risks should be referred to the NWSSP SLG for possible inclusion on the Corporate Risk Register. Directorate Management Teams monitor and review

their risk register on a regular basis. Review of Directorate key risks is also a standing agenda item for the Quarterly Reviews undertaken by the Managing Director and senior colleagues.

Operational risk registers at service or departmental level should also be maintained where appropriate to the inherent level of risk to the organisation, for example cyber security and information governance.

**Risk Escalation**

The SLG, assisted by key senior officers, are responsible for ensuring that risk management policies are implemented within NWSSP and that both risk assessment and incident reporting operates appropriately within the various areas of responsibility and in a climate where staff are encouraged to report incidents without fear of blame.

The process of escalation is used where a risk is unmanageable or uncontrolled or where the risk is significant or critical (15 and above). The purpose of the escalation process is to ensure that all managers at all levels across NWSSP have the option to escalate a risk where they are not able to manage or control it within their area. These risks are discussed at SLG.

**Training and Awareness**

All NWSSP staff receive basic risk management awareness as part of their statutory training. This training can be facilitated at induction or via eLearning and includes:

- principles of risk management;
- roles and responsibilities for management of risk within NWSSP;
- techniques for identification and evaluation of risk;
- how to report hazards, incidents, and near misses;
- awareness that risk is everyone's business; and
- policies that cover risk management and assessment.

Directors and Managers ensure that all staff involved in the risk assessment process have sufficient knowledge, experience and understanding of risk and are provided with sufficient training to ensure competence is demonstrated.

Managers ensure that risk assessment training is included in local training programmes.

**Risk Appetite**

High level risk appetite statements and risk tolerance limits should be in place for principal risk categories/types. The SSPC reviews its Risk Appetite Statement on an annual basis, and this is reported to the

NWSSP Audit Committee. The Risk Appetite Statement aligns with the SSPC's strategic objectives, and this is structured according to risk domains following the Good Governance Institute model. The risk appetite established by the SSPC is embedded in decision-making within the governance and accountability framework within which NWSSP operates.

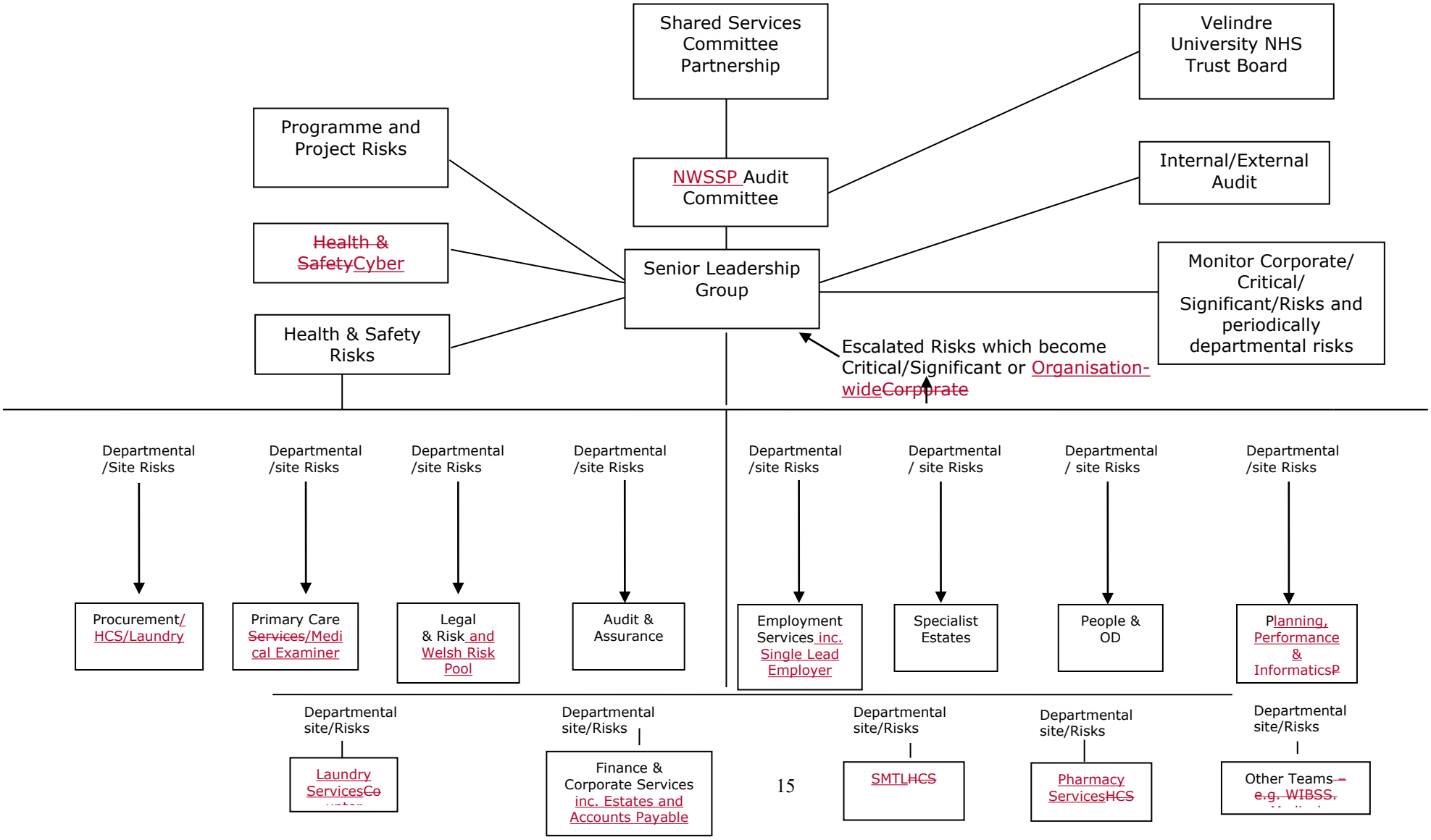
**Review Mechanism**

The risk management process is continually evolving, and it is therefore intended to review this Protocol on a bi ~~bi-~~ennial~~annual~~ basis with the Audit Committee in light of changes in guidance, best practice, and legislation.

**Annex 1**

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Shared Services Partnership

## ASSURANCE FRAMEWORK



**Tick the Type of Risk Assessment:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Business & Org | | Operational | | Clinical | | Quality | | Health & Safety | |
| Strategic | | Financial | | Legal | | Project. | | Environmental | |

Describe the situation or the work activity or process being assessed.
Summarise the specific risks to NWSSP

**Please give a full range of Hazards:**
**Include any Materials, Biological, Chemical, Environment, Ergonomic and Psychological etc.**

| **Hazards identified:** | **Impact Severity** | **Likelihood** | **Risk Rating** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Who is affected by the hazards and how many: Whole organisation, division, department, ward etc.
**All, Many or One** - staff, visitors, contractors or service users etc. may be harmed.

Evaluate Overall **Initial** – Risk : I x L= Risk Rating

| | **Impact** | **Likelihood** | **Rating** |
|---|---|---|---|
| | | | |

**List control measures in place: Are they acceptable Y/N**

Evaluate **Current** – Risk with controls: I x L= Risk Rating

| | **Impact** | **Likelihood** | **Rating** |
|---|---|---|---|
| | | | |

**Further action required - additional control measures - to reduce risk**

| |
|---|
| |
| **Actions Agreed by Manager:**<br><br>**Managers Name & Signature :** |

Evaluate **Target** – Risk with actions completed: I x L= Risk Rating **Impact** **Likelihood** **Rating**

| | | | |
|---|---|---|---|
| | | | |

**Risk Assessment performed by:**

| Print Name/s | Signature/s | Date |
|---|---|---|
| | | |

**Progress Report on further Actions: include review dates:**

| |
|---|
| |

# Applying risk appetite matrix

| RISK APPETITE LEVEL ▶ / RISK TYPES ▼ | 0 NONE<br>Avoidance of risk is a key organisational objective. | 1 MINIMAL<br>Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential. | 2 CAUTIOUS<br>Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential. | 3 OPEN<br>Willing to consider all potential delivery options and choose while also providing an acceptable level of reward. | 4 SEEK<br>Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk). | 5 SIGNIFICANT<br>Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust. |
|---|---|---|---|---|---|---|
| **FINANCIAL**<br>**How will we use our resources?** | We have no appetite for decisions or actions that may result in financial loss. | We are only willing to accept the possibility of very limited financial risk. | We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern. | We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor. | We will invest for the best possible return and accept the possibility of increased financial risk. | We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks. |
| **REGULATORY**<br>**How will we be perceived by our regulator?** | We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements. | We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential. | We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision. | We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully. | We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks. | We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders. |
| **QUALITY**<br>**How will we deliver safe services?** | We have no appetite for decisions that may have an uncertain impact on quality outcomes. | We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings. | Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. | We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation. | We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains. | We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement. |
| **REPUTATIONAL**<br>**How will we be perceived by the public and our partners?** | We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation. | Our appetite for risk taking is limited to those events where there is no chance of significant repercussions. | We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout. | We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders. | We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks. | We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders. |
| **PEOPLE**<br>**How will we be perceived by the public and our partners?** | We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest. | We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere. | We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision. | We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff. | We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains. | We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chan. |

| | |
|---|---|
| **Risk Management** | The co-ordinated activities to direct and control the organisation with regard to risk. |
| **Risk Management Process** | A systematic application of risk management policies to the task of identifying, analysing, evaluating, controlling and the monitoring and review of risk. |
| **Risk Assessment (Pro-active)** | A careful examination of the hazards in the workplace that may cause harm, to people the environment or the business and these include processes and tasks. The formal recording on a documented form. |
| **Risk Assessment (Re-active)** | A risk assessment that has been completed following an incident occurring, this may form part of the investigation process or may be a review of the original risk assessment in light of the incident and its severity. |
| **Risk Appetite** | The level of risk SSPC~~NWSSP~~ is prepared to pursue or accept before action is deemed necessary to reduce it. |
| **Risk Acceptance** | The risk is managed to a level defined as reasonably practicable and where to implementation of any further controls will outweigh any benefit. |
| **Residual Risk** | The risk remaining following treatment or control. |
| **Risk Register** | The risk register is a term for a detailed list of risk assessments, the format for the register itself has been agreed at the SLG. |
| **Risk Inventory** | A risk inventory or profile has no agreed format it may be a shortened version of the risk register or a more detailed profile. A risk inventory is normally less formal that a register and is managed at department level. |
| **Risk Structure** | A formal management structure that outlines the basic reporting and communication links and committees and groups that provides assurance to the SLG that risk is being effectively managed across all Service Divisions. |
| **Risk Matrix** | This is a tool developed to quantify risk, by scoring the impact x the likelihood that the risk will probably be realised to establish a Risk Rating. This tool can be used by Managers to prioritise significant risks. |
| **Risk Impact** | Potential harm scored via an impact matrix rising from 1-5 |
| **Risk Likelihood** | Potential for occurrence scored via a likelihood matrix from 1-5 |
| **Significant Risk** | Risk that are scored 15 and above that require treatment and control within 6-month period. |
| **Critical risk** | Risk scored 15 and above requiring immediate Senior management control. |

| | |
|---|---|
| **MEETING** | Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership |
| **DATE** | 07 July 2026 |
| **PREPARED BY** | James Quance, Assistant Director of Corporate Services |
| **PRESENTED BY** | James Quance, Assistant Director of Corporate Services |
| **RESPONSIBLE HEAD OF SERVICE** | Alison Ramsey, Director of Finance and Corporate Services |
| **TITLE OF REPORT** | NWSSP Corporate Risk Register |

**PURPOSE**

To provide the Audit Committee with an update as to the progress made against the NWSSP Corporate Risk Register.

A deep dive of the NWSSP Corporate Risk Register was conducted at the Informal Senior Leadership Group (ISLG) at its meeting on 7 May 2026, to review is effectiveness and ensure all risks are being appropriately managed, clearly articulated and fully updated. A number of actions were identified and assigned to responsible owners, with updates provided during this reporting cycle and through future reports.

*The information presented in this report is accurate as of 27 June 2026 and does not include any updates received after this time.*

## 1. INTRODUCTION

Since the Audit Committee meeting on 28 April 2026, several changes have been made to the NWSSP Corporate Risk Register, as outlined below.

The NWSSP Corporate Risk Register is presented at **Appendix 1,** for information.

## 2. RISKS FOR ACTION

The ratings are summarised below in relation to the Risks for Action:

| Current Risk Rating | July 2026 |
|---|---|
| Red Risk | 8 |
| Amber Risk | 10 |
| Yellow Risk | 0 |
| Green Risk | 0 |
| **Total** | **18** |

Red-rated Risks

There are currently eight red-rated risks recorded within the 'Risks for Action' category of the NWSSP Corporate Risk Register. The risk relating to TrAMS has increased and has been separated into two risks, to provide clearer oversight of the specific service-related risks. The risk relating to the Future Workforce Solution has also been reviewed and separated into two distinct risks to reflect workforce capacity and programme governance considerations. A summary of the current red-rated risks is provided below:

1. The threat of a successful cyber-attack resulting in potential loss of access to systems and/or sensitive data, with consequential impacts on service delivery (A1);
2. The risk of disruption to the supply of pharmaceuticals as a result of external factors, leading to significant restrictions in provision (A3a);
3. The risk to patient services should the planned development of the Radiopharmacy and TrAMS hub be unable to progress due to funding or planning constraints (A8);
4. Workforce shortages across Pharmacy Services, including the risk that there may be insufficient trained staff to support the simultaneous operation of legacy services and validation of new hubs. This may impact TrAMS service provision and the continued delivery of legacy services within Health Boards and Trusts during the transition phase and beyond TrAMS go-live (A11);
5. The sustained shortage of trained pharmacy staff across NHS Wales, which may affect the ability of the South-East Hub aseptic unit to recruit and retain the workforce required to operate at planned capacity once fully live (A12);
6. Workforce capacity, capability and transition challenges arising from the Future Workforce Solution programme, combined with funding uncertainty, programme delays and unclear workforce requirements, may reduce organisational resilience and hinder the delivery of safe, effective and sustainable services (A13);

7. Uncertainty regarding programme governance, funding, milestones and delivery may reduce confidence and hinder workforce planning (A14);
8. The reputational risk to NWSSP arising from forecast accuracy in respect of the Welsh Risk Pool (A16).

Newly Escalated Risks

Since the last meeting, no risks have been escalated to the NWSSP Corporate Risk Register. However, for completeness, it is useful to note that both the risks relating to TrAMS and the Future Workforce Solution have been split into two separate risks, respectively, as detailed above. As a result, two additional red-rated risks have been added to the Risks for Action section of the Register.

De-escalated risks

Since the last meeting, the following risk has been de-escalated from the Risks for Action section and transferred to the Closed Risks section, following an assessment that the controls and arrangements in place to manage the risk are now embedded as business as usual and that stockholding levels continue to meet Welsh Government requirements.

- Risk A3a disruption in the Personal Protective Equipment (PPE) supply chain.

Risk Trends

As mentioned above, two risks have been reviewed and subsequently separated into four distinct risks, resulting in changes to the overall risk profile. Three of the revised risks are demonstrating an increased trend. These relate to the nationwide staffing shortage challenges associated with TrAMS, as outlined in risk A11, and the insufficient assurance and confidence in the delivery of, and funding constraints associated with, the Future Workforce Solution, as outlined in risks A13 and A14.

In addition, risks A15, relating to the reputational risk associated with NWSSP's role in Student Streamlining, and A16, relating to forecast accuracy within the Welsh Risk Pool, are now demonstrating a stable trend.

Risks at Target

At present, seven Risks for Action are assessed as being at their target risk level.

Since the last meeting, the following target dates have been revised:

- A1: The target date has been extended from 30 June 2026 to 31 December 2026, to allow completion of the Cyber Assurance Framework remediation plan, further cyber control improvements.

- A4a: The target date has been extended from 31 May 2026 to 31 August 2026, to allow further work to be completed in support of the Decarbonisation and Adaptation workstreams.
- A4b: The target date has been extended from 31 May 2026 to 31 August 2026, to allow further work to be completed on the delivery of planned schemes, future TEF programme planning, and the development of investment proposals through the Decarbonisation and Adaptation workstream.
- A7: The target date has been revised from 30 June 2026 to 30 September 2026 to enable the implementation of recommendations arising from the Welsh Government Independent Review of NWSSP Governance and Accountability Arrangements.
- A15: The target date has been extended from 11 May 2026 to 31 July 2026, to allow time for the outcome of the Graduate Summit to be reviewed, next steps for unsuccessful students to be agreed, and communications to be issued.

At the deep dive of the Corporate Risk Register conducted at the Informal Senior Leadership Group in April 2026, it was determined that several risks for action had transitioned to business-as-usual arrangements, with strong mitigations and controls in place to manage the associated risks.

Revised target dates for Actions A13 and A14 relating to Future Workforce Solutions are expected to be confirmed shortly, as they are contingent on review mechanisms in the wider programme.

## 3. RISKS FOR MONITORING

Since the last meeting, one risk has been transferred from the Risks for Monitoring section to the Closed Risks section, relating to recruitment and retention previously M4.

Risks at Target

Since the previous meeting, there have been no material changes to overall risk trends within the Risks for Monitoring section.

There are **four** risks currently retained on the NWSSP Corporate Risk Register for monitoring, reduced from **five** reported at the previous meeting; these are set out below:

| Current Risk Rating | July 2026 |
|---|---|
| Red Risk | 0 |
| Amber Risk | 2 |
| Yellow Risk | 2 |
| Green Risk | 0 |
| **Total** | **4** |

## 4. EMERGING RISKS

Since the last meeting there are no matters to report in this section.

## 5. RECOMMENDATION

- The NWSSP Audit Committee is asked to **NOTE** the update to the NWSSP Corporate Risk Register and discuss the changes applied and commentary regarding risk trends.

# NWSSP Corporate Risk Register

| Ref | Risk Summary | Inherent Risk | | | Existing Controls & Mitigations | Current Risk | | | Further Action Required | Progress | Trend since last review | Target & Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Likelihood | Impact | Total Score | | Likelihood | impact | Total Score | | | | |
| **Risks for Action** | | | | | | | | | | | | |
| **A1** | If NWSSP does not maintain an effective and continually improving cyber security control environment (including cyber hygiene, vulnerability management, monitoring and incident response), then there is an increased likelihood of a successful cyber attack impacting NWSSP systems and services, resulting in loss of confidentiality, integrity and availability of critical data and national systems, disruption to essential NHS Wales services, regulatory penalties, financial loss, and reputational damage.<br><br>**Strategic Objective - Service Development** | 5 | 5 | 25 | Security Information and Event Management (SIEM) Monitoring: provides real-time visibility of security events across NWSSP systems, enabling early detection and response to potential cyber threats.<br><br>M365 Enhanced Security Controls: strengthen identity, access management and threat protection across core productivity services, reducing the risk of compromise and data exfiltration.<br><br>Operating System Patching: ensures timely remediation of known vulnerabilities, reducing the exposure window to widely exploited threats. Vulnerability Management: identifies, assesses and prioritises security weaknesses across the environment, enabling targeted remediation and reduction of attack surface.<br><br>Cyber Assessment Framework (CAF) Baseline Assessment: provides a structured view of current cyber maturity and control effectiveness, informing prioritised improvement planning. | 3 | 5 | 15 | CAF Remediation Programme Delivery: implements prioritised improvements across all CAF domains to strengthen overall cyber resilience and control maturity, including:<br><br>Access logs for NWSSP tested successfully, and to be progressed to completion<br><br>Vulnerability Remediation: addresses identified vulnerabilities in line with risk prioritisation, reducing exploitable weaknesses across systems and services.<br><br>Business Impact Assessments (BIA): defines critical services, dependencies and recovery requirements, improving organisational resilience and incident response planning.<br><br>Incident response workshops are scheduled for 09/2026 | CAF Remediation Planning: a structured remediation plan has been developed, aligned to CAF domains, providing a clear roadmap for improving cyber control maturity.<br><br>Service catalogue being released w/c 22/06/2026<br>Oracle Cloud and Cleric logs being passed to the SIEM<br><br>Active Control Improvements: delivery of vulnerability management, SIEM enhancement, patching and resilience activities is underway to reduce risk exposure and strengthen operational controls, including:<br>Performance Monitoring and Reporting: cyber KPIs have been defined and will be reported through SLG governance, providing regular oversight of control effectiveness and risk position.<br><br>Assurance and External Engagement: ongoing engagement with Heads of Cyber Security sub-group and the National Cyber Resilience Unit continues to provide external challenge, alignment with national expectations, and independent assurance of progress.<br><br>**Risk Lead: Director of Planning, Performance and Informatics** | → | **31/12/2026** |
| **A2** | There is a risk that NWSSP is not adequately prepared for a future pandemic or public health emergency resulting in excessive risk to its people and inability to react to rapid escalation in demand for services.<br><br>**Strategic Objective - Services** | 4 | 5 | 20 | Emergency Planning and Business Continuity Plans in place and maintained up to date.<br>Part of four nations approach and reliant upon horizon scanning at UK Government level.<br>Learning from Covid Pandemic including external reviews.<br><br>Director of Planning Performance and Informatics or the Head of Emergency Preparedness attends weekly High Consequence Infectious Disease (HCID) meetings to represent NWSSP and participation on the NHS Executive Emergency Planning Advisory Group.<br><br>NWSSP is also representation on the NHS Executive Emergency Planning Advisory Group and HCID group, provides NWSSP with early indication of emerging risks and the necessary response levels.<br><br>Local Resilience Forums are also included in the NWSSP planning network and operational considerations. NWSSP is included in pandemic planning and exercises with WG and PHW.<br>IT systems to support mass numbers of staff to work remotely have been sufficiently stress tested as we now adopt agile working as business as usual arrangements. | 2 | 5 | 10 | Training sessions on the Chemical Biological Radiological and Nuclear (CBRN) equipment and processes needs to be completed with HCS staff and an exercise testing the distribution and handling of drugs is required in conjunction with the Pharmacy Business Continuity Lead, NWSSP Pharmacy unit of NWSSP and HBs. This will be planned and executed following the completion of pharmacy works on the Radiopharmacy unit as there is currently no capacity to run the exercise.<br><br>NWSSP have requested that HBs collate and forward their Highly Contagious Infectious Disease (HCID) stock requirements for their training programmes to ensure that demand can be met, and that NWSSP are assured that if the equipment is procured that HBs will requisition it appropriately and not increase stock holding risks to NWSSP.<br><br>The planning and exercising of internal plans will be highlighted in the programmed Business Continuity Compliance Reviews. In addition NWSSP will be engaged in the Exercise Programme of the NHS P&I, which will test plans against the NHS Wales Health Risk Register. | Business Continuity plans will continue to be tested, to include other pandemic scenarios and interdependencies with other NHS organisations.<br><br>NWSSP was part of Operation Pegasus which took place Sept-Nov 2025. We are awaiting the external key findings and recommendations which will be reported in early 2026. An audit programme will commence in May 2026 which will further enhance the compliance of departments to the requirements of good BCMS practice aligned to iso 22301 along with continued training and development and exercising.<br><br>PPE stock is now nearing achievement of the agreed WG levels. There are no actions for NWSSP from the Modules of the Covid Inquiry to date that need specific actions. NWSSP will continue to ensure preparedness through engagement with the NHS P&I and exercising with HBs.<br><br>Highly Contagious Infectious Disease (HCID) equipment has been distributed to HBs. NWSSP have are working with WG and PHW to ensure that the future demand and procurement of replacement HCID equipment is clear and HBs informed of the process. NWSSP have responded to a demand for additional HCID equipment as part of the Hantavirus response by BCUHB and successfully managed redistribution of equipment to ensure potential replenishment could meet set timescales.<br><br>**Risk Lead: Director of Planning, Performance and Informatics** | → | **At target** |
| **A3a** | There is a risk that disruption in the supply chain of pharmaceuticals caused by external factors or supplier failure results in significant restriction in provision because there are potentially limited options for stock piling for medicines.<br><br>**Strategic Objectives - Services** | 5 | 5 | 25 | Regular and ongoing monitoring of stock levels and supplier performance to identify risks early. Agreement in place for NWSSP to hold buffer stocks on behalf of NHS Wales.<br>Contract reallocation, insofar as when awarded suppliers withdraw, the National Medicines Procurement Team reallocates contracts to alternative manufacturers able to supply. We have introduced and manage a contingency stockpile which is a controlled reserve of critical pharmaceutical products is maintained to mitigate short-term supply chain disruptions. Despite these measures, the risk remains high due to global market volatility, geopolitical pressures, and potential changes in trade tariffs. This risk has also been considered as part of overarching business continuity planning. | 5 | 4 | 20 | Whilst further actions remain limited at this time in terms of pharmaceuticals, largely due to the fact that NWSSP are dealing with global manufacturers and therefore, also subject to the geopolitical pressures and wider market forces, we will continue to conduct heightened monitoring of availability of supply and stock levels and sourcing teams continue to look for suitable alternative products. | There is increasing supply chain instability due to global instability including manufacturing shortages, political conflict and tariffs. This applies not only to pharmaceutical sector but increasingly to other sectors as well. Additional actions will be driven largely to direction by Welsh or UK Governments. Despite the existing controls and mitigation measures, the risk remains high due to global market volatility, geopolitical pressures, and potential changes in trade tariffs. Continued visibility remains essential at this time.<br><br>No change to the stated position as at 26.05.26. Agreed actions, insofar as they are within the control of NWSSP, as they relate to contract management and stockpile remain as stated within the existing controls and mitigations.<br><br>**Risk Lead: Director of Procurement, Supply Chain, Logistics, Transport and Laundry Services and Director of Pharmacy Technical Services** | → | **30/09/2026** |

| Ref | Risk Summary | Inherent Risk | | | Existing Controls & Mitigations | Current Risk | | | Further Action Required | Progress | Trend since last review | Target & Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
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| **A4a** | Resource restraints prevent the ability of NWSSP to meet the expectations of Welsh Government and the public in playing a leading role in delivering the newly published 2025 NHS Wales SDP for Decarbonisation and associated Climate Adaptation planning measures.<br><br>Consequences of such failure would mean that the Welsh Government could fail in its response to its declaration of a Climate Emergency.<br><br>**Strategic Objective - Service Development** | 4 | 4 | 16 | Regular liaison with Welsh Government.<br>Attendance and leadership of workstreams at National Programme Board.<br><br>Funding received from Welsh Government to support national programme across TMO, SES and Procurement Services. | 3 | 4 | 12 | Development of a new reporting format for monitoring progress against the updated SDP initiatives; followed by reporting of the risk through to the National Programme Board through the NWSSP CAP team.<br><br>Leadership of national / joint SDP initiatives.<br><br>Promotion of success through case studies. Additional capital funding has been made available to NHS Wales for 2025-2027 through the Targeted Estates Fund which should help to enable some objectives within local DAPs. | A new reporting arrangement and format has been developed for use with the updated SDP for the Decarbonisation and Adaptation workstreams.<br><br>Whilst the availability of finance is the principal risk, there is also a requirement to change custom and practice which requires behavioural change. This too is difficult to influence and change. The need to recoup investment over relatively short financial planning cycles makes this more difficult to achieve. NWSSP will continue to raise risks and opportunities through the National Programme Board.<br><br>NWSSP are engaged with delivery and coordination of relevant national initiatives listed in the updated SDP.<br><br>NWSSP have developed case studies for schemes and will use various forums (Estates, BELP, TAP etc) to promote wider application. NHS Wales progress on delivery of the 2025-2027 TEF programme is being monitored with no significant delays to report.<br><br>**Risk Lead: Director of Specialist Estates Services** | ➔ | **31/08/2026** |
| **A4b** | Resource restraints, most notably capital funding, prevent the ability of NWSSP to deliver its own Decarbonisation Action Plan, updated SDP initiatives and associated climate Adaptation planning measures, hindering the ability of Welsh Government to achieve its ambition to respond to the declared Climate Emergency.<br><br>**Strategic Objective - Service Development** | 4 | 4 | 16 | NWSSP Decarbonisation & Adaptation Programme Board in place - Project Execution Plan and TMO Support in place.<br><br>NWSSP DAP published and submitted to Welsh Government.<br><br>Regular monitoring of progress against objectives is in place.<br><br>Internal audit review in 2024 was limited assurance but recommendations have been implemented and signed off by A&A in June 2024 | 3 | 4 | 12 | Progression of activities listed within the 2025 SDP.<br><br>Work is being done by the NWSSP Decarbonisation & Adaptation Delivery Group to target deliverable amounts for investment within the current environment and to continue research into potential wider funding sources.<br><br>A new Decarbonisation Action Plan will be developed in the coming months with estimated costs for inclusion in the 27/28 IMTP update.<br><br>Following on from Risk Assessments in 2025, Adaptation Option appraisals and associated costs are being progressed and proposals will be submitted to WG by Dec 2026 (and inclusion of costs within the IMTP as appropriate).<br><br>Progress on Decarbonisation Training in NWSSP to be monitored. | The following schemes have been funded through the WG TEF Programme 25/26 - 26/27.<br>a) Denbigh Stores RM PV and infra-red heating: Completed Mar 26.<br>b) Matrix House EV Charging & Infrastructure Upgrade: Completed Mar 26.<br>c) Waste Water Heat Reclaim Systems (GV,CV&YGC laundries): Completed Feb 26.<br><br>It is anticipated that details of the 2027/28-2028/29 TEF Programme will be released in the coming months.<br><br>Work will continues with oversheeting the roof at IP5 and should complete in July 2026. Research will now commence on potential for incremental roof mounted PV development.<br><br>NWSSP CAP team are progressing with delivery and oversight of the NWSSP obligations as listed in the SDP.<br><br>The NWSSP Climate Adaptation risk assessment was completed in December 2025 and following Programme Board and SLT approval was issued to WG. The D&A Delivery Group are leading a process of option generation and appraisal so as to have investment proposals ready for the Autumn IMTP planning round.<br><br>Progress on implementation of Decarbonisation Training is being monitored as appropriate.<br><br>**Risk Lead: Director of Specialist Estates Services** | ➔ | **31/08/2026** |
| **A5** | The COVID Inquiry places extreme demands on staff groups, particularly Procurement, and impacts the delivery of business-as-usual services.<br><br>**Strategic Objective - Services** | 5 | 4 | 20 | Appointment of Legal Counsel<br>Support from Legal & Risk<br>COVID Inquiry Planning Readiness Group has met its terms of reference<br>Reflection Documents completed<br>Central Store of relevant documents<br>Core Participant status for Module 5 confirmed.<br>Evidence provided for Module 5 and Module 3 with further clarification and other requests arriving from the Inquiry Team. | 3 | 4 | 12 | With support from Legal and Risk Services, legal Counsel and Finance & Corporate Services, the Director of Procurement and Health Courier Services provided evidence to Module 5 (Procurement) of the Inquiry through witness statements and requested documentation and in person in March 2025. | We will continue to monitor the progress of the Inquiry but we would not expect to be significantly involved in future modules. There may be ongoing work in relation to the committee style review that Welsh Government set up, to capture issues that weren't covered by the main UK Public Inquiry.<br><br>We will work with partners and Welsh Government on any relevant recommendations arising from the final report.<br><br>A motion to dissolve the Wales COVID-19 Inquiry Special Purpose Committee was made on 8 October 2025. However, pending the outcome of the Senedd elections in May 2026, this position may change significantly dependent upon the elected party and their associated manifesto / policies.<br><br>**Risk Lead: Director of Finance and Corporate Services** | ➔ | **At target** |
| **A6** | The financial climate in NHS Wales poses significant threats to the delivery of existing services and the development of new services as set out in our 2026-2029 IMTP.<br><br>**Strategic Objective - Services** | 5 | 4 | 20 | Monthly Finance Reports to SLG<br>Finance Report to SSPC and to Audit Committee through Managing Directors update<br>Three Service Improvement workshops with SLG over the summer sharing tools and techniques to develop plans. These have helped informed 2025-2028 plans.<br>Vacancy Control Arrangements implemented | 3 | 4 | 12 | All savings plans have been identified to meet the IMTP target requirement and are on track to be achieved.<br>At the end of May 2026, NWSSP reported a surplus of £0.813m which will either be used to fund pressures within NWSSP, be reinvested within NWSSP and/or distributed to NHS Wales/WG | The IMTP for 2026-2029 was submitted to Welsh Government before 31 March 2026 and we await a response. Reporting to SLG has commenced on progress to recurrently identify savings to reduce vacancy/turnover factors that have been budget set.<br><br>**Risk Lead: Director of Finance and Corporate Services** | ➔ | **At Target** |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Likelihood | Impact | Total Score | | Likelihood | impact | Total Score | | | | |
| **A7** | The increasing range and complexity of NWSSP services leads to exposure to a wide range of risks of non-compliance with law and regulatory requirements.<br><br>**Strategic Objective - Services** | 4 | 5 | 20 | Internal and external assurance and compliance reviews undertaken on a regular basis.<br>Highly regulated areas, i.e. medicines have systemic and operational compliance processes in place which are tested regularly.<br>Professional routes into WG and UK government to shape and plan for changes and to support recruitment for leadership roles.<br>Specific re-accreditation targets within individual Divisions are scrutinised through the Quarterly Review process. Assurance maps updated for all Divisions. Internal audit programme will now consider governance reviews of new or more recent areas of business on a cyclical basis. | 3 | 4 | 12 | Development of Register of all regulatory requirements is nearing completion.<br>Hosting assurance mapping is being undertaken as part of the implementation of the Welsh Government Accountability and Governance review which will inform the development of assurance arrangements further in NWSSP. | Register or regulatory requirements and Hosting assurance mapping due to be completed in the next quarter. Reviews to support the Annual Governance Statement and other annual reports produced for the 2025-26 financial year do not identify areas for concern regarding compliance and the Managing Director has provided the annual declaration of compliance to the Trust for hosting assurance. Radiopharmacy go live will be supported by reporting of arrangements for compliance with licensing and permit requirements for assurance.<br><br>**Risk Lead: Responsible Directors** | ➔ | **30/09/2026** |
| **A8** | The threat to patient services if the planned developments of the Radiopharmacy and hub TrAMS service is not allowed to progress due to funding or planning limitations.<br><br>**Strategic Objective - Services** | 5 | 5 | 25 | TrAMS Programme Board in place and regular reporting to SSPC<br>MO expertise and experience in place<br>Work progressing with delivery of the Radiopharmacy unit following initial delays with funding approvals and planning permission. | 4 | 5 | 20 | Funding for the next phase of works on the Radiopharmacy Unit has been approved and released by Welsh Government, following planning permission granted by Newport County Council for the TrAMS unit.<br><br>Oversight of the delivery of the Radiopharmacy Unit sits with the Programme Board.<br>Submission of South East Hub FBC to Welsh Government is anticipated July 2026, this will determine any funding limitations to the TrAMS hub service. | Extensive testing continues across the SE Radiopharmacy, with a particular focus upon pressure balancing and environmental validation. Some delay has been experienced to the commissioning timeline due to fluctuating pressures alongside the hot weather conditions which are nearing conclusion in their investigation. Discussions are ongoing with key stakeholders regarding updated timelines, with Swansea Bay UHB continuing to support service continuity arrangements to ensure resilience during transition.<br><br>Significant progress has been made with the South East Hub Full Business Case (FBC) now fully developed and formally circulated to all relevant organisations for review, supported by a comprehensive Estates Annex and a set of Frequently Asked Questions (FAQs). The FBC has now been approved at both the South East Hub Project Board and the TrAMs Programme Board and is now progressing through internal Health Board and Trust governance routes, culminating in Public Board approvals on 30th July, prior to submission to WG.<br><br>North and South West projects have been mobilised in February 2026, with dedicated Project teams to further reduce the risk of poor hub service progression.<br><br>**Risk Lead: Director of Pharmacy Technical Services** | ➔ | **31/07/2026** |
| **A9** | There is a risk that a significant business continuity event causes a loss of critical infrastructure for an extended period resulting in an inability to provide priority services.<br><br>**Strategic Objective: Services** | 5 | 5 | 25 | Head of Emergency Preparedness and Planning and a Business Continuity Co-ordinator post in place. Network of Business Continuity Champions. Business Continuity Plan and Impact. All departments are now required to carryout a departmental specific Business Impact assessment to inform their Business Continuity Plans in line with ISO 22301 for Business Continuity. Directorate Action Cards were appropriate are being utilised.<br><br>Internal Compliance Review and Support Programme in place to identify opportunities for improvement at departmental level leading to organisational risk management improvement. BCP App available and SLG What's app available and has been tested through incident escalation in 2025/26. A training programme is in place to provide training to managers in: Major Incident and Business Continuity Response, Business Continuity Management, Major Incident and Business Continuity Loggist and Incident/Exercise Debriefing.<br><br>A number of departments have tested their plans during 2025/26 a total of 20 exercises have been carried out since May 2025. A lessons learned log is now in place to highlight incident and exercise learning outcomes - reported to the SLG. 14 Incidents reported to date.<br><br>There is a generic risk register for potential risk impact from risks on national risk registers to NWSSP. This along with the training and exercise programme that is being developed with the NHS P&I will ensure that NWSSP is part of National Testing of plans for registered risks. In addition NWSSP internal exercises. | 2 | 5 | 10 | Implemented recommendations from Internal Audit Report (30 June 2024) have been largely completed.<br><br>Business Impact assessment workshops have been delivered to Business Continuity Champions.<br><br>Training and organisational development is now aimed at alignment to the principles and requirements of ISO 22301.<br><br>Further work to embed this in the organisation will enhance preparedness and response to Business Continuity events. | A series of courses have been published to provide Business Continuity Impact Assessment and Business Continuity Plan development guidance and courses to prepare managers for the management of business continuity and major incident event management. Business Impact assessment workshops have been delivered to Business Continuity Champions. Mass Causalities Management Report was presented to SLG in November 2025.<br><br>Impact analysis of Martyns Law presented to SLG In 2025 and planned programme of Departmental BCM Compliance and support visits commences in July 2026 which will further enhance the compliance of departments to the requirements of good BCMS practice aligned to ISO22301 along with continued training and development and exercising.<br><br>Implementations of the recommendations from Internal Audit Report (30 June 2024) has been largely completed: 1.1. A new BIA process and guidance is in place. 1.2 Pharmacy are in the process of new BCPs. 1.3 NWSSP HCS & Supply chain have an effective On Call Handbook detailing BCP responses. 2.1 Dedicated posts are now in place. 3.1 There is now an expectation and support for regular testing of departmental BCPs.<br><br>In addition to this the NWSSP are overseen by the NHS P&I Team within who's remit is the training and exercising of Welsh Health Plans. Departments who have not completed a BCP test within a 12 period will be picked up in the compliance reviews and regular monitoring of departmental activity via the BC Champions Group. 4.1. All SLG members except one newly appointed role have completed the Major Incident and Business Continuity Response Course which covers and exceeds the aspects of the Introduction To Emergencies on line learning.<br><br>BC Champions and Tactical Leads are now being targeted for training and development. 5.1 The engagement of the NWSSP Communications Team and individual stakeholder contact and communications are covered in the new BCP templates. A cyber Incident Management Plan is being reviewed and developed by the Cyber Team, this will have escalation and response processes clearly guiding managers and staff in the correct processes to carryout in the case of ICT failure or cyber attack.<br><br>**Risk Lead: Director of Planning, Performance and Informatics** | ➔ | **At target** |
| **A10** | There is a risk that there is insufficient capital funding to support the development of services and delivery of the IMTP and Ministerial priorities.<br><br>**Strategic Objective - Service Development** | 5 | 4 | 20 | Estates and digital strategies<br>Capital and estates prioritisation returns submitted to WG.<br><br>Close contact maintained with WG Capital Team<br>Track record of delivery and effective use of resources.<br><br>NWSSP Capital Priority Group has been put in place and meet at least once a month and more frequently during key times of the financial year.<br>Joint Executive Team (JET) meetings with WG which provide updates to areas of risk.<br><br>IMTP objective status forms part of the internal quarterly reviews and risk in relation to funding is discussed.<br>Discretionary Capital budgets agreed and in place for Laundry Services and IP5. | 3 | 4 | 12 | Preparatory work though the Capital Prioritisation Group (CPG) supported successful capital bids into Welsh Government for 2025-26 which we are continuing into 2026-27. | NWSSP Capital Prioritisation Group (CPG) will continue to refine the internal arrangements.<br><br>The Capital Financial Control Procedure (FCP) was approved by NWSSP Audit Committee in May 2025 to support larger capital schemes and capital panning FCP is under development in 2026/27.<br><br>There remains a residual risk that NWSSP is reliant on slippage capital allocations from Welsh Government late in the financial year. To maximise value for money, the CPG will work with Divisions to ensure business cases are completed earlier in the planning cycle to accommodate potential slippage allocations received in year.<br><br>It is essential to engage with potential suppliers to understand potential costs and lead times, as supply chain pricing remains unpredictable due to global instability. We are submitting funding requests for estates and digital backlog schemes to WG by 26 June 2026 and are also seeking TEF slippage monies if available.<br><br>**Risk Lead: Director of Finance and Corporate Services** | ➔ | **At Target** |

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| **A11** | Due to nationwide shortages of staff across pharmacy, it is possible there will be insufficient trained staff to complete simultaneous operation of legacy service and validation of new hubs. Potentially impacting both TrAMs service provision and legacy services continuing within Health Boards and Trust during transition phase and ongoing beyond TrAMs go-live. | 5 | 5 | 25 | Existing mitigations centre on proactive workforce expansion, accelerated training and skills uplift, and structured transition planning. This includes funded training programmes, recruitment of additional staff to support double running, phased deployment (new staff prior to transfers), and formal TUPE-based workforce planning. Further controls include development of validation plans with QA leads, alignment of staffing with build timelines, and programme phasing to reduce peak workforce pressure. Collectively, these measures are intended to increase workforce supply, capability, and resilience to support both legacy services and hub validation during transition. | 5 | 4 | 20 | Continue to scale workforce capacity through sustained training and skills development, finalise and implement the transition plan (including phased deployment of new and transferring staff), progress the next organisational change plan to enable recruitment and headroom, and complete QA-led validation planning to support compliant double running, with ongoing national workforce engagement and alignment to programme timelines to maintain service continuity. | 20/04/26 Workforce principles agreed by NHS Wales organisations to support staff transition and workforce planning. | ↑ | **30/09/2026** |
| | **Escalated Divisional Risk**<br>***RISKS SPLIT INTO TWO AS PREVIOUSLY AGREED WITH SENIOR LEADERSHIP GROUP*** | | | | | | | | | **Risk Lead: Director of Pharmacy Technical Services** | | |
| **A12** | Due to a sustained shortage of trained pharmacy staff across NHS Wales, the SE Hub aseptic unit may be unable to recruit and retain the workforce required to operate at its planned capacity once fully live, resulting in a widening gap between the staffing available and the staffing needed for safe, compliant production. This could lead to failure to meet licensing requirements, reduced production throughput, and interruptions to product availability for patients and services. | 5 | 5 | 25 | Existing controls focus on increasing workforce supply, capability and resilience through coordinated national workforce planning. This includes funded recruitment and training programmes, delivery of skills uplift initiatives, and implementation of a centralised workforce model designed to account for demand, leave and training requirements. Workforce Principles (including TUPE arrangements) underpin staff transfer and retention, supported by ongoing engagement and consultation.<br><br>Capacity risk is further mitigated through phased programme delivery, resource mapping and alignment with build timelines, alongside development of QA-led validation plans. Collectively, these measures aim to ensure sufficient trained staff are available to operate the SE Hub safely and in compliance with licensing requirements. | 4 | 4 | 16 | Further action is required to implement a coordinated national workforce plan to improve recruitment, retention and skill mix; optimise the regional operating model and maximise cross Wales capacity utilisation; strengthen TUPE and transition arrangements to secure workforce supply to the SE Hub; and maintain robust QA, audit and contingency arrangements (including outsourcing and demand prioritisation) to ensure regulatory compliance and continuity of patient supply during periods of workforce constraint. | 20/04/26 Workforce principles agreed by NHS Wales organisations to support staff transition and workforce planning. | → | **30/09/2026** |
| | **Escalated Divisional Risk**<br>***RISKS SPLIT INTO TWO AS PREVIOUSLY AGREED WITH SENIOR LEADERSHIP GROUP*** | | | | | | | | | **Risk Lead: Director of Pharmacy Technical Services** | | |
| **A13** | There is a risk that workforce capacity, capability, and transitional impacts arising from the Future Workforce Solutions Programme adversely affects the organisation's ability to deliver safe, effective and sustainable services.<br><br>This is compounded by ongoing funding uncertainty, delays within the national programme, and lack of clarity regarding workforce requirements, which may impact workforce planning, service resilience, and delivery of core operational and transactional services. | 5 | 5 | 25 | The Full Business Case (FBC), informed by the preferred bidder, includes provision for the resource required by each user organisation to prepare for and support transition to the Future Workforce Solution (FWS). This assumes up to two additional Agenda for Change Band 8a full-time equivalent (FTE) resources per organisation, for a defined period, reflecting organisational size and implementation complexity, to support local project and change management activity. The total allocation for Wales £86k p.a.<br><br>Workforce planning processes in place to assess capacity and capability requirements<br><br>Operational performance monitored through governance and escalation routes | 4 | 5 | 20 | Seek and document clarity from the national programme on workforce requirements, including scale, timing, and impact on Employment Services and transactional services.<br><br>Confirm sufficiency and allocation of funding for NHS Wales to support required workforce capacity.<br><br>Clearly define and monitor escalation triggers (e.g. funding slippage, lack of documentation, programme delays) and ensure these are formally recorded, noting thresholds have been reached.<br><br>Strengthen workforce modelling and scenario planning to quantify service impact and identify mitigation requirements.<br><br>Align workforce assumptions and plans with updated national programme milestones as clarity improves. | Workforce assumptions were established through the Full Business Case (FBC), equating to £86k p.a for Wales.<br><br>Agreement has been secured via Workforce Directors (WODs), the All Wales Steering Group and SSPC to establish a central transformation team within NWSSP. This team will support a safe transition and ensure the availability of skilled implementation capability. Funding is confirmed through to the completion stages C3 and C4 including handover to Hypercare.<br><br>Work us underway to map resource requirements against current team capacity with the aim of identifying the scale of the recruitment effort required.<br><br>NWSSP along side NHSBSA and consortium partners is working with early adopters organisations on Foundational Readiness. This includes supporting the completion of a defined set of readiness activities such as demonstrating Board-level commitment. Completion of the scoping document will enable organisations to formally enter the Early Adopter stage by July 26. | ↑ | **At Target April 2026 to support Early Adopter Organisations**<br><br>**Programme completion date 2030.**<br><br>**Interim target milestones TBC** |
| | **Strategic Objective: Services**<br>***RISKS SPLIT INTO TWO AS PREVIOUSLY AGREED WITH SENIOR LEADERSHIP GROUP*** | | | | | | | | | **Risk Lead: Director of People, Organisational Development and Employment Services** | | |
| **A14** | There is a risk that there is insufficient assurance and confidence in the delivery of the national Future Workforce Solutions Programme, including its governance, progress, and ability to realise intended outcomes, which may impact the organisation's ability to plan effectively and achieve its strategic workforce objectives.<br><br>This is compounded by ongoing funding uncertainty, delays within the national programme, and a lack of clarity regarding contract management and associated funding arrangements from Welsh Government, which may impact financial planning, delivery readiness, and decision-making. | 5 | 5 | 25 | NWSSP is represented on the Future Workforce Solutions Transformation Programme Board, CEO Board, and Advisory Board, providing oversight and early visibility of emerging risks and required responses.<br><br>Regular engagement is in place with NHSBSA Senior Leadership Team, alongside ongoing liaison with Welsh Government, including via Joint Executive Team (JET) meetings.<br><br>The programme is reflected within the IMTP and subject to scrutiny through the quarterly performance review process.<br><br>A Wales Steering Group has been established, with governance routed through SSPC, Workforce Organisational Development (WOD) groups, and Directors of Finance (DoFs). | 4 | 5 | 20 | Seek and document formal clarification from Welsh Government on contract management responsibilities and funding arrangements.<br><br>Clearly define and maintain escalation triggers (including funding slippage, lack of programme documentation, and delivery delays) and ensure these are actively monitored and formally recorded.<br><br>Formally document and escalate NWSSP concerns in writing to NHSBSA regarding funding delays, lack of clarity, and missing programme documentation, copying Welsh Government colleagues.<br><br>Strengthen assurance reporting from the national programme, including clarity on milestones, delivery progress, benefits realisation, and programme documentation.<br><br>Seek and confirm clarity on national programme milestones, task allocation, and workforce requirements, including impacts on Employment Services and transactional services.<br><br>Update internal plans and risk assessments in line with confirmed national assumptions and timelines. | Governance and engagement arrangements remain in place, with continued NWSSP representation at national boards and regular engagement with NHSBSA and Welsh Government.<br><br>Six-weekly meetings with Welsh Government are established to support ongoing dialogue and escalation. Formal updates are anticipated following discussions at the Transformation Programme Board (end of June)<br><br>Work is underway to formally document and escalate NWSSP concerns regarding funding uncertainty, programme delays, and gaps in documentation. | ↑ | **April 2026 to support Early Adopter Organisations**<br><br>**Programme completion date 2030.**<br><br>**Interim target milestones TBC** |

| Ref | Risk Summary | Inherent Risk | | | Existing Controls & Mitigations | Current Risk | | | Further Action Required | Progress | Trend since last review | Target & Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Likelihood | Impact | Total Score | | Likelihood | impact | Total Score | | | | |
| | **Strategic Objective: Services**<br>***RISKS SPLIT INTO TWO AS PREVIOUSLY AGREED WITH SENIOR LEADERSHIP GROUP*** | | | | | | | | | **Risk Lead: Director of People, Organisational Development and Employment Services** | | |
| **A15** | There is a reputational risk for NWSSP its role in student streamlining with the availability of vacancies declared by Health Boards to support the National Nurse Student Streamlining arrangements being much reduced leading to a lack of available roles.<br><br>**Escalated Divisional Risk** | 4 | 3 | 12 | NWSSP provided HEIW colleagues with early notice of low vacancy numbers being released into Streamlining. HEIW commitment to engage Health Boards to increase activity resulted in c300 Nursing (unconfirmed) and c20 Midwifery (unconfirmed).<br><br>HEIW communicated to students informing of postponed release.<br><br>HEIW established a Strategic Oversight Board with the aim of improving visibility and planning for the pipelines of students in the Education Commissioning system. | 3 | 3 | 9 | Heath Boards - Workforce, Nursing and Finance Directors to support HEIW and NWSSP on the Streamlining Programme and ensure that vacancies match commissioning numbers for nursing and midwifery identifying additional vacancies before 11.05.26.<br><br>Early decision to be taken in respect of Autumn 2026 Streamlining commitment. | The closing of the scheme to vacancies has resulted in approximately a 200 vacancy shortage across nursing and Midwifery, which was a much better position than expected. On 18th June a Graduate Summit was held with WG, HBs and HEIs. From this meeting a number of suggestions were put forward. Over the coming weeks these will be reviewed and if applicable taken forward. On 25th June we will be informing successful students and advising students who have been unsuccessful on next steps which are still be be agreed. Next steps will be agreeing a position on students which are unsuccessful and communicating this to students on 25th June.<br><br>**Risk Lead: Director of People, Organisational Development and Employment Services** | ➔ | **31/07/2026** |
| **A16** | There is a reputational risk for NWSSP regarding the accuracy of the forecast for the Welsh Risk Pool which, materially impacts the financial position of NHS Wales Organisations due to the costs they are required to fund under the Risk Sharing agreement.<br><br>**Escalated Divisional Risk** | 3 | 4 | 12 | Experienced business partner in place with support from Management Accountant. Regular reporting to Shared Services Partnership Committee and Welsh Risk Pool Committee.<br>During 2025/26 additional reporting to Chief Executive Offices, Directors of Finance and Deputy Directors of Finance commenced because of increasing financial pressure on the Welsh Risk Pool contributions from NHS Organisations being insufficient to meet the value of settlements. This will continue into future years. Touchpoint meetings with NHS Resolution to compare trends and approaches etc. New case management system implemented in April 2025 and staff training provided, this should improve the accuracy and timeliness of information used for forecasting. | 4 | 4 | 16 | Work with FP&D data science team to facilitate additional insights into forecasting options they can support. Working with NHSR colleagues to understand their forecasting model in more detail. Monthly forecast meetings with senior LARS colleagues to ensure understanding of key cases, timings and values that will impact the forecast. Regular communications with DoFs & DDoFs on any risks to the forecast position | Significant pressure on the Welsh Risk Pool for 2026/27 and future years. The 2026/27 WELSH Risk Pool risk share contributions as included in out IMTP are £162m. A WRP Programme of work has been agreed with 3 workstreams being taken forward to: (1) Stress test the current forecast and model (with NHSP&I input) (2) Develop specific actions to appropriately challenge and mitigate pressure in 2026/27 (3) Develop preventative actions to address the challenge over the longer term. Workstream 1 is within the remit of Finance and TMO support has been utilised to manage the workstream - 2 meetings have been held with NHS P&I and key trend data shred with them. A DPIA has been signed and NHS P&I will have access to key WRP files to enable regression model to be developed to support understanding of key variables that have changed over the years that have impacted the increase in the forecast costs. An update is planned for DoFs on 19 June 2026.<br><br>**Risk Lead: Director of Legal & Risk Services & Director of Finance & Corporate Services** | ➔ | **31/03/2027** |
| **A17** | There is a risk that NWSSP and NHS Wales organisations will not achieve the required readiness to support implementation of the Wales Resident Doctor Contract Reform Programme, resulting in delays to contract activation, rota compliance, payroll accuracy and supporting system delivery.<br><br>**Strategic Objective - Services** | 5 | 4 | 20 | Contract documentation and associated policies are in final refinement; onboarding and payroll processes are progressing well; rota compliance work continues with Health Boards; and joint work with RLDatix and Health Boards is ongoing. Engagement from organisations has improved, and Guardians of Safe Working recruitment is underway. | 3 | 3 | 9 | Updated compliance numbers provided for the SSPC deep dive. Continued work required to finalise ESR e rostering automation, resolve rota complexities, and ensure consistent organisational readiness. | Engagement from Health Boards has strengthened, and collaborative work with RLDatix is supporting improved consistency. As a result, there is increased optimism that the required position will be achieved. The principal risk remains the potential failure to achieve go live in August 2026, and this is now explicitly reflected in the narrative.<br><br>Current Risk (Amber) The risk remains amber at this stage. Progress is being made and confidence has increased, but key dependencies remain—particularly system readiness and full rota compliance across all specialties.<br><br>**Director of People, Organisational Development and Employment Services** | ➔ | **30/06/2026** |
| | **Risks for Monitoring** | | | | | | | | | | | |
| **M1** | Suppliers, Staff or the general public committing fraud against NWSSP.<br><br>**Strategic Objective - Value For Money** | 5 | 3 | 15 | Dedicated NWSSP LCFS<br>Counter Fraud Service Wales<br>Internal Audit<br>Audit Wales<br>PPV<br>National Fraud Initiative<br>Counter Fraud Steering Group<br>Policies & Procedures<br>Fraud Awareness Training<br>Fighting Fraud Strategy & Action Plan | 2 | 3 | 6 | LCFS Manager continues to deliver the LCFS plan to NWSSP in accordance with required standards and reports to each meeting of the Audit Committee.<br><br>The majority of his work is proactive and there is a high degree of awareness within the critical areas of the organisation of fraud risk, re-enforced by Wales specific training. | Significant progress being made in the rollout of all-Wales counter fraud training throughout higher risk areas in NWSSP.<br><br>NWSSP LCFS attends the Counter fraud Liaison Group which enables all LCFSs to come together and share good practice and peer support.<br>At a national level, the NHSCFA has established a Centre for Specialised Learning and a presentation was provided to DoFs in October.<br><br>It is hoped all NHS Wales Counter fraud staff including LCFSs will be able to access this CPD resource when it goes live, hopefully in the calendar year.<br><br>**Risk Lead: Director of Finance and Corporate Services** | ➔ | **For Monitoring** |
| **M2** | Lack of storage space across NWSSP due to increased demands on space linked to COVID and specific requirements for IP5<br><br>**Strategic Objective - Service Development** | 4 | 4 | 16 | IP5 Board<br>Additional facilities secured at Picketston<br>Regular review at SLG<br>Formal project for Companies House relocation from the Repository is underway | 3 | 4 | 12 | Greater clarity on PPE stockholding has been received and so the next phase of work will include an assessment of warehousing requirements.<br>Some racking in IP5 has been moved to Bridgend stores to make room for<br>Radiopharmacy enabling works.<br>The move from Brecon House to Dupont has now ben completed. | Head of Estates and Facilities is exploring longer term storage solution for records currently in the CoHo. A project group has been established to look at future PPE stockholding which will include warehousing for PPE requirements.<br>Document culling arrangements for primary care records in line with retention procedures have been paused as a consequence of the decision by UK government and Welsh government on retention requirements for potential future IBCA claims..<br>All boxes in IP5 that have needed to be moved from the proposed Radiopharmacy area have now been moved. Options for document storage preferably as part of PPE storage are being actively explored and will form part of IMTP for 2026-2029.<br><br>**Risk Lead: Director of Finance and Corporate Services** | ➔ | **For Monitoring** |
| **M3** | The level of stock that we are being asked to hold is likely to mean that some items go out-of-date before being issued for use and need to be written off causing a loss to public funds and possible reputational damage to NWSSP. | 5 | 5 | 25 | Internal Audit Review of Stores<br>Stock Rotation - based on FIFO<br>Ongoing discussions with WG<br>Regular reporting of losses through the Audit Committee | 2 | 3 | 6 | Welsh Government has now confirmed PPE stockholding levels and this risk will continue to be a feature as the burn rate of PPE is much lower for business as usual activity (even during Winter months) than during the reference period of the 2nd wave of the pandemic. | Stock levels and shelf life continue to be actively monitored. Approvals for stock write offs require Welsh Government approval and will be reported to the NWSSP Audit Committee.<br><br>Treatment of stock provisions and write downs is agreed with Welsh Government as part of year end processes and in line with Accounting Standards.<br><br>**Risk Lead: Director of Finance and Corporate Services** | ➔ | **For Monitoring** |

| Ref | Risk Summary | Inherent Risk | | | Existing Controls & Mitigations | Current Risk | | | Further Action Required | Progress | Trend since last review | Target & Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Likelihood | Impact | Total Score | | Likelihood | impact | Total Score | | | | |
| **M4** | There is a risk due to the volume of data that NWSSP handles that a significant data breach causes a consequent significant impact upon those impacted by the breach, loss of reputation and financial penalty for NWSSP.<br><br>**Strategic Objective: Services** | 3 | **5** | 15 | Established arrangements in place including:<br>Information Governance Manager<br>Information Governance Steering Group (IGSG)<br>On-line mandatory e-learn for all staff and two-yearly refresher training<br>Data Privacy Impact Assessments<br>Policies and Procedures<br>Guides to Good practice<br>regular communications<br>Accountability through breach reporting<br>Cyber Essential criteria applied as part of procurement processes. | 2 | 4 | 8 | Continue to monitor e-learning training compliance and cause of any data breaches through IGSG. | Controls are well embedded in the organisation with staff reminded of need for vigilance as often as possible.<br><br>Director of Finance and Corporate Services (SIRO) and Medical and Deputy Medical Director attending joint training session Working Together with Velindre NHS Trust colleagues on 6 May 2025 covering Caldicott, Data protection and wider information governance. More training is being arranged nationally.<br><br>There is a link to cyber security training and awareness due to the high dependency on data systems.<br><br>NWSSP needs also to assess the impact of data breaches by others e.g. suppliers or other NHS organisations and the impact on NWSSP or wider NHS service delivery, tested through business continuity planning. Need to link to work on Cybersecurity and our supply chain.<br><br>**Risk Lead: Director of Finance and Corporate Services** | ➔ | **At target** |

Key to Impact and Likelihood Scores

| | | Impact | | | | |
|---|---|---|---|---|---|---|
| | | Insignificant | Minor | Moderate | Major | Catastrophic |
| | | 1 | 2 | 3 | 4 | 5 |
| Likelihood | | | | | | |
| 5 | Almost Certain | 5 | 10 | 15 | 20 | 25 |
| 4 | Likely | 4 | 8 | 12 | 16 | 20 |
| 3 | Possible | 3 | 6 | 9 | 12 | 15 |
| 2 | Unlikely | 2 | 4 | 6 | 8 | 10 |
| 1 | Rare | 1 | 2 | 3 | 4 | 5 |

| | |
|---|---|
| Critical | Urgent action by senior management to reduce risk |
| Significant | Management action within 6 months |
| Moderate | Monitoring of risks with reduction within 12 months |
| Low | No action required. |

| | |
|---|---|
| **MEETING** | Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership |
| **DATE** | 07 July 2026 |
| **PREPARED BY** | Carly Wilce, Corporate Services Manager |
| **PRESENTED BY** | James Quance, Assistant Director of Corporate Services |
| **RESPONSIBLE HEAD OF SERVICE** | Alison Ramsey, Director of Finance and Corporate Services |
| **TITLE OF REPORT** | Progress of Agreed Management Actions |

**PURPOSE**

This report provides an update to the NWSSP Audit Committee on progress against agreed management actions by service area within NWSSP, including the current implementation position, any actions dependent on third-party organisations, and requests for extension to target dates.

*The report reflects progress updates received as at 30 June 2026, in accordance with the governance reporting cycle.*

## 1. INTRODUCTION

NWSSP records and monitors agreed management actions raised by Internal Audit, Audit Wales and other external assurance bodies, as appropriate. Maintaining stakeholder confidence is essential and is supported through the effective, timely and evidenced monitoring, escalation and implementation of agreed management actions. This process provides the Committee with assurance that agreed actions are subject to ongoing oversight and that exceptions are identified and escalated through the established governance reporting cycle.

## 2. CURRENT POSITION

The detailed agreed management actions raised in respect of NWSSP services have been captured within the agreed management actions database. A summary extract is attached at **Appendix A** for information and assurance.

There are **49** reports covered within this review: **13** reports achieved **Substantial** assurance; **25** reports achieved **Reasonable** assurance; **3** reports achieved **Limited** assurance; no reports were awarded **No Assurance**; and **8** reports were categorised as **Assurance Not Applicable**. These reports include **132** agreed management actions. Of these, **118** actions have been implemented, **13** are not yet due, no actions are overdue, and **1** action is dependent on third-party organisations. This represents a strong overall implementation position and provides positive assurance that agreed management actions continue to be actively monitored and progressed.

Table 1 - Summary of Agreed Management Actions

| As at 30 June 2026 | | | | | |
|---|---|---|---|---|---|
| **Key Findings** | | **Implemented** | **Not Yet Due** | **Overdue** | **Overdue, but dependent on third party organisations** |
| **Internal Audit** | **127** | **113** | **13** | **0** | **1** |
| *High* | 16 | 15 | 0 | 0 | 1 |
| *Medium* | 79 | 66 | 13 | 0 | 0 |
| *Low* | 13 | 13 | 0 | 0 | 0 |
| *Not Applicable* | 19 | 19 | 0 | 0 | 0 |
| **External Audit** | **2** | **2** | 0 | 0 | **0** |
| *High* | 0 | 0 | 0 | 0 | 0 |
| *Medium* | 2 | 2 | 0 | 0 | 0 |
| *Low* | 0 | 0 | 0 | 0 | 0 |
| *Not Applicable* | 0 | 0 | 0 | 0 | 0 |
| **Other Audit** | **3** | **3** | **0** | 0 | 0 |
| *High* | 0 | 0 | 0 | 0 | 0 |
| *Medium* | 0 | 0 | 0 | 0 | 0 |
| *Low* | 3 | 3 | 0 | 0 | 0 |
| *Not Applicable* | 0 | 0 | 0 | 0 | 0 |
| **TOTALS:** | **132** | **118** | **13** | **0** | **1** |

## 3. NWSSP OVERDUE AGREED MANAGEMENT ACTIONS

There are no overdue agreed management actions for NWSSP in this category. This provides positive assurance to the Committee that implementation is being maintained within agreed timescales.

## 4. DEPENDENT ON THIRD-PARTY ORGANISATIONS

Where NWSSP is reliant on a third-party organisation to complete the work required to fully implement an agreed management action, the action should be escalated to the relevant contact and marked as 'dependent on third-party organisations', with the action taken clearly recorded in the progress update.

These actions should continue to be followed up with the relevant third party and closed on the tracker once implemented. This approach supports transparency, evidences the steps taken by NWSSP, and provides assurance that external dependencies remain under active review.

There is one agreed management action for NWSSP in this category. Full details of the action are provided in Appendix A for the Audit Committee's attention.

## 5. INTERNAL AUDIT REPORTS ADDED TO THE MASTER AGREED MANAGEMENT ACTIONS TRACKER SINCE THE LAST MEETING

Following the extraordinary meeting of the NWSSP Audit Committee held on 15 June 2026, six Internal Audit reports, identifying 17 agreed management actions, have been added to the Agreed Management Actions master register and tracker. The reports are as follows:

- 2025–26: People, Organisational Development (POD) – Recruitment and Retention – Substantial Assurance
- 2025–26: Finance and Corporate Services – Budget Setting – Substantial Assurance
- 2025–26: Procurement Services – Reasonable Assurance
- 2025–26: Procurement Services – Health Courier Services (Vehicle Management) – Reasonable Assurance
- 2025–26: Pharmacy – South-East Radiopharmacy – Reasonable Assurance
- 2025–26: Planning, Performance and Informatics – Cyber Security – Limited Assurance (all agreed management actions from this review have been implemented).

## 6. REQUESTS FOR EXTENSION TO TARGET DATES

Reference 2: SSP-2526-04, Procurement Services: Single Tender Actions & Declarations of Interest

The Director of Procurement, Supply Chain, Logistics, Transport and Laundry Services has discussed this matter with Hywel Jones, Director of Finance, NHS Wales. Further clarification is being sought and discussions with relevant colleagues are ongoing. The action remains under active review, with appropriate senior engagement in place to support resolution.

As the implementation of this action is not wholly within NWSSP's control, the Director of Procurement, Supply Chain, Logistics, Transport and Laundry Services is requesting a one-month extension to allow sufficient time for the outstanding matters to be resolved and for the action to be fully implemented. The proposed extension is proportionate and reflects the dependency on external clarification rather than a lack of progress within NWSSP.

In light of the above, approval is sought to extend the target completion date from 30 June 2026 to 31 July 2026. Progress will continue to be monitored through the agreed management actions tracker and reported through the established governance route.

## 7. RECOMMENDATIONS

The NWSSP Audit Committee is asked to:

- **NOTE** the progress made to date regarding implementation of agreed management actions, including the absence of overdue actions and the continued monitoring of actions not yet due or dependent on third-party organisations.
- **APPROVE** the proposed revised deadline, as follows:
    - *REFERENCE #2 – extension from 30 June 2026 to 31 July 2026.*

| Internal Audit Report Ref | Rec No | Directorate | Report Title | Status | Issue Identified | Risk Rating | Key Finding | Responsibility for Action | Agreed Management Action | Original Deadline | Updated Deadline | Update On Progress Made |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NWSSP-2425-10 | 1 | Planning Performance& Informatics | Digital Service Management | **NYD** | There has been no delegation for monitoring the performance of services provided by DHCW. | **Medium** | To produce a process map, example disseminated documentation and example feedback | Chief Digital Officer | Chief Digital Officer to create process for dissemination of performance monitoring to appropriate service leads and capturing feedback. Note: achievement of this management action depends upon the outcomes of the actions on key findings 1 and 2. | 31/01/2026 | **31/10/2026** | To be developed during the monitoring period and released once the agreed service schedule is complete. |
| SSP-2526-04 | 2 | Procurement Services | Procurement Services: Single Tender Actions & Declarations of Interest | **NYD** | The SFIs require dual approval for Single Tender Actions (STAs) valued above £25,000 by the Chief Executive (or designated deputy) and the Director of Finance. The STA template form does not reflect this requirement.<br>In some cases there was evidence of delegation from the CEO to the DoF, but this practice falls short of the dual approval required by SFIs. Eight STAs had been approved by only the Director of Finance, and a further two had been approved by a Head of Finance or equivalent, neither of whom are authorised approvers under the SFIs.<br>We also identified two STAs with electronic or typed signatures without supporting email evidence to verify the source, despite being an explicit requirement noted on the form. | **High** | Expected Evidence of Implementation:<br>Email correspondence from health bodies confirming STA approval delegation arrangements.<br>Email correspondence from WG clarifying the requirement for dual approval of STAs over £25k.<br>Updated STA template subject to the clarification provided by WG. | Jonathan Irvine, Director of Procurement & Health Courier Services | STA approval delegations will be confirmed with health bodies.<br>Clarity will be sought from WG regarding the requirement for and the nature of the dual approval for STAs over £25k, where the CEO delegates authority to a designated deputy and the dual requirement for Director of Finance approval. The STA template will be amended as necessary based on the clarification provided by WG. | 30/06/2026 | **31/07/2026** | The Director of Procurement, Supply Chain, Logistics, Transport and Laundry Services has discussed this matter with Hywel Jones, Director of Finance, NHS Wales. Further clarification is being sought and discussions with relevant colleagues are ongoing. |
| SSP 2526-14 | 3 | Planning, Performance & Informatics | Digital Strategy | **NYD** | There is no single dedicated digital steering group which connects divisions with digital and enables ownership of digital or consolidated report that provides an overall view of portfolio progress, interdependencies and cumulative exposure. | **Medium** | Expected Evidence of Implementation: Review to report back to PPI Director advising of findings. | Chief Digital Officer | A review of existing digital communication and governance structures will be undertaken to determine how they can better provide consolidated portfolio-level visibility of Digital Strategy progress, interdependencies and risks, and support clearer shared ownership across divisions. | 31/10/2026 | | |
| SSP 2526-14 | 4 | Planning, Performance & Informatics | Digital Strategy | **NYD** | There is no single, aggregated strategic digital risk that captures cumulative delivery risk exposure across the full portfolio | **Medium** | Expected Evidence of Implementation: Review to report back to PPI Director advising of findings. | Chief Digital Officer | Review of all digital risks within the scope of informatics-supported works, including mechanism for capture and recording, to be undertaken. | 31/10/2026 | | |
| SSP 2526-14 | 5 | Planning, Performance & Informatics | Digital Strategy | **NYD** | While the IMTP framework provides a structured roadmap and prioritisation mechanism, there is no single consolidated digital roadmap document that presents sequencing, interdependencies and overall delivery trajectory in one place. As a result, portfolio level visibility requires review of multiple reports. | **Medium** | Expected Evidence of Implementation: Review to report back to PPI Director advising of findings. | Chief Digital Officer | Review of current mechanisms for capturing digital roadmap and identification of any appropriate opportunities to consolidated recording and reporting. | 31/10/2026 | | |
| SSP 2526-14 | 6 | Planning, Performance & Informatics | Digital Strategy | **NYD** | There is no consolidated portfolio level resource model bringing together cumulative workforce demand, specialist capability requirements and financial commitments across the full digital roadmap. | **Medium** | Expected Evidence of Implementation: Publication of refreshed digital strategy | Chief Digital Officer | Delivery of a refreshed digital strategy will include assessment of workforce, capabilities and financial commitments and set out the strategic route forwards. | 31/10/2026 | | |
| SSP-2526-05 | 7 | Procurement Services | Health Courier Services: Vehicle Management | **NYD** | FleetCheck requires manual population and has not been kept up to date. The system notifies when a vehicle is due for service/maintenance/tax but a system report identified that the service due date field is blank for 48% of vehicles.<br>Sample testing of 20 vehicles selected from the Cleric (HCS scheduling) system confirmed that all were recorded on FleetCheck, but there was very little information and evidence within FleetCheck to confirm compliance with statutory and<br>organisational requirements relating to servicing, MOT, tax and safety inspections.<br>Evidence of compliance was sourced predominantly from Chevin (a WAST system), and third parties for leased and electric vehicles. The necessity for a separate system should be reviewed. | **Medium** | Rationalisation of fleet systems enabling access to accurate data applicable to the vehicle requirements when required to evidence compliance with statutory and regulatory standards. | Jonathan Irvine, Director of Procurement & Health Courier Services | The feasibility of adopting the Chevin system as a single, central fleet management solution will be explored and the ongoing requirement for the separate FleetCheck system will be assessed.<br>Planned engagement with WAST to review Chevin functionality and determine suitability for HCS use. This will inform the service specification to progress with awarding a compliant contract in due course with the aim for a Once for Wales solution aligned to the Welsh Government Decarbonisation Strategy's Initiative 18 – subject to funding availability and necessary approvals. | 31/03/2027 | | |
| SSP-2526-05 | 8 | Procurement Services | Health Courier Services: Vehicle Management | **NYD** | Daily Vehicle Checks<br>Review of a Datix incident report highlighted nine instances (representing <3% of all incidents reported) where failure to adequately perform vehicle checks was identified in the investigation as a contributory factor. Examples include pathology items left in vehicles and vehicle damage not identified/reported. | **Medium** | More robust mechanisms for the completion and review of daily vehicle checks – SOP and Cleric evidence<br>Enhanced awareness of the importance of accurate daily vehicle check completion and acknowledgement of the consequences of non-conformance. – SOP and measurable reduction in Datix incidents linked to a vehicle check failure issue.<br>Dependant on logistics planning platform version developments in late Summer/early Autumn 2026, using photographic evidence to support daily vehicle check auditing. | Jonathan Irvine, Director of Procurement & Health Courier Services | Agreed Action:<br>The requirement for daily vehicle checks, including clear expectations regarding accountability and ownership for their completion, will be reinforced through the fleet management policy – see action 1.<br>Alternative solutions to the current system for recording daily vehicle checks are being explored, including options that incorporate photographic evidence to strengthen assurance that checks are undertaken and completed to the required standard.<br>Existing daily vehicle checks are being strengthened with a review of resource management functionality within the logistics planning platform (Cleric).<br>Discussions held with the logistics planning platform suppliers to review development of photo capture and early indications it may be available in version 6.3 due to be released in Summer 2026.<br>Any HCS Operatives who have evidently not adhered to established requirements aligned to daily vehicle check completion have been and will continue to be managed in line with Workforce policies. | 26/10/2026 | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SSP-2526-05 | 9 | Procurement Services | Health Courier Services: Vehicle Management | **NYD** | Post Investigation Feedback & Lessons Learned<br>Sample testing of 20 incidents identified 15 with no feedback form or action report, and three with no lessons learned form.<br>Whilst lessons learned are recorded within the appropriate field on Datix, there are currently no formal mechanisms in place to support the wider dissemination of this learning, and it is not routinely communicated beyond the system. | **Medium** | Governance group meeting papers demonstrating review / discussion / dissemination of lessons learned. Correspondence with staff (e.g. newsletters, team briefings) demonstrating shared learning.<br>The completed HCS RTI Datix Investigation Checklist will be added to Datix to evidence closure of the process and documentation trail. | Jonathan Irvine, Director of Procurement & Health Courier Services | Implement a formal process to ensure that lessons learned from incidents recorded on Datix are systemically shared across the service via governance meetings, team briefings, and integrated into training materials to support continuous improvement and mitigate the risk of recurrence. A lessons learned log is now in place with a requirement for all lessons learnt to be logged and tracked, reviewed by Regional Managers and disseminated to the wider HCS and SC,L&T teams where applicable. An HCS RTI Datix investigation checklist is in development capturing the relevant documentation that is required to be completed and uploaded to Datix in relation to different categories of report submitted. Not all documents are relevant to all reports. Current mechanisms for sharing information include issuing National Notices which are shared on noticeboards, local communication channels, toolbox talks, driver partner meetings; local comms shared via messaging platforms, local noticeboards etc.; Service wide messages via the logistics planning platform Cleric with the use of mobile messages and messages of the day; and notices added to the content locker accessible via PDAs. | 06/07/2026 | | |
| SSP-2526-17 | 10 | Pharmacy Services | SE Radiopharmacy 2 | **NYD** | Contractual Control (Build Contract)<br>A contract applying standard NHS Procurement terms and conditions was applied to the construction phase. This was coupled with a statement of the tender information as to the design and costings.<br>However, typical contractual controls within construction contracts include:<br>•Programme control (notably agreed start and end dates, a contractually agreed / revised programme and delay damages);<br>•defects liability;<br>•costed programme activities;<br>•priced risks;<br>•methodologies for agreeing changes to time and cost (including information / costing response times);<br>•inflationary uplift methodology; and<br>•performance monitoring.<br>Full details can be found in the full report | **Medium** | South West and North Wales Hubs will have appropriate building contracts. | Programme Manager | Since this finding was reported in an earlier audit report action has been taken to ensure that other contracts have appropriate building contract terms. For future construction contracts such as the South West Wales and North Wales TRAMS hubs an appropriate building contract will be used.<br><br>Additional comment:<br>It is worth noting that close working with the contractor and monitoring by the project team have mitigated risks ensured that the building has been delivered under budget. | 30/06/2027 | | |
| SSP-2526-17 | 11 | Pharmacy Services | SE Radiopharmacy 2 | **NYD** | [illegible] controlling contract changes e.g. the Project and Finance Teams escalate to the Project Board for consideration where there may be an impact on project contingency.<br>However, the processes operated were not fully described within project controls.<br>Variation Orders issued by the Contract Administrator acted as the primary mechanism for pricing changes, ahead of formal approvals (via Contract Change Requests and Contract Change Notifications).<br>For Contract Change Notification 3 a Contract Change Request was approved by the project manager, service director and Director of Finance on 30th July 2025 and enacted as an agreed Contract Change Note (CCN) with the Contractor on 1st August 2025). | **Medium** | Capital financial control procedure to be revised. | Programme Finance Lead | The capital financial control procedure will be revised to detail requirements for the processing of variation orders and change request forms. | 30/09/2026 | | |
| SSP-2526-17 | 12 | Pharmacy Services | SE Radiopharmacy 3 | **NYD** | Change control arrangements did not clearly distinguish between contractor-initiated (technical) changes and client or user-initiated changes. As a result, reporting did not consistently attribute cost and programme impacts to their underlying cause, reducing transparency for management and the Project Board. Clearly differentiated change documentation can facilitate more effective scrutiny, better inform approval decisions, and contribute to learning about design maturity and contractor versus client risk allocation for future project stages. Such procedures, applicable across all projects would usefully be specified within Capital Procedures (being referenced from the Project Initiation Document) e.g. via client and contractor variation forms. | **Medium** | Revised change request forms and associated reporting delineating between client and contractor change. | Programme Finance Lead | Review and amend report templates to make contractor versus client changes explicitly clear for future project | 30/09/2026 | | |
| SSP-2526-17 | 13 | Pharmacy Services | SE Radiopharmacy 4 | **NYD** | At the time of audit, the equipment monitoring schedule included a material proportion of items recorded as "not defined", representing a residual value pending specification or confirmation. While overall equipment expenditure remained within the approved budget, the absence of full definition limited the completeness and reliability of reporting at an advanced stage of the project. Full details can be found in the report. | **Medium** | Project monitoring and reporting at future programme stages will fully allocate and identify any equipment contingency by the latter stages of the project. | Programme Finance Lead | At future programme stages we will look to fully allocate and identify any equipment contingency by the latter stages of the project | 30/09/2026 | | |
| SSP-2526-09 | 14 | Budget Setting | CORP/2025-26/3 | **NYD** | Three columns exist [Sent, Signed, Copy returned]within [Recurrent budget 2025-26 for budget setting final ]the spreadsheet used to ensure the correct budget holder letter goes to the correct budget holder, on inspection by IA the majority of the columns were not used in any way to control the issue and return of budget holder letters.<br>On reconciliation of budget holder letters returned to the IMTP it was found that one of the returned letters covering five | **Medium** | Template updated with new fields to be used to monitor issue and return of budget holder letters from 2026/27 | Head of Financial Resources, Systems & Planning | Refresh of budget holder letter control template to be undertaken to include fields to confirm the budget holder letter for the correct year has been issued and returned. Ensure all fields of the template are completed and monitored and retrospectively used for the 2026/27 budget holder letters issued in March 2026 | 30/09/2026 | | |

| | |
|---|---|
| **MEETING** | Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership |
| **DATE** | 07 July 2026 |
| **PREPARED BY** | Carly Wilce, Corporate Services Manager |
| **PRESENTED BY** | James Quance, Corporate Services |
| **RESPONSIBLE HEAD OF SERVICE** | Alison Ramsey, Director of Finance and Corporate Services |
| **TITLE OF REPORT** | NWSSP Audit Committee Annual Report 2025-26 |
| **PURPOSE**<br>The Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership Audit Committee Annual Report 2025-26 is presented to the Committee, for **APPROVAL**. | |

## 1. INTRODUCTION

In accordance with the Audit Committee Terms of Reference, the Audit Committee produces a written Annual Report to inform the Shared Services Partnership Committee and the accountable officer on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of NWSSP's assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards.

The Annual Report of the NWSSP Audit Committee, for the reporting period 2025-26, highlights the activities and details the performance of the Committee. The purpose of the Audit Committee is to review the establishment and maintenance of the effective systems of internal control and risk management. In achieving this aim, the Committee assesses the work undertaken by Internal Audit, External Audit and Local Counter Fraud Specialists, together with management in areas of governance, risk and control.

The Committee shall endeavour to continue to develop its functions and effectiveness and intends to seek further assurance, throughout 2026-27.

## 2. RECOMMENDATION

- The Audit Committee is asked to:
    - **APPROVE** the Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership Audit Committee Annual Report 2025-26.

# Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership

# Annual Report 2025-2026

## 1. FOREWORD

I am pleased to present the Annual Report of the Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership (the Committee). It outlines the coverage and results of the Committee's work for the year ending 31 March 2026.

I have acted as the Chair of the Audit Committee since 1 February 2024 and have been ably supported by Independent Member, Vicky Morris, throughout the year. I would like to take this opportunity to put on record my sincere thanks to Vicky for her significant contributions made during the year. I wish to record my thanks also to John Union (Independent Member (Finance)) who observed the February meeting of the Audit Committee. He will be joining the Committee as an additional Independent Member.

I would also like to express my thanks to all the NWSSP Officers supporting the Committee who have supported and contributed to the work carried out on its behalf and for their commitment in meeting important targets and deadlines. I also wish to record my appreciation for the support and contribution given by Internal Audit at NWSSP, Local Counter Fraud Services and by Audit Wales.

During 2025-26 NWSSP has continued to grow both in terms of size and complexity. The total revenue expenditure for the year was £1,146m, compared to less than £50m when NWSSP was first established in 2011. The wide range of services provided by NWSSP significantly changes its risk profile and requires the Committee to work with its auditors in particular, in ensuring that appropriate assurances are in place.

Most meetings continue to be held virtually and have worked well, albeit that we have reintroduced one face-to-face meeting annually. A characteristic of the Committee's work and its related meetings has been the willingness of all parties to raise issues, acknowledge shortcomings and put forward positive suggestions to help bring about meaningful improvements to services, systems, and day-to-day working practices. This approach is to be welcomed and is very much appreciated by the Committee.

I am keen to foster and promote a culture of continual improvement and, as a Committee, we continued to conduct a brief effectiveness review session at the end of each meeting and introduced topical service presentations to the agenda in order to strengthen and engage in a meaningful way with this process. We also conduct an annual survey which seeks the opinion of Committee members and those who attend the meetings as to the effectiveness of the Committee and its proceedings.

Looking forward, the Committee intends to continue to pursue a full programme of work covering a wide range of topics and subject areas as part of its long-term aim to help further strengthen the governance arrangements of NWSSP, in order to achieve better value for money and high quality, sustainable outcomes for NHS Wales.

**Mr Gareth Jones**
**Chair of the Velindre University NHS Trust Audit Committee for NWSSP**

## 2. INTRODUCTION

The Committee's business cycle runs from the closure of the Annual Accounts in one financial year to the next. This reflects its key role in the development and monitoring of the Governance and Assurance framework for NWSSP, which culminates in the production of the Annual Governance Statement.

This report sets out the role and functions of the Audit Committee and summarises the key areas of business undertaken during the year. In addition, the report sets out some of the key issues, which the Committee will be focussing on over the next few years.

## 3. ROLE, MEMBERSHIP, ATTENDEES AND COMMITTEE ATTENDANCES

### 3.1 Role

The primary role of the Velindre University NHS Trust Audit Committee for Shared Services Partnership (the Audit Committee) is to review and report upon the adequacy and effective operation of NWSSP's overall governance and internal control system. This includes risk management, operational and compliance controls, together with the related assurances that underpin the delivery of NWSSP's objectives as set out in the Audit Committee Terms of Reference, which were reapproved in July 2024 to ensure these key functions were embedded within the SSPC Standing Orders and governance arrangements. The membership of the Audit Committee comprises Trust Board members. Therefore, the Audit Committee provides assurances to the SSPC and also to the Trust as host.

The organisation's system of internal control has been designed to identify the potential risks that could prevent NWSSP achieving its aims and objectives. It evaluates the likelihood of the risks being realised, considers the impact should they occur and seeks to manage them efficiently, effectively, and economically. Where appropriate, the Committee will advise the SSPC and Velindre University NHS Trust as host, where appropriate and the Accountable Officers of NWSSP and the Trust on where and how the Assurance Framework may be strengthened and developed further.

The Committee operates in accordance with Terms of Reference which are included within the Standing Orders for the SSPC and Velindre University NHS Trust.

### 3.2 Governance Framework

NWSSP is a non-statutory hosted organisation. It operates within an established governance and accountability framework set out by Welsh Ministers. This framework, as set out below, is designed to ensure that NWSSP operates in true partnership, owned and operated by the NHS in Wales operating under a hosting arrangement with Velindre University NHS Trust.

Decisions on NWSSP services are made on an all-Wales basis by the Shared Services Partnership Committee (SSPC). The SSPC was established in accordance with the Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 and the functions of managing and providing shared services (professional, technical, and administrative services) to the NHS in Wales is included within the Velindre National Health Service Trust (Establishment) (Amendment) Order 2012. The Regulations were subsequently amended in 2021 to include Special Health Authorities (SHAs) via the Velindre National Health Service Trust Shared Services Committee (Wales) (Amendment) Regulations 2021.

Model Standing Orders are issued by Welsh Ministers to Local Health Boards and Welsh NHS Trusts using powers of direction provided in section 12(3) of the National Health Services (Wales) Act 2006.

Velindre University NHS Trust (the Trust) must agree Standing Orders for the regulation of the Shared Services Partnership Committee's (the SSPC) proceedings and business. These SSPC Standing Orders form an Annexe to the Trust's own Standing Orders and have effect as if incorporated within them.

They are designed to translate the statutory requirements set out in the Velindre University NHS Trust Shared Services (Wales) Regulations 2012 (2012/1261 (W.156)), amended 2021 and the Trust's Standing Order 3 into day-to-day operating practice. These together with the adoption of a scheme of decisions reserved to the SSPC; a scheme of delegation to NHS Wales Shared Services Partnership officers and others; and in conjunction with Velindre University NHS Trust Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the SSPC.

Health Boards, NHS Trusts and, latterly the two Special Health Authorities have collaborated over the operational arrangements for the provision of shared services and have an agreed Memorandum of Co-operation to ensure that the arrangements operate effectively through collective decision making in accordance with the policy and strategy set out above, determined by the SSPC.

A Hosting Agreement dated June 2012 between the Partners provides for the terms on which Velindre University NHS Trust will host NWSSP and an Interface Agreement between the Chief Executive of the Trust (as the Accountable Officer for the organisation) and the Managing Director of NWSSP (as the Accountable Officer for NWSSP) dated June 2012 defines the respective roles of the two Accountable Officers.

These documents together form the basis upon which the SSPC governance and accountability framework has developed. Together with the adoption of the Trust's Standards of Behaviour Framework, this is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

Welsh Government Independent Review of NHS Wales Shared Services Partnership Accountability & Governance Arrangements

In April 2025, Welsh Government commissioned an independent review of NWSSP accountability and governance arrangements, recognising the increasing scale, complexity and maturity of the organisation since the current framework was established. This followed commitments set out in A Healthier Wales (2018) to review hosted and national functions to consolidate national activity and provide greater clarity of governance and accountability.

The Independent Review, published in December 2025, concluded that the overall governance framework for NWSSP is fundamentally sound, while making recommendations to strengthen clarity of accountabilities, assurance to NHS Boards, and the effectiveness of key governance arrangements. This included particular emphasis on the operation of the Shared Services Partnership Committee (SSPC) and the relationship between NWSSP and Velindre University NHS Trust, as the statutory host organisation.

Throughout the review and implementation of its recommendations, which is ongoing, NWSSP has continued to operate within the requirements of the existing governance framework, maintaining effective accountability and assurance arrangements. The Review and its ongoing implementation provide an opportunity for governance arrangements to be actively strengthened, with continued oversight through established governance structures into 2026–27.

## 3.2 Membership

The Audit Committee for NWSSP is a sub-committee of Velindre University NHS Trust and operates alongside the Trust's own Audit Committee. Membership during the year has been two Independent Members who serve on both Audit Committees, with one being the Chair which satisfied the quorum requirements.

The Terms of Reference of the Committee provide for there to be three members who are Independent Members of the Trust. However, for 2025-26 there were two dedicated Independent Members, both of whom attended every meeting of the Committee ensuring that each meeting was quorate.

During the year, the Trust appointed a dedicated Independent Member for Finance who observed the February 2026 meeting of the Audit Committee and subsequently joined the Committee as a member.

## 3.3 Attendees

The Committee's work is informed by reports provided by Audit Wales, Internal Audit, Local Counter Fraud Services and NWSSP officers. Although they are not members of the Committee, auditors, and other key personnel from both Velindre University NHS Trust, as host, and NWSSP are invited to attend each meeting of the Audit Committee. Invitations to attend the Committee meeting are also extended where appropriate to staff where reports relating to their specific area of responsibility are discussed.

### 3.4 Attendance at Audit Committee 2025-26

During the year, the Committee met on four occasions. All meetings were quorate and were well attended as shown in **Figure 2** overleaf:

### Figure 2: Meetings and Member Attendance 2025-26

| In Attendance | 13/05/2025 | 8/07/2025 | 07/11/2025 | 10/02/2026 | Total |
|---|---|---|---|---|---|
| **Members** | | | | | |
| Gareth Jones, Chair & Independent Member | ✓ | ✓ | ✓ | ✓ | **4/4** |
| Vicky Morris, Independent Member | ✓ | ✓ | ✓ | ✓ | **4/4** |
| **Audit Wales** | | | | | |
| Audit Team Representative | ✓ | ✓ | ✓ | ✓ | **4/4** |
| **NWSSP Audit and Assurance Services** | | | | | |
| Director of Audit & Assurance | ✓ | ✓ | ✓ | ✓ | **4/4** |
| Head of Internal Audit | ✓ | ✓ | ✓ | ✓ | **4/4** |
| **NWSSP Counter Fraud Services** | | | | | |
| Local Counter Fraud Specialist | ✓ | ✓ | ✓ | ✓ | **4/4** |
| **NWSSP** | | | | | |
| Professor Tracy Myhill OBE, Chair of SSPC | x | ✓ | ✓ | x | **2/4** |
| Neil Frow OBE, Managing Director | ✓ | ✓ | ✓ | ✓ | **4/4** |
| Alison Ramsey, Director of Finance & Corporate Services | ✓ | ✓ | ✓ | ✓ | **4/4** |
| Linsay Payne, Deputy Director of Finance & Corporate Services | ✓ | ✓ | ✓ | ✓ | **4/4** |
| James Quance, Assistant Director of Corporate Services | ✓ | ✓ | ✓ | ✓ | **4/4** |
| Carly Wilce, Corporate Services Manager | ✓ | ✓ | ✓ | ✓ | **4/4** |
| **Velindre University NHS Trust** | | | | | |
| Matthew Bunce, Executive Director of Finance Services | ✓ | x | x | ✓ | **2/4** |
| David Donegan, Chief Executive, Part year to November 2025 | ✓ | x | - | - | **1/2** |
| Carl James, Deputy Chief Executive and Interim Chief Executive Officer from November 2025 | - | ✓ | ✓ | x | **2/4** |
| Non Gwilym, Interim Director of Corporate Governance | ✓ | ✓ | x | x | **2/4** |

## 3.5 AUDIT COMMITTEE BUSINESS

The Audit Committee provides an essential element of the organisation's overall assurance framework. It has operated within its Terms of Reference in accordance with the guidance contained within the NHS Wales Audit Committee Handbook.

The Audit Committee agenda broadly follows a standard format, comprising of four key sections; External Audit, Internal Audit, Counter Fraud Services and 'Internal Control and Risk Management'. These are discussed further below.

### 3.5.1 EXTERNAL AUDIT (AUDIT WALES)

Audit Wales provides an Audit Position Statement at each meeting, summarising progress against its planned audit work. The following additional reports were presented during the year:

- Audit Wales Nationally Hosted NHS IT Systems Assurance Report
- Audit Wales Management Letter
- Audit Assurance Arrangements

Audit Wales have stated that the findings of their work enable them to place reliance on the services provided by NWSSP.

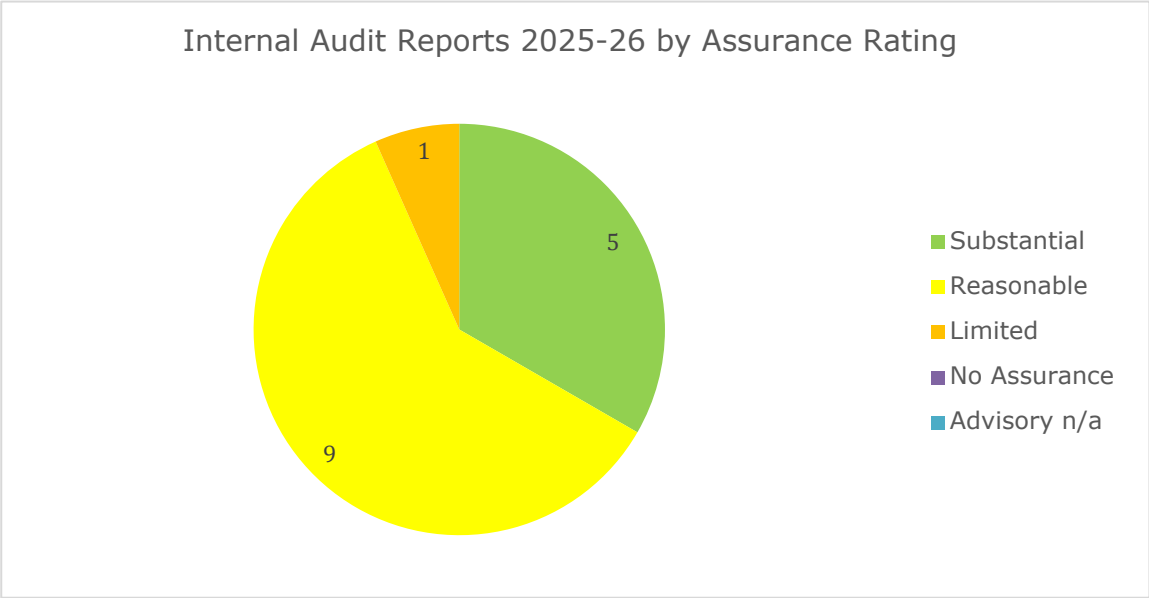
### 3.5.2 INTERNAL AUDIT

Internal Audit have continued to support the organisation in the development and improvement of its governance framework by providing proactive advice and support on new developments and ensuring that the existing systems and processes of control are reviewed, weaknesses identified, and suggestions for improvement made.

**15** Internal Audit reports were generated during 2025-26 and they achieved assurances as follows:

- Five reports achieved Substantial Assurance;
- Nine reports achieved a Reasonable Assurance;
- One achieved Limited Assurance;
- None were Advisory/Non-Opinion; and
- None were rated as No Assurance.

**Figure 3: Internal Audit Reports 2025-26 by Assurance Rating**




During 2025-26, the reports to Committee on Internal Audit's programme of work included:

- Internal Audit Position Statement at each meeting;
- Head of Internal Audit Opinion and Annual Report;
- Quality Assurance and Improvement Programme Report;
- Internal Audit Operational Plan; and
- Internal Audit Reports, as detailed in Appendix A.

**Figure 4: Head of Internal Audit Opinion: Reasonable Assurance**

| | |
|---|---|
|  Reasonable | The Shared Services Partnership Committee can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved. |

### 3.5.3 LOCAL COUNTER FRAUD SERVICES

The work of the Local Counter Fraud Services is undertaken to minimise the risk of and incidence of fraud (and/or corruption) within NWSSP to an absolute minimum. Regular reports were received by the Committee to monitor progress against the agreed Counter Fraud Plan, including the following:

- Counter Fraud Work Plan 2025/26
- Counter Fraud Progress Update at each meeting; and
- Counter Fraud Annual Report 2025/26.

NWSSP's dedicated local Counter Fraud specialist operates a regular annual programme of raising fraud awareness, for which a number of days are allocated and included as part of a Counter Fraud Work Plan which is approved annually by the Audit Committee. In addition, staff newsletters are produced periodically and are published on NWSSP's intranet; all successful prosecution cases are publicised to obtain the maximum deterrent effect.

### 3.5.4 INTERNAL CONTROL AND RISK MANAGEMENT

In addition to the audit reports dealt with by the Committee during the reporting period, a wide range of internally generated governance reports/papers were produced for consideration by the Audit Committee including:

***Annual Governance Statement*:** During 2025-26, the NWSSP produced its Annual Governance Statement which explains the processes and procedures in place to enable NWSSP to carry out its functions effectively. The Statement brings together all disclosures relating to governance, risk, and control for the organisation.

***Tracking of Audit Recommendations*:** The Committee has continued focus on the timely implementation of audit recommendations. The overall position with this is very positive but occasionally requests are made to extend the date of an agreed action due to a change in circumstance. All such requests have to be approved by the Committee.

Following the introduction of the Global Internal Audit Standards (GIAS) from April 2025, Internal Audit reporting terminology has been updated. Audit recommendations are now referred to as key findings, and progress against management responses is monitored through the Agreed Management Actions Tracker, replacing the previous Tracking of Audit Recommendations report.

***Audit Committee Effectiveness Survey:*** The Audit Committee completes an annual committee effectiveness survey evaluating the performance and effectiveness of:

- the Audit Committee members and Chair;
- the quality of the reports presented to Committee; and
- the effectiveness of the Committee secretariat.

The survey questionnaire comprises self-assessment questions intended to assist the Audit Committee in assessing their effectiveness with a view to identifying potential areas for development, going forward.

The annual committee effectiveness survey was discussed at the Audit Committee meeting in April 2026, having been deferred pending the outcome of the Welsh Government Review. The Review sought evidence regarding its operation and made no recommendations regarding the effectiveness of the Committee. Consequently, it was agreed to undertake the survey in May 2026

and report back the findings, including any agreed development actions, to the Audit Committee meeting in July 2026.

In addition, Audit Committee Members were invited to participate in the Autumn Committee Development Day held in October 2025, which provided a dedicated forum for members to reflect on and inform the strategic direction of NWSSP. The session included a review and refresh of the NWSSP Strategy Map, consideration of the MAG report and broader organisational priorities, and discussion on how NWSSP can further support health organisations in delivering their plans. Updates were also provided on key transformation programmes, including Transforming Access to Medicines (TrAMS) and the Electronic Staff Record (ESR), alongside collective reflections from members to support continuous improvement in the effectiveness and impact of the Committee.

### *Private Meeting with Auditors*

In line with recognised good practice, an annual private meeting was held in January 2026 between Audit Committee members, Internal Audit, External Audit, and the Local Counter Fraud Specialist. This provided an opportunity for any matters of concern to be raised without the involvement of NWSSP corporate directors. No issues of concern arose from the meeting. All auditors are also aware that they can directly approach the Chair at any time with any matters that concerns them.

## 5. REPORTING AND COMMUNICATION OF THE COMMITTEE'S WORK

The Committee reports a summary of the key issues discussed at each of its meetings to the Senior Leadership Group, Shared Services Partnership Committee and to Velindre University NHS Trust Board by way of an Assurance Report. In addition, this Annual Report seeks to bring together details of the work carried out during the reporting period, to review and test NWSSP's Governance and Assurance Framework. The outcome of this work has helped to demonstrate the effectiveness of NWSSP's governance arrangements and underpins the assurance the Committee was able to provide.

## 6. CONCLUSION AND FORWARD LOOK

The work of the Audit Committee in 2025-26 has been varied and wide-ranging. The Committee has sought to play its part in helping to develop and maintain a more effective assurance framework in a constantly changing and developing organisation, and improvements have been evidenced by the findings of internal and external audit.

Looking forward to 2026-27 the Audit Committee will continue to explore the financial, management, governance and quality issues that are an essential component of the success of NWSSP.

Specifically, the Audit Committee will:

- Continue to examine the governance and internal controls of NWSSP;

- Monitor closely risks faced by NWSSP;
- Work closely with external and internal auditors, on issues arising from both the current and future agenda for NWSSP;
- Ensure that the SSPC and Velindre's Trust Board is kept aware of its work including both positive and adverse developments; and
- Request and review a number of deep dives into specific areas to ensure that it provides adequate assurance to both the Audit Committee and the SSPC.

**APPENDIX A**

**List of Internal Audits Undertaken and Assurance Ratings**

| Internal Audit Assignment | Assurance Rating 2025-26 | Date Presented To Audit Committee |
|---|---|---|
| Primary Care Service - Ophthalmic | Substantial | 7 November 2025 |
| Targeted Estates Funding | Substantial | 10 February 2026 |
| Payroll Services | Substantial | 28 April 2026 |
| NWSSP Recruitment and Retention | Substantial | 15 June 2026 |
| Budget Setting | Substantial | 15 June 2026 |
| Accounts Payable | Reasonable | 7 November 2025 |
| Risk Management | Reasonable | 7 November 2025 |
| Radiopharmacy (1) | Reasonable | 7 November 2025 |
| TrAMS Digital | Reasonable | 10 February 2026 |
| Single Lead Employer | Reasonable | 28 April 2026 |
| Digital Strategy | Reasonable | 28 April 2026 |
| Procurement (Single Tender Actions and Declaration of Interests) | Reasonable | 15 June 2026 |
| Health Courier Services | Reasonable | 15 June 2026 |
| Radiopharmacy (2) | Reasonable | 15 June 2026 |
| Cyber Security Governance Arrangements | Limited | 15 June 2026 |
| *Substantial Assurance Rating* | *5* | |
| *Reasonable Assurance Rating* | 9 | |
| *Limited Assurance Rating* | *1* | |
| *No Assurance Rating* | *0* | |
| *Assurance Not Applicable* | *0* | |
| **Total** | **15** | |

**APPENDIX B**

## Internally Generated Assurance Reports/Papers

| Report/Paper | Every Meeting | Annually | As Appropriate |
|---|---|---|---|
| Tracking of Audit Recommendations | ✓ | | |
| Governance Matters | ✓ | | |
| Corporate Risk Register | ✓ | | |
| Audit Committee Forward Plan | ✓ | | |
| Annual Governance Statement | | ✓ | |
| Audit Committee Effectiveness Review and Results | | ✓ | |
| Audit Committee Annual Report | | ✓ | |
| Audit Committee Terms of Reference | | ✓ | |
| Assurance Mapping | | ✓ | |
| Information Governance Annual Report | | ✓ | |
| NWSSP Integrated Medium Term Plan (IMTP) | | ✓ | |
| NWSSP Annual Review | | ✓ | |
| Welsh Language Annual Report | | ✓ | |
| Review of Stores Write-Offs | | ✓ | |
| Review of the Shared Services Partnership Committee's Standing Orders (SSPC SOs) | | | ✓ |

# Welsh Language Annual Performance Report

# 2025 - 2026

## Contents: Page:

## Introduction

This Welsh Language Annual Performance Report highlights our key achievements in 2025/26 in delivering services through the medium of Welsh, alongside our performance against the Welsh Language Standards (No. 7) 2018, the Welsh Language (Wales) Measure 2011, and our wider statutory duties including the Duty of Quality.

Throughout the year, we have maintained careful oversight of our compliance with the Welsh language standards, reviewed our processes and protocols to drive ongoing improvements, and pursued innovative approaches to support other NHS organisations with translation services, enabling them to meet compliance requirements and provide Welsh language services for patients and the public.

Our work continues to be guided by the Welsh Language Standards (No. 7) 2018 and the priorities outlined in the *More Than Just Words* Strategy 2022–2027, as well as the long-term vision of *Cymraeg 2050*, which seeks to increase the use of Welsh across all aspects of public life. These frameworks, together with the Well-being of Future Generations (Wales) Act 2015, ensure that our Welsh language services are planned sustainably, with consideration for the needs of both current and future service users.

The delivery of Welsh language services is embedded within our integrated medium-term plan, ensuring that the requirements of services and service users are met in the short, medium, and longer term, while upholding our commitment to high-quality, accessible services through the medium of Welsh.

## Service Delivery Standards (Standards 1 – 64)

We continuously monitor compliance with the Welsh Language Standards through a structured, cyclical process. Each year, every division and service area completes a self-assessment, with the following year dedicated to addressing any issues identified.
Directors, deputy directors, heads of service, and managers use the compliance notice and code of practice to guide their evaluations, providing evidence to demonstrate adherence to the standards.

The self-assessment also sparks local improvement plans, highlighting areas for additional support and creating opportunities to share best practice across the organisation.

The results of the 2025/26 self-assessment for service delivery standards are as follows:

| Set of Standards | Level of compliance 2023/24 | Level of compliance 2024/25 | Level of Compliance 2025/26 |
|---|---|---|---|
| Correspondence (1,4,5,6,7) | Medium level of compliance | Medium level of compliance | Medium to high level of compliance |
| Telephone services main number/contact centres (8,9,10,11,12,13,14,15,16) | Medium level of compliance | Medium level of compliance | Medium level of compliance |
| Telephone services direct numbers (16,17,18, 19) | Low to medium level of compliance | Medium level of compliance | Medium level of compliance |
| Telephone automated systems (20) | High level of compliance | High level of compliance | High level of compliance |
| Meetings (21,22, 22A, 22CH) | High level of compliance | High level of compliance | High level of compliance |
| Public Meetings (26,27,28,29) | Not applicable | Not applicable | Not applicable |
| Displaying written material at public meetings (30) | Not applicable | Not applicable | Not applicable |
| Public Event (31,32,33,34) | Medium to high level of compliance | Medium to high level of compliance. | Medium to high |
| Forms to be completed by individuals (36) | High level of compliance | High level of compliance | High level of compliance |
| Documents available to individuals (37) | High level of compliance | High level of compliance | High level of compliance |
| Documents and Forms (38) | High level of compliance | High level of compliance | High level of compliance |
| Websites (39,40,,41,42,43) | High level of compliance | Medium level of compliance | High level of compliance |
| Apps (used on electronic devices) (44) | High level of compliance | High level of compliance. | High level of compliance |

| | | | |
|---|---|---|---|
| Social media (45,46) | Medium to high level of compliance | Medium level of compliance | High level of compliance |
| Signage in publicly accessible areas (47,48,49) | Medium to high level of compliance | Medium to high level of compliance | Medium to high level of compliance |
| Reception services (50, 52, 53) | Medium level of compliance | Medium level of compliance | High level of compliance |
| Applications and documents for grants (54,55,56) | High level of compliance | High level of compliance | High level of compliance |
| Invitations to Tender (57,58,59) | Low to medium level of compliance | Low to medium level of compliance | Medium level of compliance |
| Promote Welsh language services (60-61) | High level of compliance | High level of compliance | High level of compliance |
| Corporate Identity (62) | High level of compliance | High level of compliance | High level of compliance |
| Public Address Systems (64) | Not applicable | Not applicable | Not applicable |

Over the past three years, we have continued to strengthen compliance with the Welsh Language Standards across our services. Several areas have demonstrated notable improvement:

- **Correspondence** has progressed from a medium level of compliance in 2023/24 and 2024/25 to a medium-to-high level in 2025/26, reflecting targeted efforts to ensure written communication meets Welsh language expectations. This has been achieved by better sign-posting to our SOPs on our intranet.

- **Reception services** have moved from medium compliance in previous years to a high level in 2025/26, demonstrating enhanced front-line delivery of Welsh language support.

  We have strengthened our reception services by ensuring that all job descriptions and advertisements clearly specify the requirement for Welsh language skills at Level 3 (Foundation Level B1/B2 CEFR). Over the past year, we successfully recruited to vacant posts by promoting opportunities widely, including on NHS Jobs, our own website, social media, and external platforms such as Lleol.net and Swyddi 360. These measures have enhanced our front-line capacity to deliver Welsh language services and contributed to achieving a high level of compliance in reception services.

- **Procurement and Invitations to Tender (Standards 57, 58 and 59):**
  In 2025/26, we delivered a dynamic and innovative initiative to develop and pilot an assessment tool to determine whether Invitation to Tender specifications should include Welsh language requirements.

  This work ensured that the needs of Welsh-speaking patients and public health service users across Wales were fully considered and that tender documentation clearly identified where translation and bilingual provision were

required. In doing so, it directly supported improved access, equity, and service effectiveness in line with the Duty of Quality.

The work contributed to compliance with Welsh Language Standards 57, 58 and 59 by strengthening processes for considering and embedding Welsh language requirements at the procurement stage. It also aligned with the *More Than Just Words Strategic Framework*, particularly its emphasis on integrating Welsh language provision into health and social care services as an essential component of safe, person-centred care.

A key enhancement through this work was the clearer articulation of expectations placed on third-party contractors delivering patient care services, including those providing digital systems, platforms, and interfaces used by staff and the public.

This ensured that Welsh language requirements were explicitly considered not only in direct service delivery, but also in the design, functionality, and usability of systems where patient-facing or staff-facing interaction occurs, thereby strengthening accountability for linguistic accessibility across the full-service pathway.

A key strength of the initiative was the collaborative approach, with consultation sessions undertaken with Heads of Procurement within NWSSP and Welsh Language Leads across all NHS organisations in Wales. This ensured a consistent, system-wide approach to Welsh language considerations in procurement practice.

Furthermore, the project supported the principles of the Duty of Quality by embedding a structured, evidence-based method to improve decision-making, accessibility, and equity of service delivery. It also aligns with the Foundational Economy priorities in Wales by strengthening local public service delivery systems, improving responsiveness to population needs, and ensuring that procurement activity contributes to social value, inclusion, and long-term public benefit.

By combining evidence-driven analysis with practical testing, the project set a new benchmark for accessibility, inclusivity, and linguistic responsiveness in public health procurement across Wales.

We expect to see level of compliance move from low to medium during 2026/27 and 2027/28 and moving to high level of compliance for 2028/29.

- **Social media platforms** have risen from medium compliance in 2024/25 to a high level of compliance in 2025/26, reflecting more consistent use of Welsh in digital engagement.

- **Websites** have returned to a high level of compliance after a temporary dip in 2024/25, following updates to digital content and accessibility and a full audit of our website.

Other areas, including telephone automated systems, forms, documents, apps, and corporate identity, have maintained consistently high levels of compliance, reinforcing our ongoing commitment to delivering high-quality Welsh language services.

Some areas, such as public meetings and public address systems, remain not applicable, while core contact centres and direct telephone lines continue to maintain medium levels of compliance, highlighting opportunities for further focus in the coming years.

We are currently undertaking a programme of work to review all job descriptions, which will support the implementation of an assessment tool to determine whether posts require Welsh Essential or Welsh Desirable skills. As this work progresses, and as posts become vacant or new roles are created, we expect to strengthen compliance, moving from medium/high to consistently high levels.

In addition, we have successfully recruited Welsh speakers to our administrative bank and have begun incorporating references to the CEFR framework within updated job descriptions to further standardise language requirements.

Overall, these results reflect steady progress and demonstrate the effectiveness of our cyclical self-assessment and improvement process, which continues to drive higher standards and more accessible Welsh language services across the organisation.

## Policy Making Standards (Standards 69 – 77)

### Policy Making Standards (Standards 69–77)

The Welsh language is consistently considered as part of all local NWSSP policy development and review processes.

Following the seminar hosted by the Welsh Language Commissioner in November 2023, and a subsequent workshop in April 2025, we undertook a review of our existing approach. This led to the development of a more robust Welsh Language Impact Assessment tool, enabling us to assess whether proposed Organisational Protocols or Policy Changes will have a positive, neutral, or negative impact on the Welsh language.
Authors, divisions, and services are encouraged to identify and implement solutions that maintain or enhance positive impacts wherever possible.

We have continued to strengthen this approach throughout the year to ensure that Welsh language considerations are fully embedded in all policy decisions. During 2025/26, we completed 15 Welsh Language Impact Assessments, demonstrating ongoing commitment to consistent and meaningful application of the framework.

| Set of Standards | Level of compliance 2023/24 | Level of compliance 2024/25 | Level of compliance 2025/26 |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Standards 69 to 77 | Low level of compliance | Medium level of compliance | High level of compliance. |

As highlighted in NWSSP's 2024/25 Performance Report, the Concerns & Complaints Policy was reviewed and updated to provide all staff with clear guidance and operating procedures for handling complaints or concerns received in Welsh. Complaints specifically relating to Welsh language services are led by the Head of Welsh Language Services and Compliance, who oversees the investigation, ensures conclusions are reached, and drives actionable recommendations.

The policy is fully accessible to the public and service users via the NWSSP website, with both Welsh and English versions available.

Compared to the expectations outlined in the Welsh Language Commissioner's 2025/26 Line of Enquiry, NWSSP's arrangements demonstrate strong alignment: bilingual guidance is visible online, internal processes are fully integrated to manage Welsh complaints, informal concerns can be captured, and senior oversight is clearly assigned.

Any perceived gaps in the Commissioner's report—such as visibility of a Welsh-specific complaints section or markers—are already addressed in practice, with NWSSP providing clear, accessible information and robust internal procedures.

## Operational Standards (Standards 79 – 114)

Operational Standards were reviewed through our self-assessment process, with the outcomes summarised as follows:

| Set of Standards | Level of compliance 2023/24 | Level of compliance 2024/25 | Level of compliance 2025/26 |
|---|---|---|---|
| Welsh Language Policy – Using Welsh internally (79) | Medium level of compliance | Medium level of compliance | Medium to high level of compliance |
| Contract of Employment (80) | High level of compliance | High level of compliance | High level of compliance |
| Documents relating to employment of employees (81) | High level of compliance | High level of compliance | High level of compliance |
| Policies relating to employment & workplace (82) | High level of compliance | High level of compliance | High level of compliance |
| Complaints made by staff & disciplinary matters (83 – 88) | High level of compliance | High level of compliance | High level of compliance |
| Computer software for spelling and grammar & interfaces (89) | Medium to high level of compliance | Medium to high level of compliance | Medium to high level of compliance |
| Intranet pages (90 – 95) | High level of compliance | High level of compliance | |

| | | | |
|---|---|---|---|
| Assessing Welsh language skills of employees (96) | Medium to high level of compliance | Medium to high level of compliance | High level of compliance |
| Training for staff in key areas (97 & 98) | Medium to high level of compliance | Medium level of compliance | Medium to high level of compliance |
| Opportunities to learn Welsh (99 – 103) | High level of compliance | High level of compliance | High level of compliance |
| Email signatures, wording and Welsh language logo (104) | High level of compliance | High level of compliance | High level of compliance |
| Welsh badges and branding for staff (105) | High level of compliance | High level of compliance | High level of compliance |
| Assessing skills, advertising, recruiting & onboarding (106 – 109) | Medium level of compliance. | Medium level of compliance | Medium to high level of compliance |
| Signage & notices (113) | High level of compliance | High level of compliance | High level of compliance |
| Recorded announcements (114) | Not applicable | Not applicable | Not applicable. |

All intranet pages detailed in our compliance notice are available in Welsh. When a new page is produced and published it is done so in Welsh at the same time as the English version of the page. Any reviews and updates are undertaken in both languages at the same time.

NWSSP's compliance for recording Welsh language skills is currently at 96% a 1% increase since 2023/24. We recognise that we need to find a solution to enable trainees on the SLE programme to be able to access ESR from smart laptops and devices to be able to update their skills on ESR. We will be looking into this further during 2025/26.

We have developed several training modules in Welsh. All statutory and mandatory training on ESR is available in Welsh, these also include dealing with the public and health & safety. The quality of courses is scrutinised and tested to ensure that they are fully operational prior to publication or launch. We encourage open dialogue for constructive feedback to make continuous improvement. Our E-Ateb team supports all NHS Wales staff with queries relating to their employment and training on our Electronic Staff Record (ESR) System, and the support on this helpline is available in Welsh.

In 2024/25, 284 members of staff received induction training, and within that training there is specific information about the Welsh language and their obligations as employees to comply with our Welsh language standards. They are also informed and signposted to where they can find support to deliver our services through the medium of Welsh.

We offer several opportunities to introduce our staff to the Welsh language and culture as specified in Standards 99 to 103. To support this piece of work, a business case was made in the IMTP planning process to be able to recruit a Welsh Language Facilitation Officer which has been successful. This means we will be advertising the role during the first half of 2025/26 with a view to have the vacant post filled by September 2025.

During 2025/26 we will review current training for managers across the organisation and will embed Welsh language awareness into relevant managers' training, rather than create separate modules of training as a stand-alone. The reasoning behind this is that the Welsh language should be embedded into everything that we do, and not something we need to do as an add on.

### Staff Learning Welsh 2025/26

We actively promote and provide Welsh language courses to staff in line with Standards 99, 100, and 101. In 2025/26, 62 staff participated, a decrease from 73 in 2024/25, primarily due to individuals choosing not to continue their learning or leaving the organisation.

A further 16 members of staff at Intermediate Level

| CEFR Learning Level | Number of staff registered on courses |
|---|---|
| Entry Level 1 (A1) | 16 |
| Entry Level 2 (A1) | 12 |
| Foundation Level 1 (A2) | 13 |
| Foundation Level 2 (A2) | 0 |
| Intermediate Level 1 (B1) | 5 |
| Intermediate Level 2 (B1) | 4 |
| Advanced Level 1, 2 and 3 (B2) | 9 |
| Proficiency (C1/C2) | 3 |
| **Total** | **62** |

During Q4 of 2025/26, 16 staff members at Level 3 (Intermediate B1) participated in one-to-one Welsh language sessions over a 10-week period to build confidence. We have invited these participants to share their experiences through case studies and vlogs, aiming to encourage wider uptake of this development opportunity in 2026/27.

## Record Keeping Standards (115 – 117)

### Record Keeping Standards - Complaints and Concerns - Standard 115:

No official complaints or concerns were received via the Welsh Language Commissioner's Office during 2025/26.

However, we received two queries to support the Commissioner to establish the current position on two specific matters:

### Delivering Consent in Welsh: Bank and Agency Workforce Guidance

The Welsh Language Commissioner raised a query following information received from a Health Board which suggested that certain guidance relating to consent for bank and agency workers may have been of national origin.

To clarify the position and ensure accuracy across the system, this prompted a piece of investigative work to establish the provenance of the “Local Induction Checklist for Bank and Agency Workers” and the extent to which it was being referenced or relied upon within wider All Wales practice.

Through engagement with colleagues within the All-Wales Consent Group and wider workforce and organisational development contacts, including discussions facilitated via NHS Wales Shared Services Partnership (NWSSP), it was confirmed that the document in question is not a nationally issued resource. Instead, it is a locally developed tool created within a single Health Board as part of a previous workforce optimisation initiative and had subsequently been referenced more widely in error.

This clarification was shared and discussed with relevant stakeholders, and further dialogue with the Welsh Language Commissioner’s office and All Wales Consent colleagues provided an opportunity to reset the position collaboratively and ensure a shared understanding of the status of the document.

The discussion also highlighted the importance of maintaining clear governance over guidance materials used across NHS Wales, particularly where they relate to consent processes and Welsh language delivery.

As a result of this work, the All-Wales Consent Group has been progressing the development of clearer, system-wide guidance to support consistent practice in relation to consent through the medium of Welsh, particularly for bank and agency workers. The intention is for this guidance to be issued through People and Organisational Development divisions across all Health Boards and Trusts, ensuring it is embedded within induction and onboarding processes.
The guidance will reinforce the importance of offering and recording consent appropriately through the medium of Welsh and will include clear signposting to relevant learning resources via platforms such as Learning@Wales and ESR.

This will ensure that bank and agency staff have straightforward access to training and support materials as part of their core induction requirements.

Overall, this work will help to clarify a misunderstanding at system level, strengthen collaboration between national stakeholders, and support the development of more consistent and accessible guidance for temporary workforce groups across NHS Wales.

### Clarification regarding requests for interviews through the medium of Welsh

The second query was received from the Welsh Language Commissioner in support of an investigation into a complaint regarding a Health Board’s failure to offer a candidate an interview in Welsh, despite this preference being clearly stated at the application stage.

The recruiting manager indicated that the request was not visible following shortlisting; however, this was not accurate.

We were able to confirm that the language preference remained visible within the system by providing supporting screenshots, while ensuring that no personal identifiable information relating to the candidate was disclosed.

### Allegation of advertising a Welsh Essential Role in English only

A concern was raised directly with the Head of Welsh Language Services and Compliance late in Q4 regarding the advertising of the Welsh Language Facilitation Officer post. The individual alleged that the post had been advertised only in English and closed within 24 hours with a single applicant.

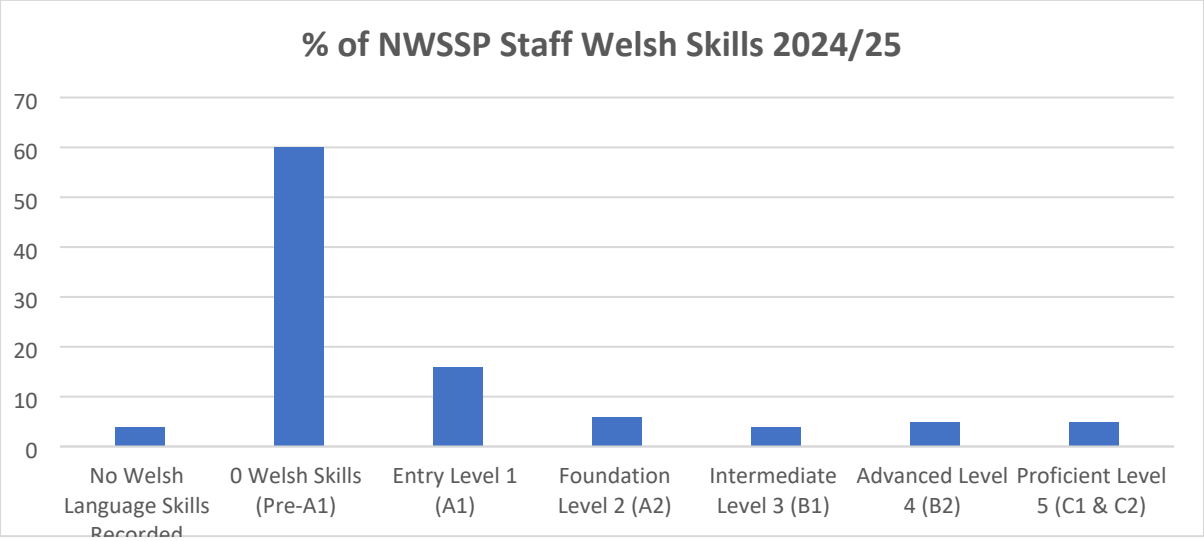
Following a thorough investigation, the allegation was unfounded.

The post was advertised bilingually across multiple platforms, including the NWSSP homepage, NHS Jobs, Health Jobs, Lleol.net, and Swyddi360, for the full period of 1–31 March 2026. A total of 44 applications were received, including 26 applicants with no Welsh language skills.

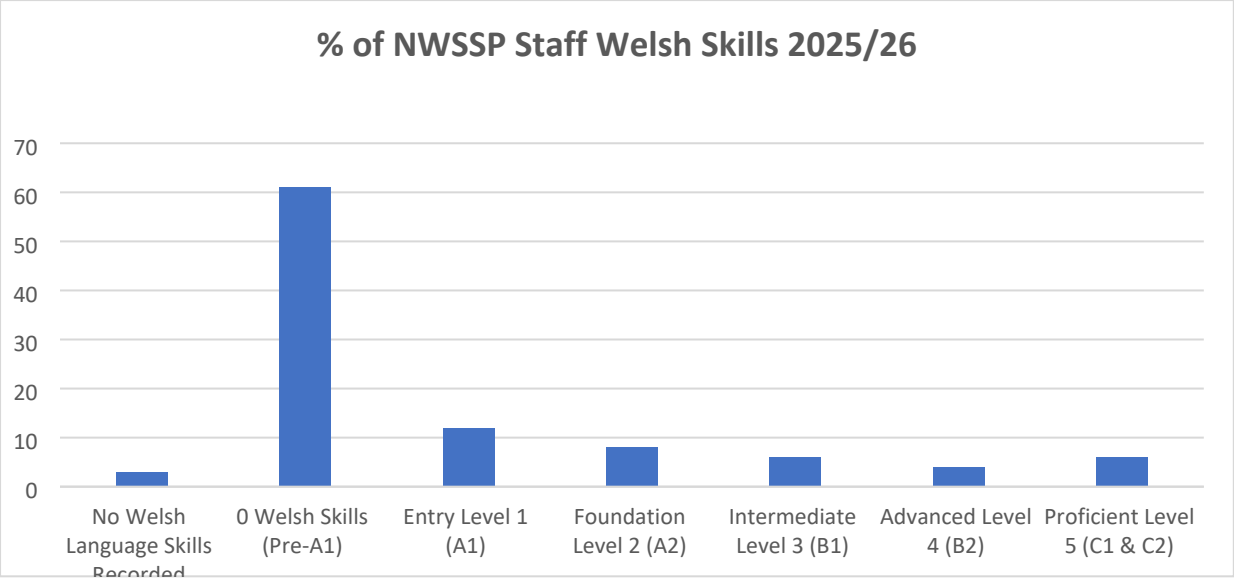
The concern arose from a LinkedIn notification issued in English by the platform's algorithm, and a single "apply" click did not reflect the number of completed applications submitted via the website. The Commissioner's Office was notified, and the matter was closed with no further action required.

### Welsh Language Skills Recording (Standard 116)

All staff are required to record their Welsh language skills within the Electronic Staff Record (ESR). In 2024/25, the proportion of staff who had recorded their skills—across speaking and understanding, and reading and writing in Welsh—was as follows:



During 2025/26 we saw a slight flux in Welsh language skills:




A comparison of 2024/25 and 2025/26 shows a broadly stable profile in Welsh language skills across NWSSP, with some positive movement in capability levels.

The proportion of staff with no Welsh skills (Pre-A1) remains the largest group and has stayed broadly consistent at around 60%. The percentage of staff with no skills recorded has reduced slightly, indicating improved compliance with ESR recording requirements.

At the same time, there has been a shift towards higher proficiency levels. Entry level (A1) has decreased modestly, while Foundation (A2) and Intermediate (B1) levels have both increased, suggesting progression among learners. Proficient (C1/C2) levels have also risen slightly, indicating a strengthening of advanced Welsh language capability within the organisation. Advanced (B2) remains broadly stable.

Overall, the data demonstrates steady improvement in Welsh language capability, with measurable progression beyond entry level and a modest increase in higher-level proficiency. This reflects both improved recording compliance and targeted recruitment, where Welsh language skills are specified as desirable or essential. To strengthen oversight, a Power BI reporting tool has been implemented to enable monthly monitoring of Welsh language skills across the organisation.

Building on this, a robust workplan is in place for 2026/27 to increase Welsh language capability in key operational areas, supported by the appointment of a Welsh Language Facilitation Officer.

### Record Keeping Standards - Advertising vacancies – Standard 117:

| **Total number of vacancies advertised as:** | |
|---|---|
| Welsh language skills are essential | 6 |
| Welsh language skills are desirable | 435 |
| Welsh language skills need to be learnt when appointed to the post | 0 |
| Welsh language skills are not necessary | 0 |

| | |
|---|---|
| Total Number of vacancies advertised 01/04/2022 - 31/03/2023 | 437 |

NHS Wales Shared Services Partnership's Senior Leadership Group agreed in 2020/21 that the baseline requirement for advertising vacancies is that Welsh language skills are specified as "desirable". NWSSP is an inclusive organisation that values and actively promotes Welsh language capability within its workforce.

A clear protocol is in place for advertising vacancies in Welsh, supported by a fully bilingual recruitment process. All job descriptions and person specifications are translated and uploaded via the TRAC recruitment system, which integrates directly with the NHS Jobs portal, ensuring consistent bilingual publication for all vacancies.

To strengthen oversight, a Vacancy Control Panel has been established, comprising the Director of People and OD, Director of Finance & Corporate Services, and Director of Planning and Performance. The Panel ensures Welsh language requirements are appropriately considered for each post, supporting service continuity and alignment with operational need.

During 2024/25, work commenced to develop a structured assessment tool to support recruiting managers in determining whether posts should be advertised as Welsh Essential or Welsh Desirable, including the level of language competency required. The tool also prompts consideration of service user demographics and existing workforce capability data held on ESR. This work has been delivered alongside job description review activity agreed with Welsh Government and was subject to testing and pilot during 2025/26, ahead of full implementation in 2026/27.

As part of early testing, the assessment tool has been applied to roles including reception staff, call handling teams (main telephone and helpline services), and communications functions. This has helped validate the approach and ensure relevance in frontline service areas.

Further development is underway to support a broader NWSSP Welsh Language Strategy, which will focus on increasing organisational capacity to deliver services through the medium of Welsh. The strategy development has been temporarily paused to allow completion of foundational work, including the development of a robust Internal Use of Welsh Language Policy, which will underpin the strategic framework.

Despite delays linked to capacity and resourcing, testing of skills assessment tools has continued throughout 2025/26 to ensure compliance, consistency, and auditability.

The full rollout is planned for 2026/27, supported by a comprehensive communications and training programme for recruiting managers and business partners, and aligned to the Vacancy Control Panel governance structure.  This area of work was also outlined in our IMTP for 2025/26.

### Engagement with Single Lead Employer on Welsh Language Requirements

The Single Lead Employer (SLE) model in Wales primarily applies to postgraduate medical and dental training, including foundation doctors, specialty trainees, General Practice trainees, and dental foundation and specialty trainees. It exists to support rotational training by providing continuity of employment across multiple placements and Health Boards. In this arrangement, employment is managed centrally by NHS Wales Shared Services Partnership, while training design, delivery, and quality assurance are overseen by Health Education and Improvement Wales.

This separation ensures that trainees remain on a single employment contract while progressing through structured, nationally recognised training programmes aligned to UK professional standards set by the relevant Royal Colleges and regulated by bodies such as the General Medical Council and General Dental Council.

Within this system, Health Boards are responsible for delivering the day-to-day clinical environment in which training takes place. They provide clinical supervision, manage rotas and service delivery, and ensure access to appropriate learning opportunities to meet curriculum requirements. They also hold operational responsibility for ensuring compliance with statutory and mandatory training requirements, including those recorded through systems such as the Electronic Staff Record, and are expected to actively monitor, facilitate, and enforce completion of required modules to support patient safety and service readiness. In addition, Health Boards organise local teaching, support workplace-based assessments, and provide first-line management of concerns relating to workload, supervision, wellbeing, or workplace culture.

NWSSP, as the Single Lead Employer, underpins the system by providing the employment framework for trainees, including contracts of employment, HR policy application, payroll, and access to ESR. While operational responsibility for ensuring completion of mandatory training sits primarily with Health Boards, NWSSP retains responsibility where non-compliance escalates into formal employment or contractual matters.

HEIW, meanwhile, does not directly monitor ESR compliance but retains oversight of training progression and quality, with concerns arising from persistent non-compliance addressed through educational supervision or formal assessment processes where appropriate.

Together, these arrangements ensure that responsibility for mandatory training compliance is primarily exercised at service level, supported by employment governance through NWSSP and educational oversight through HEIW, enabling a coordinated approach to safe training delivery across Wales.

In relation to Welsh language development, NWSSP has been working to improve uptake of the Welsh Language Awareness Training Module in line with the *More*

*Than Just Words* strategy and the duty of quality under the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

This has included targeted email communications, simplified access via Microsoft Forms, and signposting through ESR, although completion and response rates remain very low.

Further engagement activity is being developed, including outreach to Welsh-speaking trainees as peer advocates, the creation of a forum of Welsh language champions, and the development of supporting case studies and vlogs. Trainees are also being directed towards Welsh language learning opportunities and resources such as the *Gofalu Trwy'r Gymraeg* app to strengthen awareness and engagement.

However, to achieve sustained improvement, further strategic, cross-organisational discussions across NHS Wales will be required to strengthen engagement with the Welsh Language Awareness Training Module on ESR and to ensure consistent and accurate recording of trainees' Welsh language skills on the system.

### Medicines Homecare Service

The NHS Wales Shared Services Partnership (NWSSP) Medicines Homecare Service continued to operate in alignment with Welsh Government policy requirements during 2025/26, with specific advice provided by the Head of Welsh Language Services and Compliance to ensure appropriate integration of Welsh language considerations within service delivery.

This included strengthening compliance with the principles of the *More Than Just Words* framework and supporting the organisation's responsibilities under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, including the duty of quality. Key considerations included ensuring that patients can access medicines homecare services in their preferred language, that bilingual communication is embedded across patient-facing correspondence and information materials, and that Welsh language standards are reflected in provider arrangements and contractual expectations where applicable.

The service has incorporated this guidance into operational practice, and ongoing advisory support will continue to be provided to ensure sustained compliance, continuous improvement, and equitable access to services for Welsh-speaking patients.

### Procurement Planning Processes - Standards 57, 58, 59

This work delivers a comprehensive assessment tool designed to support procurement and contracting teams across NHS Wales in determining when Welsh language requirements must be embedded into service contracts, invitations to tender, and associated procurement documentation. It has been developed through extensive engagement with 14 NHS organisations across Wales, alongside national and local procurement teams and Welsh language leads.

The intention is to address long-standing inconsistency in how Welsh language obligations are interpreted and applied within procurement processes, and to provide a clear, structured approach that strengthens decision-making and compliance.

The tool responds directly to the statutory context of Welsh language requirements in Wales, where public bodies are expected to comply with Welsh Language Standards set under the Welsh Language (Wales) Measure 2011. In practice, contact managers and procurement teams have often struggled with inconsistent interpretation of when Welsh language service delivery is required, with a tendency to rely on generic references to standards rather than embedding clear, contract-specific requirements. This has resulted in variability in approach, unclear expectations for suppliers, and missed opportunities to ensure meaningful Welsh language provision in commissioned services.

The purpose of the tool is to introduce a standardised and defensible framework that allows procurement professionals and Welsh language leads to establish, at the earliest stage of procurement, whether services, systems, or goods will be delivered to patients, the public, or staff through the medium of Welsh. It ensures that where required, Welsh language specifications are explicitly included within the invitation to tender rather than being deferred to general compliance statements that bidders may not fully understand or be able to interpret consistently.

It also supports better design of procurement documentation by identifying when bilingual ITT documents are required in line with statutory obligations, including compliance with Standard 57. In addition, it enables Welsh language capability to be appropriately considered within evaluation frameworks, ensuring that delivery in Welsh is not treated as an afterthought but as a structured element of contract assessment and award.

The development of the tool has been based on extensive collaboration and iterative refinement. Engagement was undertaken with 14 NHS organisations across Wales, involving procurement managers, contracting leads, and Welsh language specialists.

The resulting tool operates as a structured decision-making framework that guides users through key considerations about service delivery, including whether services involve direct interaction with patients or the public, whether digital or face-to-face communication is involved, and the extent of potential Welsh language need. It also considers linguistic risk, including the likelihood and impact of Welsh language usage within a service, as well as the potential for exclusion if Welsh language provision is not adequately considered. From this, it determines the appropriate contractual response, whether that is no specific requirement, inclusion of Welsh language conditions, development of a bespoke specification, or mandatory bilingual publication of procurement documents.

The tool is designed to be embedded directly into procurement workflows. It can be used at the pre-ITT stage to inform commissioning decisions, during ITT development to shape specifications and contractual requirements, and during

evaluation to support structured assessment of Welsh language capability. It also provides an audit trail for decision-making, supporting governance, consistency, and assurance across organisations.

A key outcome of the tool is its contribution to a clear compliance improvement trajectory across NHS Wales. In the short term, over a period of two years, it is intended to support a shift from low to medium compliance by standardising how Welsh language requirements are assessed and applied. In the medium term, over two to four years, it is expected to support progression to high compliance, with Welsh language considerations becoming embedded as a routine part of procurement design rather than a reactive or interpretive exercise.

The broader value of the work lies in improving consistency across organisations, strengthening supplier understanding of Welsh language expectations, and reducing ambiguity in procurement processes. It enhances governance and audit readiness, improves alignment with statutory requirements, and ultimately supports better service outcomes for Welsh-speaking patients, the public, and NHS staff.

Overall, this work represents a significant shift in how Welsh language considerations are integrated into procurement practice within NHS Wales. It replaces fragmented interpretation with a structured, transparent, and consistent approach that strengthens compliance while also improving the quality and clarity of procurement activity across the system.

**Direct engagement with Welsh speaking communities:**

Targeted engagement with Welsh-speaking communities was delivered throughout 2025/26 as part of a coordinated programme of outreach activity designed to strengthen visibility, understanding, and confidence in the role of NHS Wales Shared Services Partnership within the NHS Wales structure with Welsh-speaking populations.

This included attendance at major cultural events such as the Urdd Eisteddfod and the National Eisteddfod, alongside structured engagement with Cardiff University and Bangor University, as well as targeted sessions with secondary schools and colleges across Wales.

Attendance at the Urdd Eisteddfod and National Eisteddfod provided a highly effective platform for direct engagement with Welsh-speaking audiences in environments where the language is actively used and celebrated. These events enabled meaningful conversations about the importance of Welsh language provision within NHS Wales, while also raising awareness of NWSSP as an employer and its role in supporting service delivery across the health system. The informal, high-footfall nature of these events allowed for accessible, two-way dialogue and helped reinforce the organisation’s commitment to operating bilingually.

Engagement at Cardiff University and Bangor University provided an opportunity to connect with students at a critical stage of career decision-making. These sessions highlighted the importance of Welsh language capability within NHS Wales systems, not only in frontline service delivery but across procurement, commissioning, communications, and corporate functions. They also helped broaden awareness of career pathways within NWSSP and reinforced the message that Welsh language skills are a valued and practical asset in public service roles.

Work with secondary schools and colleges extended this engagement further by introducing younger learners to the relevance of Welsh language in public sector careers at an earlier stage. This helped reinforce the idea that Welsh is a working language with clear professional application, supporting longer-term language confidence and encouraging consideration of future roles within Welsh public services.

Across all settings, a key benefit has been the ability to ground Welsh language policy in real-world context, linking it directly to service delivery, patient experience, and public accountability. This approach has strengthened understanding, improved organisational visibility within Welsh-speaking communities, and supported broader workforce and recruitment objectives by positioning NWSSP as an organisation where Welsh language capability is both valued and actively embedded.

### Audit and Review NWSSP Websites/Social Media

The audit and review of NHS Wales Shared Services Partnership (NWSSP) website and social media content was undertaken during Q1–Q2 2025/26 and led by the Head of Welsh Language Services and Compliance.
This work formed part of a wider programme to strengthen Welsh language assurance across digital communications and ensure that organisational output

aligns consistently with Welsh Language Standards and internal compliance expectations.

The review involved a detailed examination of web pages, social media channels, and associated digital content across all relevant NWSSP service areas. Each item of content was assessed against Welsh language compliance requirements, with particular attention given to bilingual presentation, accuracy of translation, consistency of terminology, and the accessibility of Welsh language content in comparison to English. Consideration was also given to how frequently pages were updated, whether Welsh content was being maintained in parallel with English versions, and whether social media output demonstrated consistent bilingual practice in line with organisational expectations.

Overall compliance was found to be high at 96%, which reflects a strong baseline of Welsh language integration across NWSSP digital platforms. However, the audit identified a small number of non-compliant or partially compliant pages where Welsh language content was either missing, outdated, inconsistently applied, or not fully aligned with required standards. These issues were not widespread but were significant enough to warrant structured follow-up to ensure that compliance expectations were fully met and sustained over time.

Where gaps were identified, relevant divisions were formally contacted and provided with clear feedback outlining the specific issues and required corrective actions. Action plans were agreed with each area to ensure that remedial work was completed in a timely and consistent manner. This process also included clarification of responsibilities for content ownership, particularly in relation to ensuring that Welsh language versions of pages and posts are created and maintained concurrently with English-language updates rather than retrospectively.

The review also highlighted the importance of clearer governance arrangements for ongoing digital content assurance. As a result, and following the appointment of the new Head of Communications and Engagement, responsibility for routine website content auditing and oversight will be formally integrated into the Communications team’s remit. This includes embedding Welsh language considerations within standard communications workflows and ensuring that compliance monitoring is not treated as a standalone exercise but as part of business-as-usual activity.

Ongoing oversight is now supported through the communications group, which brings together representatives from each division. This group provides a structured mechanism for reviewing digital content practices, sharing expectations, and ensuring consistency in how Welsh language requirements are applied across NWSSP communications channels. It also strengthens accountability by ensuring that divisions retain visibility of their responsibilities in relation to bilingual content production and maintenance.

Overall, this work has not only provided a clear compliance snapshot of NWSSP’s digital estate but has also contributed to strengthening governance, embedding

clearer accountability, and improving the long-term sustainability of Welsh language standards within organisational communications practice.

### Research and re-procure a Translation Memory System

Following a 2023/24 feasibility study, a structured pilot was undertaken to assess the most suitable translation memory systems, focusing on functionality, scalability, security, and interoperability. The outcome informed a clear specification, leading to the implementation of a centrally hosted system administered by NWSSP.

The platform is now shared by NHS Wales Shared Services Partnership, Velindre University NHS Trust, Public Health Wales, Welsh Ambulance Service Trust, and Digital Health Care Wales, with Powys Teaching Health Board, Cardiff and Vale Health Board, and Swansea Bay University Health Board successfully onboarded. Hywel Dda trialled the system but did not proceed, while Health Education and Improvement Wales received support from NHS Wales Shared Services Partnership to optimise their separate but equivalent system.

Sharing a single system reduces duplication of translation work by enabling reuse of validated content through a central translation memory. This improves turnaround times, ensures consistency of terminology, and enhances overall quality across organisations.  Notably, organisations that have been part of the system for two years or more are now seeing a reduction in their reliance on external translation services, as previously translated content is readily available for reuse.

This reduction directly translates into cost savings. By avoiding repeat translation of identical or similar content, organisations lower their spend on external suppliers. In addition, a single, once-for-Wales procurement approach removes the need for multiple organisations to run separate procurement exercises, reducing administrative overheads and leveraging collective buying power to secure better value. Over time, this delivers significant system-wide savings while ensuring consistent access to a high-quality solution.

Robust governance underpins the system, with clear protocols for managing personally identifiable, sensitive, and commercially sensitive information. These include role-based access controls, audit trails, secure storage, and defined review and approval workflows to maintain compliance and data integrity.

Comprehensive training is provided for all end users to ensure effective use of the system, supporting consistent standards and maximising efficiency.

Overall, the shared approach delivers cost efficiency, strengthens collaboration, reduces duplication, and supports high-quality, consistent multilingual communication across the NHS Wales organisations using the system.

### “Y Sgwrs / The Conversation” Roadshow

The People and OD team has been engaging directly with colleagues across all areas of the organisation to gather insights on employee experience and

organisational culture. This has included exploring perceptions of what it is like to work here, identifying key strengths, and highlighting opportunities for improvement.

As part of this programme, the Head of Welsh Language Services and Compliance has joined visits to several sites, with a specific focus on the Welsh language. This has included assessing accessibility, understanding of organisational responsibilities, and perspectives on developing a genuinely bilingual workplace. Feedback has been largely positive, alongside constructive insights to support further progress.

The findings from this engagement will directly inform the People and OD Strategy for 2026–2030. This will include a dedicated Welsh language section, aligned with and underpinned by the Welsh Language Policy developed through extensive consultation over the past year, ensuring a coherent and forward-looking approach to embedding bilingualism across the organisation. We visited all our sites to discuss staff priorities.

## Welsh Language Media Training

We commissioned and delivered training for staff in strategic and senior-facing roles within NHS Wales Shared Services Partnership (NWSSP) as part of a broader programme to strengthen organisational capability in responding confidently and appropriately to media engagement through the medium of Welsh.

The focus of this work was to ensure that NWSSP can respond effectively to Welsh language media queries received via key outlets such as BBC Cymru Wales, BBC Radio Cymru, S4C, and other Welsh-medium press and digital platforms.

The training was designed specifically for roles where media engagement is either frequent or likely, particularly where organisational reputation, service delivery, and public accountability may be communicated externally. A key driver for the programme was the recognition that while Welsh language compliance in written communications was well established, confidence and fluency in real-time or reactive Welsh language media situations varied across senior teams. This created a potential risk in terms of responsiveness, consistency of messaging, and the ability to engage naturally and credibly with Welsh-speaking audiences.

The sessions focused on building practical capability rather than linguistic theory, with emphasis placed on handling interview scenarios, responding to unexpected questions, and maintaining clarity and control when communicating under pressure in Welsh. Consideration was also given to how messages are prepared in advance, how key organisational narratives can be translated and delivered effectively in Welsh, and how staff can work with communications teams to ensure accuracy and consistency in bilingual messaging.

A further important element of the training was confidence-building. For some participants, Welsh was a working language but not one they regularly used in high-profile or external-facing contexts. The training therefore supported staff in developing fluency for professional media situations, helping to reduce hesitation and improve the natural flow of communication. This was particularly important in ensuring that Welsh language engagement is not treated as an exception or a secondary channel, but as a normal and confident part of organisational communications practice.

The programme also reinforced internal processes for managing Welsh language media enquiries, ensuring that there are clear escalation routes, defined roles, and appropriate support available when responding to Welsh-medium outlets. This includes strengthening coordination between communications functions and operational leads to ensure that responses are timely, accurate, and fully aligned with organisational position.

Overall, the training has contributed to a stronger organisational capability within NWSSP to engage meaningfully with Welsh language media, improving both responsiveness and confidence at senior levels. It supports a more consistent and credible public presence across Welsh-medium platforms and reinforces the organisation's commitment to operating bilingually in high-profile and externally visible contexts.


## Translation Services through Service Level Agreements:

During the 2025/2026 financial year, NWSSP's Translation Unit continued to play a critical role in supporting NHS Wales organisations to meet their statutory Welsh Language obligations and deliver safe, inclusive and accessible services for patients, service users and staff. This has been achieved while maintaining a strong focus on efficiency and value for money.

The Unit sustained and further strengthened its core translation and proofreading services, ensuring consistent quality, terminology and tone across NHS Wales communications. Timely delivery of Welsh and English translations across clinical, corporate, digital and public-facing materials has enabled organisations to communicate effectively with Welsh-speaking communities and uphold the Welsh Language Standards.

A key area of focus during the year was quality assurance and linguistic consistency. Robust review and proofreading processes were applied to sensitive and high-risk content, including patient information, clinical pathways, consent documentation, job descriptions and policy materials. This work directly supports patient safety, informed decision-making and regulatory compliance.

The Translation Unit also made significant progress in supporting digital transformation across NHS Wales. Close collaboration with digital and communications teams ensured that new and updated systems, platforms and online content were bilingual by design. This proactive approach has reduced the need for retrospective translation and embedded Welsh language considerations earlier in project lifecycles.

Collaborative working relationships with Health Boards, Trusts and national programmes were further strengthened. The Unit provided responsive advice and guidance on Welsh language requirements and best practice, helping to build organisational confidence and capability in delivering effective bilingual communication.

Operational resilience remained a key strength. The team successfully managed peaks in demand, short-notice requests and priority work, while maintaining service levels. Recruitment of an experienced translator and steps to secure additional bank translator capacity have strengthened the Unit's ability to respond to anticipated future demand.

The Unit also continued to drive efficiency through shared services, reducing duplication and making effective use of translation technology, while maintaining the essential contribution of human linguistic expertise.

## Partnership Working

In collaboration with the Head of Welsh Language Services and Compliance, NWSSP's translation managers played a leading role in supporting Health Boards to adopt a centrally procured translation system. This work aligns with the Welsh Government's *More Than Just Words* strategic framework.

Extensive engagement, including regular meetings, demonstrations and mentoring sessions, enabled Powys Teaching Health Board, Swansea Bay University Health

Board and Cardiff and Vale University Health Board to be successfully onboarded ahead of schedule. These organisations are now contributing to and benefiting from a shared translation system.

This pan-Wales approach is expected to deliver significant benefits, including improved consistency and accuracy of technical translations, reduced duplication of effort, and long-term cost savings. It also supports the sharing of best practice across NHS Wales, underpinned by strong partnership working and leadership from NWSSP.

### Powys Teaching Health Board

The Health Board's translation memory was successfully uploaded to the shared system. Since adopting the system in November 2025, the translator has reported clear benefits in terms of efficiency, with measurable time and cost savings.

### Swansea Bay University Health Board

Following issues with its previous translation memory software, Swansea Bay was onboarded to the NWSSP system within 24 hours of requesting support. This ensured business continuity, and the system is now embedded in daily use.

### Hywel Dda Teaching Health Board

Accounts were created and engagement sessions were delivered to demonstrate the benefits of the shared system. While discussions were constructive, the Health Board had not committed to joining the system by the end of 2025/2026.

### Cardiff and Vale University Health Board

Cardiff and Vale joined the system in January 2026. NWSSP provided tailored training and successfully integrated their translation memory. Discussions will continue into 2026/2027 regarding a formal service level agreement to provide additional translation support.

### Health Education and Improvement Wales

Engagement took place during the year, including system access for a trial period. However, no formal commitment to adoption has yet been made.

### Public Health Wales

Public Health Wales continues to make extensive use of the translation system through a comprehensive service level agreement. NWSSP works closely with their Welsh language team, delivering large-scale and highly technical translations, often exceeding 15,000 words per project. During peak periods, output reached over 100,000 words per week, requiring a high level of linguistic expertise and quality assurance.

### Digital Health and Care Wales

Digital Health and Care Wales continue to utilise the system fully, supported through an established service level agreement.

### Velindre
Velindre makes full use of the system and benefits from a comprehensive service level agreement. NWSSP also provides additional support during periods of reduced internal capacity, alongside training opportunities.

### WAST
WAST continues to use the system extensively. A major project commenced in March 2026 to translate the NHS 111 symptom checker into Welsh. This work will improve access to appropriate healthcare services by enabling Welsh speakers to navigate care pathways more effectively, supporting better outcomes and more efficient use of NHS resources.

The project has required significant input from multiple members of the Translation Unit and has included additional value through review and refinement of the English source text in collaboration with clinical teams. This has enhanced overall quality and usability.

The work has delivered substantial cost avoidance for WAST, estimated at £20,000–£30,000 for an initial three-month period, with projected savings increasing to £50,000–£60,000 as the project continues.

## Training Offered by NWSSP's Translation Unit During 2025/2026
NWSSP continued to invest in the development of translation capability across NHS Wales. Translation managers delivered tailored one-to-one training sessions and supported staff in achieving professional accreditation, including successful attainment of full membership of the Association of Welsh Translators and Interpreters.
In partnership with the Association, NWSSP also delivered workshops for its own staff, service users and wider NHS Wales translators. As a result, NWSSP continues to play a leading role in coordinating and delivering professional development and mentoring opportunities across the NHS Wales translation community.

## Consistency of Terminology
Maintaining consistency and accuracy of terminology remained a priority. Translation managers and staff provided ongoing guidance to system users on quality assurance expectations and best practice.

During the year, new medical terminology was developed in consultation with clinical and linguistic experts, including the Association, experienced translators, Welsh Government and Canolfan Bedwyr. This ensures that the shared system remains current and reduces the need for independent research, supporting both quality and efficiency.

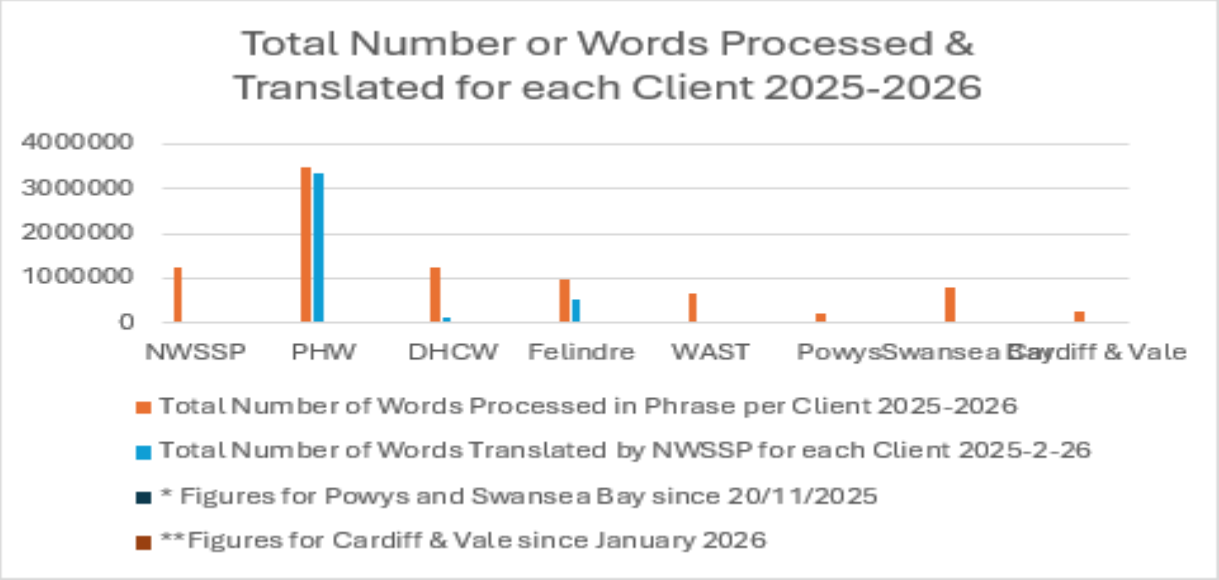
## NWSSP Translation Service Efficiency

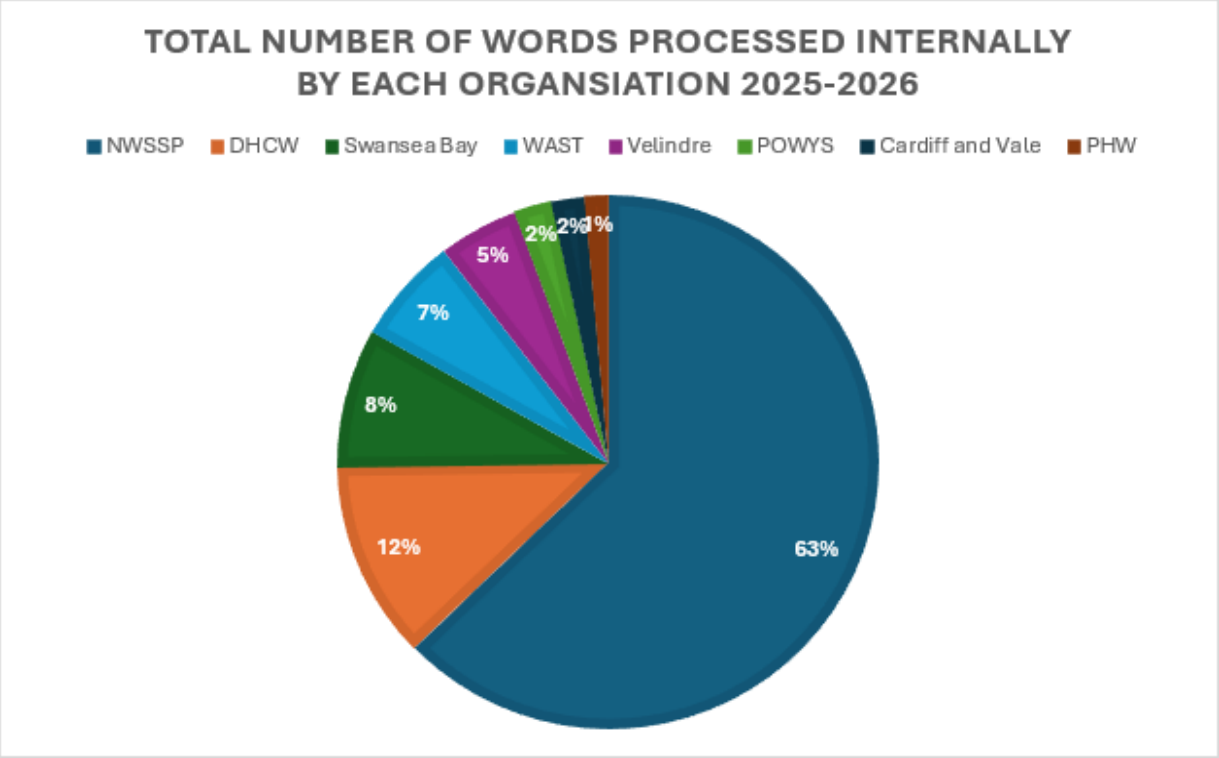
The Translation Unit maintained a high level of service performance, with over 98% of requests delivered on or ahead of agreed deadlines. A significant proportion of work was completed ahead of schedule, often on the same day.
Where delays occurred, these were typically due to issues with source material requiring clarification. This reflects an additional benefit of the service, as translators frequently identify and resolve issues in English texts, improving clarity, safety and usability.

To further enhance efficiency, the Unit developed and shared guidance for service users on best practice when commissioning translation work.

Overall, during the 2025/2026 financial year, the NWSSP Translation Unit consolidated its role as a trusted, specialist service within NHS Wales. It continues to deliver high-quality bilingual content, support statutory compliance, enhance patient safety and experience, and contribute to system-wide efficiency.

Demand for the service continues to grow, reflecting its value and importance across NHS Wales.






## Additional Activity During 2025/26

### Translation of Job Descriptions for Health Boards

A further area of work arose during the year following engagement with the Welsh Language Commissioner's office and Welsh Government officials as part of their routine compliance discussions with NHS organisations regarding Welsh Language Standards and the "More Than Just Words" strategic framework. During these discussions, it was highlighted that several Health Boards were experiencing significant challenges in translating all job descriptions into Welsh and ensuring that both job descriptions and associated vacancy advertisements were consistently published bilingually.

In response to this, both the Commissioner's officers and Welsh Government officials approached NHS Wales Shared Services Partnership (NWSSP) to explore whether there was potential for a coordinated, system-wide approach to supporting this requirement.

This included consideration of whether NWSSP could provide centralised support for translation activity, particularly using existing translation memory systems and the development of standardised or generic job description templates to reduce duplication of effort across Health Boards.

At present, three out of seven Health Boards are utilising NWSSP's translation memory system, which presents an opportunity to expand this model further in 2026/27.
However, initial scoping identified that further preparatory work is required before any full implementation can be progressed. This includes determining whether job descriptions already translated elsewhere across the system can be consolidated and uploaded into a shared translation memory and exploring the feasibility of Health Boards collaborating more formally to reduce duplication and improve consistency.

There is also potential for NWSSP to support the development of a suite of generic job descriptions for translation, which could then be adapted locally. This would need to be aligned with the wider Job Description review programme being undertaken across NHS Wales at the request of Welsh Government, to ensure consistency and avoid duplication of effort.

Due to the timing of the request and competing capacity demands during the reporting period, this work has been paused pending further scoping and will be revisited in 2026/27.

### 111 Symptom Checker Project

The editorial process for the review of the 111 Symptom Checkers has involved a structured and collaborative approach, drawing on the expertise of clinical leads, developers, and specialist language professionals. Initial discussions took place in Q3 of 2025/26 to define scope, standards, and governance, with the work formally commencing in February 2026. From the outset, the focus has been on ensuring that all English-language content is clinically accurate, accessible to users, and aligned with digital and service requirements.

Clinical leads and developers have worked closely to review and validate the underlying medical content, ensuring that symptom pathways, triage logic, and user-facing language are both safe and effective. This has been complemented by a rigorous editorial process, including detailed research, translation where required, and careful proof-reading. Emphasis has been placed on consistency of terminology, tone, and structure across the symptom checkers, ensuring a coherent user experience and reducing the risk of misinterpretation.

Translation and editing have been undertaken in-house by expert linguists with strong backgrounds in clinical and medical terminology. This has enabled a high level of precision and contextual understanding, supporting compliance with duty of quality standards. Consistency checking across multiple pathways and iterations has been a key component, alongside iterative editing cycles to refine clarity, readability, and alignment with clinical intent.

As the programme of work progressed, it became clear that the scale and complexity of the work were greater than initially anticipated. As a result, the editorial, translation, and quality assurance activities will continue into 2026/27. Maintaining this work in-house has not only safeguarded quality but has also delivered significant

efficiencies, allowing for closer collaboration, faster iteration, and better integration with clinical and technical teams ahead of launch.


## Conclusion

In 2025/26, NWSSP has demonstrated sustained progress in embedding the Welsh language across all aspects of its functions, reinforcing its role as a system leader within NHS Wales in delivering accessible, high-quality bilingual services. Performance against the Welsh Language Standards has remained strong, with clear upward trends in several key service delivery areas, including correspondence, reception services, digital platforms, and social media. These improvements reflect the effectiveness of the organisation's cyclical self-assessment approach, targeted interventions, and strengthened governance arrangements.

Significant advancements have also been made in policy making and operational standards, with Welsh language considerations now fully integrated into decision-making processes through the enhanced impact assessment framework and consistent application across the organisation. The achievement of high compliance in Policy Making Standards marks a notable milestone and demonstrates the maturity of NWSSP's approach to embedding bilingualism as a core organisational principle rather than a compliance exercise.

Throughout the year, NWSSP has continued to innovate and lead collaborative, system-wide initiatives. The development of the procurement assessment tool, expansion of the shared translation memory system, and targeted engagement with Welsh-speaking communities all represent significant contributions toward improving consistency, accessibility, and quality of Welsh language provision across NHS

Wales. These initiatives not only strengthen compliance but also deliver tangible benefits in terms of efficiency, cost savings, and service user experience.

The organisation has also maintained a strong focus on workforce development, increasing Welsh language capability through recruitment, training, and structured learning opportunities. While the overall skills profile remains stable, there is clear evidence of progression at intermediate and advanced levels, supported by improved recording, targeted programmes, and the planned introduction of a Welsh Language Facilitation Officer.
Looking ahead, there remain areas for continued focus, particularly in strengthening Welsh language provision within telephone services, further increasing workforce capability, and fully embedding new tools and frameworks such as the procurement assessment model and job description skills assessment tool. These priorities are supported by a clear and structured workplan for 2026/27 and beyond, aligned to organisational strategy and national policy frameworks.

Overall, this report evidences a positive trajectory of continuous improvement, underpinned by strong leadership, effective collaboration, and a clear commitment to delivering equitable, person-centred services through the medium of Welsh. NWSSP is well positioned to build on this progress, further strengthening its contribution to the ambitions of *More Than Just Words* and *Cymraeg 2050*, and ensuring that Welsh language services remain integral to safe, high-quality healthcare across Wales.

## Priorities outlined in our IMTP for 2026/27

Deliver our Internal Use of Welsh Language Policy in line with our People and OD Strategy 2026/2030.

Welsh Language Service Improvement Programme – auditing our telephone services and working with the Customer Excellence programme to evaluate our Welsh language services by sending out surveys to our service users.  Collate data and publish a report to be included in our Welsh language performance report for 2026/27.

Outreach activities with schools and colleges in the vicinity of our offices and locations across Wales.

Support all divisions across NWSSP Business in ensuring service delivery continues to be equitable and accessible through the medium of Welsh.